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| **Tower Hamlets Perinatal Service Referral** **Confidential** |
| **Please email to Perinatal Team** *(**elt-tr.TH-Perinatal@nhs.net**)*  |
| **Personal details** *(please enter details legibly in block capitals)* |
| First Name: Surname: |
| NHS Number: Date of Birth: |
| Address: Post Code: |
|  |
|  |
| Is this address permanent? Yes No |
| Daytime Telephone no: Mobile tel no: |
| Preferred language: Interpreter required? Yes No |
| Ethnicity: |
| **GP details** *(please enter details legibly in block capitals)* |
| Name: |
| Address: Post Code: |
| Telephone Fax: |
| **Referrer details** *(please enter details legibly in block capitals)* |
| Name: |
| Address: Post Code: |
| Telephone Fax: |
| **Reason for referral** *(brief summary of problems)* |
|  |
| Is the patient aware of this referral? Yes No |
| Attitude to referral: *(e.g. what does she want/expect from referral)* |
| Will the patient attend appointment at a psychiatric clinic? Yes No |
| **Psychiatric history** *( √ if yes,* ***no*** *if no,* ***n/k*** *if not known)* |

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| Past history of mental illness |  | Details: |
| Past history of substance misuse |  |  |
| Family history of mental issues |  |  |
| **Previous diagnosis** |  |  |
| Bipolar (manic depression)  |  |  |
| Schizophrenic |  |  |
| Puerperal psychosis |  |  |
| Depression |  |  |
| Post-natal depression |  |  |
| Anxiety disorder |  |  |

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| **Medical History** *( √ if yes,* ***no*** *if no,* ***n/k*** *if not known) Include details of allergies, relevant personal or family medical history.* |

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| Medical problems |  | Details: |
| Currently taking medication  |  |  |
| **Obstetric History** |  |  |
| Obstetrician:  | Next appt: |  |
| Date booked: |  | Named midwife:  |
| EDD: |  | Gravida / parity: | G |  | P |  |
| Attitude to pregnancy / baby: |
| **Potential social stressors** (detail problems in the areas listed, *√ if yes,* ***no*** *if no,* ***n/k*** *if not known* |
| Referral due to stillbirth / late miscarriage/ traumatic birth |  |  |
| Employment  |  | Details: |
| Financial / debts |  |
| Housing / homelessness |  |
| Relationship with partner |  |
| Relationship with family |  |
| Social support (or lack of) |  |
| **Formal Risk Assessment** (detail any evidence of risk in the areas listed, *√ if yes,* ***no*** *if no,* ***n/k*** *if not known* |
| Dangerous / risk to others |  | Details: |
| Risk of self-harm |  |
| Self-neglect |  |
| Vulnerability  |  |
| Child protection concerns |  |
| Has the child been referred to Child and Family Social Services?  | Yes |  | No |  |
| Details including named workers, if yes: |
| Signature of referrer: |  | Date: |  |
| If there is an urgent concern Monday – Friday 9am-5pm, please contact the Perinatal Service Team on 020 8121 5425.*After 5pm and at weekends please contact the Emergency Mental Health Liaison Service on 020 7943 1415*. |