**Perinatal Mental Health  
Community Service (PMHCS)**

Eligibility criteria for referrals

* Women over the age of 18 (PMHCS will work jointly with Children and Young Peoples Services (CYPS) if the young person is due to give birth after the age of 18).
* Pregnant women or women up to two years post-partum currently suffering from or with a history of severe mental illness of a degree to warrant referral for prophylactic care and or specialist medication advice (NICE Guidelines CG192).
* Women with a history of psychotic illness or severe mood disorder including bi-polar affective disorder or a postpartum psychosis.
* Women with severe anxiety disorders including Obsessive Compulsive Disorder or panic disorder.
* Women identified in pregnancy as being at high risk of having a relapse of their mental illness.
* Women discharged from a Mother and Baby Unit.
* Women who have an existing moderate to severe mental illness who are wishing to become pregnant and would like preconception counselling and advice.
* Women registered with a GP in Kent or Medway where the baby is expected to be living with the mother after birth (If it is likely an infant may be removed at birth, medication advice can be given by the PMHCS consultant psychiatrists).

**In the event of loss of pregnancy when open to PMHCS the service will continue to support the patient until a more appropriate service becomes available.**

In addition PMHCS will work in collaboration with partners to improve detection and provide early intervention to provide positive outcomes. This may include:

* Supporting primary care with short term early intervention for mothers with mild to moderate perinatal mental health issues.
* Medication advice from the PMHCS Consultant Psychiatrist to services supporting perinatal patients who do not require ongoing intervention from PMHCS.

**PMHCS is available for advice wherever possible but does not accept referrals for:**

* Young people under the age of 18 - Consultation and advice is available to Children and Young Peoples services (CYPS), primary care or maternity services. PMHCS will work jointly with CYPS if the young person is due to give birth after the age of 18.
* Those with a primary diagnosis of substance misuse or learning disability - consultation and advice is available to these services.
* Women who have been assessed not to be capable of independent functioning in caring for their baby in the community even with reasonable support.
* Women whose difficulties are due to primary, social and relationship issues in the absence of mental illness.
* Women solely requiring counselling for miscarriage or still birth who were not open to PMHCS prior to the loss (please see information on the Thrive service for details on support for birth trauma and birth loss).
* Women whose mental health can be managed within primary care (using NICE guidelines) except for early intervention work.

