**Essex Maternal Mental Health Service**

**By Your Side - Referral Form**

**Please Note** we **are not** a crisis service and **do not** provide weekend cover. If an individual’s safety is of immediate concern or is at risk of serious deterioration please contact emergency services and escalate accordingly.

Before making this referral please be aware;

* By Your Side does not offer care coordination
* If you are concerned about perinatal red flags and/or a individuals’ risk to themselves, others or from others, please contact local Perinatal Mental Health Services (*01245 315637*)
* If the mother and/or birthing parent is physically unwell, please contact their named midwife, health visitor and/or GP
* Consent must be given by the mother and/or birthing parent for this referral and for us to liaise with other professionals to support a seamless experience of care.

If you are unsure about how appropriate the referral is, please review the Eligibility Criteria that can be found on the ‘By Your Side’ webpage on the EPUT website

**Please complete all sections, non-completion will result in the form being returned to referrer and will delay patient assessment**

**Referrer details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** |  | **Profession** |  |
| **Email address** |  | **Contact No.** |  |
| **Referrer Area** |  |
| **Referrer Location** |  |
| **Referrer Team/Practice** |  |

**Patient Demographics**

|  |  |  |  |
| --- | --- | --- | --- |
| **Title** |  | **First Name** |  |
| **Surname** |  | **Date of Birth** |  |
| **NHS No.** |  | **Ethnicity** |  |
| **Religion** |  | **Cultural Heritage** |  |
| **First Language** |  | **Will they require a translator?** |  |
| **If translator required please specify language required** |  |
| **Physical Disability, if yes please detail** |  | **Learning Disability, if yes please detail** |  |
| **Current MH diagnosis** |  | **Are they currently pregnant?** |  |
| **If yes, is this the same pregnancy where the perinatal loss occurred?** |  |
| **What parental title do they prefer?** |  |
| **Current Address** |  |
| **Email Address** |  |
| **Contact No.** |  | **Can we leave a voicemail on this number?** |  |
| **Preferred contact method** |  |
| **Has the patient consented to referral?** |  | **If no, why was referral made?** |  |
| **Sexual Orientation** |  | **Is the individual currently in a romantic relationship?** |  |
| **If yes, is the romantic relationship with the biological father?** |  | **If yes, what is the gender of the partner?** |  |
| **Please detail any immediate safety concerns the team should be aware of** |  |

**Dependent Details**

|  |  |
| --- | --- |
| **Does the individual have other children?** *If yes please specify D.O.B of other children* |  |
| **Are there any other children within the household?** *(e.g step children, grandchildren, nieces/nephews)* |  |
| **Are any of the children subject to Safeguarding or Children & Family Social Services?** *If yes, please provide details* |  |

**Birthing History**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of GP** |  | **GP Contact No.** |  |
| **GP practice address** |  |
| **Name of Health Visitor** |  | **Health Visitor Contact No.** |  |
| **Name of Midwife** |  | **Midwife Contact No.** |  |
| **Birthing Hospital (planned or birthed)** |  |
| **Is the individual known to any MH service?** *If yes, please detail* |  |

**Perinatal Loss Experienced**

|  |  |
| --- | --- |
| **Stillbirth** |  |
| **Early Miscarriage** |  |
| **Recurrent Miscarriage** |  |
| **Neonatal Death** |  |
| **Ectopic pregnancy** |  |
| **Termination of Pregnancy** |  |

|  |  |
| --- | --- |
| **Date of perinatal loss** *(this can be an approximate)* |  |
| **How was the individual’s physical recovery?** *Please provide any relevant health information* |  |
| **Was there a post-mortem investigation?** *If yes, please provide details* |  |

**Loss History**

|  |  |
| --- | --- |
| **In which pregnancy did the loss occur?** *(e.g. first, second, third)* |  |
| **Has the individual experienced a perinatal loss previously?** *If yes, please provide details* |  |
| **How would the individual like us to refer to the loss of their baby?** *(e.g. death, loss)* |  |
| **Did they know the sex of the baby?** *If yes, please specify male or female* |  |
| **Did they name the baby?** |  |
| **Would the individual like us to refer to baby by name?** *If no, please specify how they would like baby referred to* |  |
| **Was the individual able to hold baby?** |  |
| **Was the individual to take photos or any other memory taking?** |  |
| **Were the family given the option of a ceremony or funeral?** |  |

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| **Please provide a brief description of your current concerns with regards to the moderate to severe distress that has prompted this referral. Please include current presentation, including loss history details if necessary and impact on;** **(1) mother and/or birthing parent****(2) partner or significant other** **(3) any other children/dependents** |
|  |
| **Please provide the desired outcome from this referral, including goals and preferences of the individual being referred.** |
|  |
| **Please provide any additional information including any relevant medical history/obstetric history/mental health concerns** |
|  |

**Thank you for your referral, please send this completed referral form to:** **Epunft.byyourside-maternalmentalhealth@nhs.net**

**The receipt of this referral does not imply the referral is accepted. Please ensure the named individual is made aware of this referral.**

**NB: We aim to respond within 2 working days**