**Maternal Mental Health Team Referrals**

**Please read the following before proceeding with your referral:**

* This service provides specialist advice, consultation, interventions, and treatment for women who are *not currently pregnant* presenting with moderate to severe and/or complex mental health difficulties alongside significant psycholological distress specific to reproductive trauma and loss within maternity context*. We accept referrals for women who have experienced reproductive trauma /loss within the previous 12 months.* This includes the following:

3 or more consecutive miscarriages

A miscarriage from 14-24 weeks of pregnancy

Stillbirth

Patients presenting to foetal medicine service’s where the pregnancy will not progress

Ectopic Pregnancy

Medical termination

Neonatal death within the first year following birth

Unsuccessful IVF treatment resulting in severe trauma or distress

Primary tokophobia when woman is not currently pregnant

* Referrals will only be considered 6 weeks post loss as NICE Guidance to allow the natural adjustment period to occur
* This service operates Monday to Friday 9am – 5pm except Bank Holidays.
* Please note that the Maternal Mental Health Service will not accept referrals for women who are experiencing a mental health crisis. These referrals should be made to the locality Single Point of Access Service or Crisis Team
* Please complete all fields of the form as it may not be processed if there is missing information. Only referrals received on this form will be processed and other documentation should only be sent as supplementary to this.
* We encourage referrers to contact the service for discussion prior to making a referral or consultation/advice. **Telephone:** **01482** **688535**
* Once complete, please email to **HNF-TR.maternalmentalhealthservice@nhs.net**

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| --- | --- |
| **Name of person being referred (including title and preferred name)** | **NHS Number** **DOB** |
| **Address of person being referred and, if not at home, current location** | **Home Number****Mobile number****Is it ok to leave a message?** |
| **Ethnicity****Spoken language/ sign language****Interpreter/ sign language user needed?** | **Self-identified gender/ chosen pronouns****Sexual orientation****Marital status** |
| **Employment status****Armed forces Y/ N****Current****Ex** | **Religion****Accomodation status** |
| **Next of kin/ significant other****Name:****Relationship:****Address:****Contact number** | **Is person referred happy for us to contact NOK/ significant other?** |
| **Is the person aware of and consenting to this referral?** Y/ N**Does the patient agree for their referral to be discussed with other relevant professionals to ensure they receive the most appropriate service** Y/N | **Date and Time of referral****Name and contact details of Referrer** |
| **GP:****Address:****Tel:**  | **Names and details of other professionals involved** |
| **Are there preferred days/ times/ means to contact the person?** | **Names and DOB of any children - has parental responsibility?****Any children not in care of person?****Current or previous Children’s Social care involvement** |

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| **Reason for referral**

|  |  |
| --- | --- |
| **Presenting needs** | **Y/N** |
| Reproductive Trauma and/or loss to have occurred within previous 12 months |  |
| 3 or more consecutive miscarriages |  |
| A miscarriage from 14-24 weeks of pregnancy |  |
| Patients presenting to foetal medicine service’s where the pregnancy will not progress |  |
| Ectopic pregnancy |  |
| Medical termination |  |
| Neonatal death within the first year following birth |  |
| Stillbirth |  |
| Unsuccessful IVF treatment resulting in severe trauma or distress |  |
| Primary tokophobia when woman is not currently pregnant |  |

Current presentation/ situation, signs of poor mental health or distress. Any emotional/ mental health treatment being provided? Are there physical health,social/ relationship factors or substance misuse issues contributing to the situation?Concerns relating to risk, nature of risk, who is risk to and from?Does the person being referred/ significant others have a different view of the situation/ risk?**Has a safeguarding referral been considered?**  |
| **Historical mental health involvement/treatment/interventions and risk** |
| **Current or historical obstetric complications/ risks** |
| **Any other physical health complications/ risks, any allergies?** |
| **Prescribed medication (please provide all current medications and any previous medications for mood or psychosis)** |
| **Any other information you feel is important to the referral** |
| **For Maternal Mental Health Team Clinicians-** if referral rejected without triage please ensure rationale is provided to the referrer and documented in notes |

**\*Expand sections as required\***