

Lothian Community Perinatal Mental Health Team

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

Livingston, EH54 6PP

Tel: 01506523918 (53918)

EMAIL: loth.perinatalcommunitymentalhealth@nhs.scot

**Referral to Community Perinatal Mental Health Team**

**If there are any questions or concerns related to referral, please:**

* Review REFERRAL CRITERIA on PAGE 4
* Contact the perinatal **advice line** for professionals, every weekday from 10:00 – 16:00 on 01506523918 (53918).
* Ensure 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:

[loth.perinatalcommunitymentalhealth@nhs.scot](mailto:loth.perinatalcommunitymentalhealth@nhs.scot)

Level of urgency – only select 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 |  | Name |  |
| Full name |  | Address |  |
| Preferred name |  |
| Address |  |
| Mobile |  | Telephone |  |
| Landline |  |  |  |

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| Referrer Details: | | | | | |
| Date of referral |  | Referrer name |  | Referrer job title |  |
| Referrer Telephone number |  | Referrer address |  | | |
| Is patient aware of referral? |  |
| Is an interpreter required? |  | If so, what language? |  | | |

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| Obstetric history: | | | | | | |
| Current perinatal status: |  | Number of previous pregnancies |  | Number of children |  | |
| Antenatal: | | Postnatal: | | | | |
| Maternity Hospital or home birth. |  | Name of baby and gender | |  | | |
| Est delivery date |  | Date baby born | |  | | |
| Intent to breastfeed? |  | Currently breastfeeding? | |  | | |
| Tick here for pre-conceptual advice only: | | | | | |  |

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| Reason for referral: |
| Current mental health symptoms (mood, self harm, suicidal thoughts, sleep, ADL’S, Psychotic symptoms, current 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) |
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| Any specific patient needs: access, disability: |

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| Psychiatric history: | | | |
| Is patient open to mental health services? |  | If yes, please provide details of team involved. |  |
| Psychiatric diagnosis and history |  | Current medication | |
| Current alcohol or drug use |  |

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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. |

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| Additional Perinatal risk factors: | | | |
| Does the patient have a history of …please select yes or no | | Is there a family history of significant mental health history from biological close family member. Details of relative: | |
| Bipolar disorder (Type 1) | YES/NO | Bipolar disorder (Type 1) | YES/NO |
| Postpartum Psychosis | YES/NO | Admission or intensive home treatment for a mental health condition in the perinatal period | YES/NO |
| Other psychotic disorder | YES/NO |
| Severe depressive disorder | YES/NO |
| Schizo-affective disorder | YES/NO |  |  |

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| RISKS: Please complete and give details | |
| Current risk to self (eg thoughts of suicide / self harm, self neglect) |  |
| Current risk to others (eg thoughts of harming child / children/ others) |  |
| Current risk from others |  |
| Details of risk ... | |
| If answered yes to above, has there been a social work referral made?  **Date of referral and outcome**: |  |
| Current alerts (inc child protection, adult support &protection, forensic history) | |

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| Details of professions currently involved (name, location, contact details) | | | |
| Midwife |  | Obstetrician |  |
| Health visitor |  | 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-month 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** |