Our teams are available Monday to Friday, 9am to 5pm (excluding bank holidays).

**REFERRAL FOR SHEFFIELD, ROTHERHAM AND DONCASTER   
PERINATAL MENTAL HEALTH SERVICE**

***Our teams are available Monday to Friday, 9am to 5pm (excluding bank holidays)***

If you have an **emergency** (4 hour assessment) or **urgent** (2 day assessment) referral outside of our operating hours, please contact the relevant

Out of Hours service via the following contact details:  
**Sheffield:** 0114 2716310 **| Rotherham:** 0800 652 9571**| Doncaster:** 01302 566999

**Please fill out all the details and once completed email to the relevant service:**

**Sheffield Service:** [**sct-ctr.sheffieldperinatalmentalhealthservice@nhs.net**](mailto:sct-ctr.sheffieldperinatalmentalhealthservice@nhs.net)

**Rotherham Service:** [**rdash.rotherhamperinatalservice@nhs.net**](mailto:rdash.rotherhamperinatalservice@nhs.net)

**Doncaster Service:** [**doncaster.spa@nhs.net**](mailto:doncaster.spa@nhs.net)

**IF ALL DETAILS ARE NOT COMPLETED IT WILL DELAY THE PROCESS OF REFERRAL**

**Please refer to guidance (last page). To complete the form tab through the boxes.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of referral** |  | | |
| **Name of referrer** |  | **Job title** |  |
| **Name of referring  agency** |  | **Source of  referral** |  |
| **Address** |  | **Email** |  |
| **Tel no** |  | **Fax no** |  |

**Please confirm the reason / required response for referral:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Pre-conception**  **advice** |  | **Emergency assessment**  **(4 hours)** |  |
| **Urgent assessment**  **(2 days)** |  | **Routine assessment**  **(10 working days)** |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patients personal details** | | | | | | | | | |
| **Is the client aware the referral is being made?** | | | | | | Yes / No | | | |
| **Title** |  | **Full name** | |  | | | | | |
| **NHS number** | |  | | | | | | | |
| **D.O.B.** | |  | | | **Age:** | | |  | |
| **Contact address**  **including postcode** | |  | | | | | | | **Text message consent** Yes / No |
| **Home tel no** | |  | | | **Can a message be left?** | | | | Yes / No |
| **Mobile tel no** | |  | | | **Can a message be left?** | | | | Yes / No |
| **Marital status** | |  | | | **Ethnicity** | | |  | |
| **Religious needs** | |  | | | **Main language** | | |  | |
| **Occupation** | |  | | | **Interpreter req’d**  **(state language)** | | | Yes / No | |
| **Any additional needs** | |  | | |
| **D.O.B. of child(ren)** | |  | | | | | | | |
| **If pregnant, state expected date of delivery** | | | | |  | | | | |
| **Hospital planned for delivery** | | | | |  | | | | |
| **Name of Health Visitor** | | |  | | | | **Contact no** | |  |
| **Name of Midwife** | | |  | | | | **Contact no** | |  |
| **Name of Social Worker** | | |  | | | | **Contact no** | |  |
| **GP name & surgery** | | |  | | | | | | |
| **Safeguarding issues** | | | YES / NO | | | | | | |
| **If yes, please provide**  **details** | | |  | | | | | | |

|  |
| --- |
| **Brief description of presenting problem - signs and symptoms:** |
|  |
| **What is the perinatal Issue? Duration or onset of current presentation?** |
|  |
| **Social issues? Who does the patient live with?** |
|  |
| **What support / interventions have been tried to support the current situation?** |
|  |
| **Risk of harm to self or to child including level of risk? Child protection concerns? Domestic abuse? Other known risks?** |
|  |
| **Current medication details?** |
|  |
| **Expectations of the Perinatal MH Service?** |
|  |

**Referral Guidance for Sheffield Rotherham and Doncaster Perinatal Mental Health Service**

Please note our response targets between referral and face to face assessment:

**Routine** = 10 working days. **Urgent** = 2 days. **Emergency** = 4 hours.

Marking a referral as urgent when it is routine will not mean the woman is seen any faster, but it may delay someone who needs seeing urgently from being seen as quickly. Please consider the level of urgency a referral requires.

|  |  |  |
| --- | --- | --- |
| ***Please tick all that apply*** | | |
| **Pre-Conception Advice** | | |
| Current or previous diagnosis of bipolar disorder, schizophrenia, schizoaffective disorder or severe depression/anxiety, previously under the care of a mental health service and planning for pregnancy |  | **Refer to Perinatal Mental Health Service for pre - conception advice (PCA)** |
| **Pregnancy** | | |
| Mild to moderate anxiety or depression |  | Refer to IAPT, Light (charity) and/or GP |
| Family history of bipolar disorder in first degree relative |  | ***Refer to Perinatal Mental Health Service*** |
| Drug or alcohol misuse in absence of primary mental health difficulties |  | Refer to Substance Misuse Services |
| Current self-harming behaviours or thoughts of suicide |  | ***Refer to Perinatal Mental Health Service*** |
| Previously under care of a psychiatrist or secondary mental health team, for treatment of OCD, Eating Disorder, Depression, Anxiety or a Personality Disorder and symptoms have increased in pregnancy |  | ***Refer to Perinatal Mental Health Service*** |
| Previous inpatient mental health care / patients discharged from Mother & Baby Unit |  | ***Refer to Perinatal Mental Health Service*** |
| Severe depression or anxiety where first line interventions in primary care have been attempted and were unsuccessful |  | ***Refer to Perinatal Mental Health Service*** |
| Require specialist prescribing advice for psychiatric medications |  | ***Refer to Perinatal Mental Health Service*** |
| Pre-existing bipolar disorder, schizophrenia, post-partum psychosis or other psychotic illness |  | ***Refer to Perinatal Mental Health Service*** |
| **Postpartum** | | |
| Mild to moderate depression or anxiety |  | Refer to IAPT, Light (charity) and/or GP |
| Severe depression or anxiety where first line interventions in primary care have been attempted and were unsuccessful |  | ***Refer to Perinatal Mental Health Service*** |
| Post-partum psychosis or other psychotic illness |  | ***Refer to Perinatal Mental Health Service*** |
| Breastfeeding mothers who require specialist psychiatric prescribing advice |  | ***Refer to Perinatal Mental Health Service*** |
| Maternal mental health significantly impacting on mother and baby relationship / bonding |  | ***Refer to Perinatal Mental Health Service*** |
| Current self-harming behaviours or thoughts of suicide |  | ***Refer to Perinatal Mental Health Service*** |

*Please note we can only accept referrals for patients who are up to 12 months postnatal and meet at least one of the criteria above. PLEASE TICK or 'fill' box to indicate and send with COMPLETED referral form.*