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| **Perinatal Mental health Referral form** |

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| **FORWARD TO:** | **Triage for Perinatal Mental Health Team****Phone:** 07 343 8781 Email: mhtriage@lakesdhb.govt.nz or 0800 166 167 for crisis teamFor clinical discussion about referrals outside this please make contact by telephone.  |
| **Client Name:** |  |
| **DOB:** |  |
| **NHI:** |  |
| **Ethnicity:** |  |
| **Address/Phone Number:**  |  |

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| **REFERRER DETAILS** |
| **Date:** |  | **Time:** |  |
| **Referrer’s name:** |  | **Treating consultant:** |  |
| **Phone:** |  | **Extension:** |  | **Pager:** |  |
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| **SITUATION**(Situation contributing to this referral, describe concerns and current reason for referral). |  |
|  | **S** |
| **BACKGROUND**Current state of pregnancy, due or post-partum date &, family/home situation & social issues include impression and details of any medications. Consider: Sleep and feeding pattern. Issues with breast feeding. Crying or colic, nutrition (mother and baby). Family health. Chronic fatigue, mood swings, being unable to cope with baby, negative feelings towards baby. Obstetric history, desire to have children, planned/unplanned pregnancy, expectations of being a mother, changes since pregnancy/baby.  |  |
|  | **B** |
| **ASSESSMENT** Current mental state. Edinburgh Depression Scale result. What is your assessment? Please include if you think there is a severe mental disorder impacting functioning. If you are not sure or mild-moderate, please see referral pathways.  |  |
|  | **A** |
| **RECOMMENDATIONS** (Be specific about exact reason for referral & expected outcome from the assessment, please justify reasons if urgent). |  |
|  | **R** |
| **RESPONSE – MH&AS USE ONLY**(Record intervention/s; include date; response; name & designation after each entry) |  |
|  | **R** |
| **Date seen:** |  | **Time seen:** |  |
| **Assessor:** |  |
|  |  |  |  |  |  |

**MH&AS PERINATAL ADULT ENTRY CRITERIA**

**Eligibility Criteria:**

Is eligible to receive public health services in NZ; or

Accepted for Crisis Assessment related to pregnancy or parenting in the first year of an infant’s life;

**AND**

Is residing within the Rotorua area of Lakes District Health Board

Is pregnant or the primary caregiver of an infant under 12 months of age

**AND**

Would meet the criteria for a severe “Serious Mental illness”

**AND**

The identified needs would not be better served by a more appropriate service provider

If already under the care of secondary mental health services, they remain the primary service and Perinatal Mental Health to offer clinical support and advice to the existing team.

* **Criteria I - Serious Mental Illness**
* **Criteria II - Associated Level of Disability and / or Risk**
* **Criteria III - Specialist Service Required**

Therefore, must include in the referral (SBARR) “the severity and urgency of the mental illness, combined with the degree of disability and / or risk for the individual is such that specialist assessment and intervention is required.”

**Include in Referral Details:**

1. Informed consent provided by client for referral to AMH&AS
2. Presenting problems
3. Client’s full contact details
4. Full medical and psychiatric history
5. Results of comprehensive physical examinations and investigations as appropriate, including baseline metabolic screening (weight, height, girth, BP)

PLEASE NOTE:

**Urgent referrals** – if immediate action is required please do not refer to the Adult Community Mental Health Service. Please contact the Crisis line directly on **0800 166 167**

**Non urgent referrals** - contact the Perinatal Triage team 073437756 or email mhtriage@lakesdhb.govt.nz