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| **Perinatal Mental Health Community Service (PMHCS)**  Referral form - CONFIDENTIAL | | | | | | | | |  | | |
| **You can contact us via telephone on 01622 722321 or 01227 768928 or you can email us: kmpt.pmhcs@nhs.net** | | | | | | | | | | | |
| **Completed referral forms can be sent via post to PMHCS at Poppy House, 20-22 Oakapple Lane, Maidstone, Kent, ME16 9NW or PMHCS at Eastern and Coastal Area Offices, Littlebourne Road, Canterbury, Kent, CT1 1AZ**  **If the referral is considered urgent (a response within 4 hours) please call 01622 722321**  **please also email the referral so this can be prioritised with the duty clinicians**  **PMHCS criteria as well as further information regarding our service can be found at www.kmpt.nhs.uk/pmhcs** | | | | | | | | | | | |
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| **Details of person being referred:** *(please enter all details legibly in block capitals)* | | | | | | | | | | | |
| **Date referral made:** | | | | | | | | | | | |
| **Surname:** | | | | | | | | | | | |
| **First name:** | | | | | | | | | | | |
| **Date of birth:** | | | | | | | | | | | |
| **NHS number: (if known)** | | | | | | | | | | | |
| **Address:**  **Post code:** | | | | | | | | | | | |
| **Daytime telephone number:** | | | | | | | | | | | |
| **Mobile telephone number:** | | | | | | | | | | | |
| **Does the patient consent to receive text message reminders for appointments prior to initial assessment?**  □ Yes □ No  If yes, please provide the number here………………………………………………………………………. | | | | | | | | | | | |
| **Does the patient consent to receive email correspondence?**  □ Yes □ No  If yes, please provide the email address here…………………………………………………………….. | | | | | | | | | | | |
| **Does the patient consent to taking part in appointments/contact via online video link (Lifesize)?**  □ Yes □ No  ***If this referral is for preconception advice/medication advice we aim where possible to host a virtual appointment. Please therefore provide an email address and consent to Lifesize, as above. If an email address is not provided here, we will send an appointment letter for attendance in person, on site.*** | | | | | | | | | | | |
| **Marital status:** | | | | | | | | | | | |
| **Ethnicity:** | | | | | | | | | | | |
| **Preferred language**: | | | | | | | | | | | |
| **Interpreter required?**  □ Yes □ No | | | | | | | | | | | |
| **Alternative contact:** *(i.e. next of kin / partner / carer / family member)* | | | | | | | | | | | |
| **Name:** | | | | | | | | | | | |
| **Phone number:** | | | | | | | | | | | |
| **Verbal permission to speak to alternative contact**?  □ Yes □ No | | | | | | | | | | | |
| **GP details:** | | | | | | | | | | | |
| **Name:** | | | | | | | | | | | |
| **Address:**  **Post code:** | | | | | | | | | | | |
| **Telephone number:** | | | | | | | | | | | |
| **Referrer details:** | | | | | | | | | | | |
| **Name:** | | | | | | | | | | | |
| **Address:**  **Post code**: | | | | | | | | | | | |
| **Telephone number:** | | | | | | | | | | | |
| **Email address:** | | | | | | | | | | | |
| **Relationship to referred person:** | | | | | | | | | | | |
| **Reason for referral**: (brief summary of problems including why person cannot refer themselves if necessary) | | | | | | | | | | | |
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| **Is the patient aware of this referral?**  □ Yes □ No | | | | | | | | | | | |
| **Obstetric history:** | | | | | | | | | | | |
| **Obstetrician:** | | | | | **Named Midwife:** | | | | | | |
| **EDD:** | | | | | **DOB of baby:** | | | | | | |
| **Gravida:**  *(The number of times the woman is or has been pregnant, regardless of the pregnancy outcome)* | | | | | **Parity:**  *(The number of pregnancies reaching gestational age / live births)* | | | | | | |
| **Psychiatric history**: *(✓ if yes,* ***no*** *if no,* ***n/k*** *if not known)* | | | | | | | | | | | |
| Bipolar disorder | |  | Schizophrenia | | | |  | Schizoaffective disorder | | |  |
| Puerperal Psychosis | |  | Depression | | | |  | Moderate/severe anxiety disorder | | |  |
| Personality disorder | |  | Eating disorder | | | |  | Substance misuse | | |  |
| Family history of severe mental illness | |  | Other (please give details) | | | |  |  | | |  |
| **Details of current and previous episodes:**  (severity and context: e.g. postnatal, treatment resistant, attachment to baby/child, effects on parenting) | | | | | | | | | | | |
| **Children:** | | | | | | | | | | | |
| **First name** | **Surname** | | **Sex** | **DOB** | | **Living where?** | | | | **With who?** | |
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| **Any past or current concerns including Child Protection?**  □ Yes □ No | | | | | | | | | | | |
| **Has a referral been made to Children and Family Social Services?**  □ Yes □ No | | | | | | | | | | | |
| **Medical history:** | | | | | | | | | | | |
| Medical problems: *(please include details of allergies and relevant personal or family medical history)* | | | | | | | | | | | |
| **Social stressors:** *(please detail problems in the areas listed: ✓ if yes,* ***no*** *if no,* ***n/k*** *if not known)* | | | | | | | | | | | |
| Stillbirth / late miscarriage / traumatic birth | | |  | Details: | | | | | | | |
| Employment | | |  |
| Financial/debts | | |  |
| Housing/homelessness | | |  |
| Relationship with partner | | |  |
| Relationship with family | | |  |
| **Formal risk assessment** *(detail any evidence of risk in the areas listed: ✓ if yes,* ***no*** *if no,* ***n/k*** *if not known)* | | | | | | | | | | | |
| Risk of self-harm | | |  | Details: | | | | | | | |
| Self-neglect | | |  |
| Vulnerability e.g. Learning Disability or adolescent | | |  |
| Child protection concerns | | |  |
| Suicidal ideation with intent/plan | | |  |
| Environmental Risks / Risks to Professionals (i.e. neighbourhood disputes, poor lighting, difficult access to property, aggressive animals) | | |  |
| Domestic violence | | |  |
| **Attitude towards pregnancy:** | | | | | | | | | | | |
| **Care Co-ordinator:** | | | | | | | | | | | |
| **Local Responsible Consultant Psychiatrist:** | | | | | | | | | | | |
| **Signature of referrer:** | | | | | | | | | | | |
| **Date:** | | | | | | | | | | | |

**ALL REFERRALS TO BE TRIAGED BY THE DUTY PERINATAL PRACTITIONER**

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| **For office use only - admin** | | |
| **Call taken by:** |  |  |
| **Scanned/uploaded to RiO?**  □ Yes □ No | | |
| **Referral opened?**  □ Yes □ No |  |  |
| **Admin to ensure this is added to the appropriate caseload/spreadsheet** | | |
| **For office use only - clinical** | | |
| **Screened by:** |  |  |
| **Referral screening form completed on RiO?**  □ Yes □ No | | |
| **Urgency:**  □ Emergency □ Urgent □ Routine | | |