Perinatal Mental Health Services Referral Form

For URGENT referrals please contact by phone

ANTENATAL *Gestation:*	**POSTNATAL** *Time since delivery:* *Type of Birth:*		
	Breastfeeding?	Yes	No

Consultant Obstetrician:		
GP (name/address):		
Outpatient	Yes	No
Inpatient *Ward:*	Yes	No
Currently attending mental health services? *If yes, please specify where:*	Yes	No
Interpreter Required? *Specify language*:	Yes	No

Patient Name:

DOB:

MRN:

Address:

Patient contact number:

[Official SPMHT stamp here]

Reason for referral (including duration of symptoms, precipitants, if relevant: depression/anxiety screening results):

Any previous history of mental health issues?	Yes	No
If yes, please specify:		
Previously attended mental health services?	Yes	No
If yes, please specify where (i.e. which Day Hospital/Community Mental Health Team):		
Previous inpatient admission?	Yes	No
If yes, please specify where:		
Any family history of severe mental illness? (e.g. postnatal psychosis/bipolar disorder/schizophrenia/severe depression)	Yes	No
If yes, please specify:		
Relevant past obstetric/medical/surgical history:		
Current medication:		
Is patient aware of referral?	Yes	No

Print Name: ______________________________

Bleep/Contact number: ____________________

Date of Referral: __________________________

Important: Referral will not be accepted if incomplete OR if name of referrer is not legible