

**Perinatal MH Referral Criteria**

**Referral to the Perinatal Mental Health Team by colleagues from teams/services outside of SWYPT should either complete the SWYT Perinatal Referral form and return by email/post (addresses and numbers on referral form); or by telephoning the Perinatal Team on 01924 316009 (please be mindful this will take approx. 10-15 mins so you may find it easier to email the referral form).**

**Referral to the SWYPT Perinatal Mental Health Team by colleagues from teams within SWYPT can be made by telephoning the team directly on 01924 316009.**

**The service works with women who are pregnant or have a baby up to the age of 1yr who cannot be effectively managed by Primary care services such as IAPT, GP, Midwives/Health Visitors etc.**

**Please see below for women who we can work with presenting with a perinatal MH problem after the baby’s first birthday up until 2ys old.**

**Please see below for further details about our referral criteria.**

* **Women with existing mental health problems who are wishing to become pregnant and require preconceptual counselling and advice.**
* **Women following discharge from a Mental Health Mother and Baby Unit.**
* **Pregnant or postnatal women suffering from Bipolar illness/postpartum psychosis, other psychoses and serious affective disorder who can be safely managed in the community.**
* **Women who are well but have a diagnosis of Bipolar illness, postpartum psychosis, other psychoses and are pregnant.**
* **Women who are identified in pregnancy as being at risk of postpartum psychosis due to family history – i.e., they have a first degree relative (mother, sister, daughter) who has been diagnosed with postpartum psychosis.**
* **Pregnant or postnatal women with other serious mental health conditions such as moderately severe to severe antenatal/postnatal depression, anxiety, OCD and birth related post traumatic disorders.**
* **If a woman’s primary diagnosis is substance misuse, eating disorder or learning disability or they are 18yrs or under, we would offer specialist advice and joint working, but would expect the appropriate service to take the lead role in the woman’s care and to make the referral to our service.**
* **If there is a clear plan from Children’s Services to remove the baby at birth we would offer specialist advice only as we are only able to work with women who have the care of their child.**

* **We offer input for women who have had a stillbirth and have developed a subsequent mental illness.**

**Our input may include joint working with other services or signposting to appropriate services. Specialist telephone advice can be provided for professionals working with antenatal or postnatal women; we aim to respond within one working day.**

**In line with the NHS Long Term Plan the service also accepts referral for women who present in the 2nd year after childbirth with a mental health illness which commenced in pregnancy or the first 6 months following birth. This may be women who present late to services with a perinatal specific mental illness such as Postnatal Depression, postnatal anxiety disorders, birth related post traumatic disorder and/or parent infant relationship concerns.**

**REFERRAL TO: SOUTH WEST YORKSHIRE NHS FOUNDATION TRUST**



**PERINATAL MENTAL HEALTH SERVICE**

**HAS THIS WOMAN CONSENTED FOR THE FOLLOWING INFORMATION TO**

**BE SHARED WITH THE PERINATAL SERVICE AND FOR THE PERINATAL**

**SERVICE TO MAKE CONTACT?** [ ]  **(PLEASE BE AWARE WE WILL NOT**

**PROCESS THE REFERRAL UNLESS THIS BOX IS TICKED)**

**Date of referral:**

**SECTION 1 – REFERRER (PLEASE COMPLETE DETAILS IN FULL):**

|  |
| --- |
| **Name:**  |
| **Designation:**  |
| **Address:**  |
| **Telephone No:**  |
| **Email address**:  |
| **Do you use SystmOne? (please click)** Yes [ ]  No [ ]  |

**SECTION 2 –PERSON REFERRED DETAILS:**

|  |
| --- |
| **Name (incl title)**:  |
| **Current address (incl postcode):**  |
| **DOB:**  | **NHS No:**  |
| **Ethnicity**:  | **Preferred language**:  |
|  **Email address**:  | **Mobile No:**  |

**NEXT OF KIN/IMPORTANT OTHERS:**

|  |  |
| --- | --- |
| **Name (incl title):**  | **Relation (i.e husband mother etc):**  |
| **Address (incl postcode):**  | **Mobile/landline No:**  |

**SECTION 2 – BABY AND CHILD DETAILS:**

|  |  |
| --- | --- |
| **Baby’s full name**:  | **DOB:** |
| **EDD if pregnant**: |

**SECTION 4 – REASON FOR REFERRAL:**

**Is this a new onset condition arising after 28 weeks pregnancy and before 6 weeks postpartum? (please click)**

Yes [ ]  No [ ]

**Please give a description of the woman’s current mental health/difficulties & any issues around bonding & attachment**:

**Medication:**

**Please give details of any past history of mental health issues**:

**Any Other Current Treatment:**

IAPT [ ]  TPTT [ ] CMHT [ ] Wellbeing [ ] VitaMinds [ ]

**RISK:**

|  |  |
| --- | --- |
| **Any child protection concerns past or present?**  |  Yes [ ]  No [ ]  |

If yes, please give details:

|  |  |
| --- | --- |
| **Current risk to self/others:** | Yes [ ]  No [ ]  |

If yes, please give details:

Thoughts of suicide [ ] **,** deliberate self-harm[ ] , neglect [ ] , thoughts of harming baby or children [ ] , any delusional beliefs involving baby or children or others [ ]

If yes to any of the above, please provide details:

|  |  |
| --- | --- |
| **Any risk of domestic violence, adult safeguarding?** | Yes [ ]  No [ ]  |

If yes, please give details:

|  |  |
| --- | --- |
| **Any current drug or alcohol use?** | Yes [ ]  No [ ]  |

If yes, please give details:

Please send this form and any other information to:

Secure Email: **perinatalteam@swyt.nhs.uk**

**Post: Perinatal Mental Health Team, Fox View, Halifax Road, Dewsbury, WF13 4AD**

**Tel: 01924 316009**

Emergency and out of hours referrals please contact your local Single Point of Access/Crisis Team on:-

Barnsley **01226 645000**

Calderdale & Kirklees **01924 316830**

Wakefield **01924 316900**