

Lothian Community Perinatal Mental Health Team

 1/2 The Residencies, St John’s Hospital, Howden Road West

Livingston, EH54 6PP

Tel: 01506 523918 (ext 53918)

email: pnmhs@nhs.scot

**Referral to the Community Perinatal Mental Health Team**

Guidance Notes: if there are any questions or concerns related to referral, please:

* Review **Referral Criteria** (see page 5).
* Contact the perinatal **advice line** for professionals, every weekday from **10:00-16:00** on **01506 523 918 (53918).**
* Ensure that the patient has been seen by GP and/or Primary Care regarding this concern. If not, please call for further guidance prior to submitting this referral.

Please complete all sections and email the referral to **pnmhs@nhs.scot**

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| **Level of urgency – select only one box**  |
| [ ]  | **Routine** - We expect to see patient within 28 working days. |
| [ ]  | **Urgent** - We expect to see patient within 5 working days.All URGENT referrals MUST be accompanied by a telephone discussion on the same day of referral (Mon-Friday 10:00 – 16:00). |

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| **Patient details:** | **General Practitioner:** |
| CHI: |  | GP Name: |  |
| Full name: |  | GP Address: |  |
| Preferred name: |  |
| Address: |  |
| Mobile: |  | GP Telephone: |  |
| Landline: |  |  |  |

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| **Referrer details:** |
| Date of referral: | Click or tap to enter a date. | Referrer name: |  |
| Referrer Tel No: |       | Referrer job title: |  |
| Is patient aware of the referral? | Choose an item. | Referrer address: |  |
| Is an interpreter required? | Choose an item. | If yes, which language? |  |

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| **Obstetric history:** |
| Current perinatal status: |       | No. previous pregnancies: | Choose an item. | No. of children: | Choose an item. |
| **Antenatal:** | **Postnatal:** |
| Planned place of birth: |       | Name of baby: |       |
| Estimated Due Date: | Click or tap to enter a date. | Baby’s sex: | Choose an item. |
| Planned feeding method: | Choose an item. | Baby’s date of birth: | Click or tap to enter a date. |
| Tick her for pre-conceptual advice only: **[ ]**  | Current feeding method: | Choose an item. |

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| **Reason for referral:** |
| **Current mental health symptoms** (For example: mood, thoughts of suicide/self-harm, sleep, ADL’s/self-care, psychotic symptoms, any current mental health diagnosis) |
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| **Relevant history including previous mental health symptoms** (previous episodes of illness and treatment currently i.e., in patient care, legal status)  |
|       |
| **Any specific patient needs: access, disability:** |
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| **Psychiatric history:** |
| Is patient open to mental health services? | Choose an item. | If yes, please provide details of team involved. |       |
| Psychiatric diagnosis and history |       |
| Current alcohol or drug use? |       |
| Current medication? |       |

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| **Risks:** |
| **Please consider the Perinatal red flags** |
| Recent significant change in mental state or new symptoms. | New thoughts or acts of violent self-harm.  | New and persistent expressions of incompetence as a birthing parent or estrangement from baby.  | Persistent insomnia. |
| **Additional Perinatal risk factors:** |
| Does the patient have a history of any of the following conditions? Please select as appropriate. | Is there a family history of significant mental health history from close biological relative? Please select as appropriate. |
| Bipolar disorder (Type 1) | Choose an item. | Bipolar disorder (Type 1) | Choose an item. |
| Postpartum Psychosis | Choose an item. | Admission or intensive home treatment for a mental health condition in the perinatal period | Choose an item. |
| Other psychotic disorder | Choose an item. |
| Severe depressive disorder | Choose an item. |
| Schizo-affective disorder | Choose an item. | Relative’s relationship to patient: |       |
| **Risks:** |
| Current risk to self (e.g., thoughts of suicide, self-harm, self-neglect) |       |
| Current risk to others (e.g., thoughts of harming child, children, others) |       |
| Current risk from others |       |
| **Social Work Referral:** |
| If a risk was identified, has there been a social work referral made?  | Choose an item. |
| If yes, what was the date of referral? | Click or tap to enter a date. |
| What was the outcome of this referral? |       |
| Are there any current alerts (inc. child protection, adult support and protection, forensic history)? | Choose an item. |
| If yes, please provide details below: |
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| **Details of professions currently involved (name, location, contact details)** |
| Midwife: |       |
| Health Visitor: |       |
| Obstetrician: |       |
| Social Worker: |       |
| Other: |       |

**Referral Criteria**

* Referrals to the CPMHT are accepted from professionals involved in the care of persons throughout pregnancy and in the 12-months post-delivery where the person has a **moderate to severe mental health disorder** or is at **high risk of serious postpartum illness**.
* Referrals are also considered for persons contemplating pregnancy who have a psychotic disorder or previous postpartum psychosis. (pre-conceptual advice).

NOTE: **sudden changes in mental state in late pregnancy or the early postpartum period should always be taken seriously.**

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| **Pre-pregnancy** |
| Pre-existing bipolar disorder, schizophrenia, schizo-affective, or previous postpartum psychosis. | **Refer to CPMHT.** |

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| **Pregnancy** |
| Pre-existing bipolar disorder, schizophrenia, schizo-affective or previous postpartum psychosis. | **Refer to CPMHT.** |
| Current suicidality, psychosis, severe depression, severe anxiety, severe OCD symptoms or eating disorder. Any other mental health conditions that have been significantly impacted by pregnancy. | **Refer to CPMHT.** |
| Previous inpatient mental health care | **Refer to CPMHT for case note review** |
| Mild to moderate depression or anxiety | **Refer to GP/primary care mental health team** |

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| **Postpartum** |
| Current suicidality, psychosis, severe depression, severe anxiety, severe OCD symptoms or eating disorder. Any other mental health conditions that have been significantly impacted by pregnancy. | **Refer to CPMHT** |
| Mild to moderate depression or anxiety | **Refer to GP/primary care mental health team** |