****

Referral to BaNES, Swindon and Wiltshire Ocean – Birth, Loss and Trauma Service



|  |
| --- |
| **BaNES, Swindon and Wiltshire Ocean – Birth, Loss and Trauma Service Referral Form** |
| **Information for Referrer:** |
| **Routine response time:** We aim to assess referrals within 2 weeks from receipt of referral.**We welcome discussion of referrals and requests for advice first before making referral. Please contact us via our admin team 01249 477399 or email on awp.bswmmhs-referrals@nhs.net.**Please be aware that we are a different service to the Perinatal team. Please contact the Perinatal team on 01249 767851 if you would like to speak to someone from that service.Ocean Service is not a crisis service and does not care co-ordinate. If you are concerned about the risk that this service user poses to themselves or others, or you think they may require crisis support, please liaise with the PCLS teams.If you are concerned for the physical health of this service user, please liaise with the service user’s GP / Primary Care Healthcare ProfessionalPlease ensure you have read the information leaflet, which provides further details on who may be eligible / not eligible for this service.Please ensure you have gained the service user’s consent to:[ ] Make this referral to Ocean Service[ ] For Ocean staff to make contact with the service user[ ] For Ocean staff to liaise with other professionals involved in the service user’s care, e.g. **To send referrals:**awp.bswmmhs-referrals@nhs.net**Please complete all sections. Failure to complete may result in delay in your referral being processed.** **We cannot accept referrals in letter or other forms.****Please note that we cannot provide urgent or emergency services.****Has the service user had any children?**[ ]  Yes, but lost during pregnancy – Please provide additional information ………………………………………………………………………..[ ]  Yes, but died following birth – Please provide date of birth and date of death………………………………………………………………[ ]  Yes, the service user does have childrenNames and Date of birth information ………………………………………………………………………..[ ]  No, the service user has not had any children[ ]  Is referral for the father/partner? Please be aware we can only offer advice and signposting to fathers and partners, not treatment.**Is the service user currently pregnant?**  [ ]  Yes E.D.D: Gestation: / 40 [ ]  No |

|  |
| --- |
| **Referral Details** |
| Referral Date:Referrer Name:Referrer Role:Location:Contact Number:Email Address:Reply to (if different): | Which of the following has the service user experienced? (Primary reason for referral to MMHS) [ ] Traumatic Birth [ ] Birth loss (stillbirth or bereavement after birth) [ ] Miscarriage [ ] Termination of pregnancy [ ] Severe fear of pregnancy (Tokophobia) [ ] Other (please state): |

|  |  |
| --- | --- |
| **Patient Demographics** | **Professionals Involved: (include email/phone number for ease of communication)** |
| Name: | GP:Surgery:Email: |
| D.O.B: |
| NHS No: | Midwife:Base:Email: |
| Ethnicity:  |
| Address:Postcode:  | Health Visitor:Base:Email: |
| Home Tel:Consent to Leave Voicemail? Y / N | Mobile Tel:Consent to send text messages? Y / N |
| Email Address:Consent to send emails (appointments/leaflets etc.) | Any other Children: | Any other professional involved:Base:Email: |
| **Next of Kin**Name:Address:Telephone: | **In case of Emergency**Name:Address:Telephone: |
| Access needs including disability/interpreter services: | Is the patient an ex-member of the British Armed Forces or dependent on such a person? Y / N |
| Reason for referral: |
|  |

|  |
| --- |
| Which interventions has this service user received previously for mental health issues resulting from the above (i.e. IAPT, Counselling, other services/agencies? If no interventions previously, please consider referring to these services in the first instance)**Please provide a brief history of this service user’s psychiatric / mental health history if there is on, including previous and current episodes of mental ill health** (i.e. mental health diagnoses, previous interventions received, medication prescribed etc.)**Please provide a brief summary of your concerns and reason for making this referral** (e.g. service user’s presentation, information they have provided, how you think they could benefit from a referral to the service: psychological therapy / specialist midwifery therapy, advice or support / peer support / links into reproductive health/other)**Risk:** (suicidal thoughts or behaviour, self-neglect, alcohol use)If yes , please give details:**Safeguarding**Any child protection concerns past or present: Yes / No |
| **Current Medication:** |
| **Relevant medical/obstetric history:** ( including past diagnosis, admissions, treatment) |

 **PHQ-9**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Over the last 2 weeks how often have you been bothered by any of the following problems? | Not at all  | Several days  | More than half the days  | Nearly every day  |
| 1 | Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2 | Feeling down, depressed or hopeless | 0 | 1 | 2 | 3 |
| 3 | Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4 | Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5 | Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6 | Feeling bad about yourself or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7 | Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8 | Moving or speaking so slowly that other people have noticed, or the opposite – being so fidgety or restless – that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9 | Thoughts that you would be better off dead or hurting yourself in some way | 0 | 1 | 2 | 3 |
|  |  | Column score: |  |  |  |  |
|  |  | PHQ-9 Total Score |  |  |  |  |

 **GAD-7**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Over the last 2 weeks, how often have you been bothered by any of the following problems?**  | Not at all  | Several days  | More than half the days  | Nearly every day  |
| 1  | Feeling nervous, anxious or on edge  | 0  | 1  | 2  | 3  |
| 2  | Not being able to stop or control worrying  | 0  | 1  | 2  | 3  |
| 3  | Worrying too much about different things  | 0  | 1  | 2  | 3  |
| 4  | Trouble relaxing  | 0  | 1  | 2  | 3  |
| 5  | Being so restless it is hard to sit still  | 0  | 1  | 2  | 3  |
| 6  | Becoming easily annoyed or irritable  | 0  | 1  | 2  | 3  |
| 7 | Feeling afraid as if something awful might happen | 0 | 1 | 2 | 3 |
|  | **Column score:**  |   |   |   |   |
| **GAD-7 total score:**  |   |  |   |  |