**Essex Maternal Mental Health Service**

**By Your Side - Consultation Form**

**Please Note** we **are not** a crisis service and **do not** provide weekend cover. If an individual’s safety is of immediate concern or is at risk of serious deterioration please contact emergency services and escalate accordingly.

**If you would like to send a referral form, please ensure referrals are made at least four weeks after the date of loss to allow the body and mind time to recover, and to enable us to offer support at the right stage in a person’s journey in line with NICE guidelines. We will accept referrals up to one year after the loss.**

Before requesting this consultation please be aware;

* By Your Side does not offer care coordination
* If you are concerned about perinatal red flags and/or a individual’s risk to themselves, others or from others, please contact local Perinatal Mental Health Services (*01245 315637*)
* If the mother and/or birthing parent is physically unwell, please contact their named midwife, health visitor and/or GP

\***Indicates mandatory field**

**Referrer details**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name\*** |  | **Profession\*** |  |
| **Email Address\*** |  | **Contact No.\*** |  |
| **Referrer Area\*** | |  | |
| **Referrer Location\*** | |  | |
| **Referrer Team/Practice\*** | |  | |

**Patient Demographics**

|  |  |  |  |
| --- | --- | --- | --- |
| **Title\*** |  | **First Name\*** |  |
| **Surname\*** |  | **Date of Birth\*** |  |
| **NHS No.\*** |  | **Ethnicity\*** |  |
| **Religion** |  | **Cultural Heritage** |  |
| **First Language\*** |  | **Will they require a translator?** |  |
| **If translator required please specify language required** | |  | |
| **Physical Disability, if yes please detail\*** |  | **Learning Disability, if yes please detail\*** |  |
| **Current MH diagnosis\*** |  | **Are they currently pregnant?\*** |  |
| **If yes, is this the same pregnancy where the perinatal loss occurred?** | |  | |
| **What parental title do they prefer?** | |  | |
| **Current Address\*** | |  | |
| **Email Address\*** | |  | |
| **Contact No.\*** |  | **Can we leave a voicemail on this number?\*** |  |
| **Preferred contact method\*** | |  | |
| **Has the patient consented to referral?\*** |  | **If no, why was referral made?** |  |
| **Gender Orientation\*** |  | **What support systems are currently in place?\***  *Eg. Current relationship, family, friendships* |  |
| **Please share current risk assessment, including historical risk (eg. Self-harm, suicidal ideation etc.) and any current or prior contact with Mental Health services\*** | |  | |

**Dependent Details**

|  |  |
| --- | --- |
| **Does the individual have other children?** *If yes please specify D.O.B of other children*\* |  |
| **Are there any other children within the household?** *(e.g step children, grandchildren, nieces/nephews)*\* |  |
| **Are any of the children subject to Safeguarding or Children & Family Social Services?** *If yes, please provide details*\* |  |

**Perinatal Loss Experienced\***

|  |  |
| --- | --- |
| **Stillbirth (loss after 24 weeks gestation)** |  |
| **Miscarriage (loss before 24 weeks gestation)** |  |
| **Recurrent Miscarriage** |  |
| **Neonatal Death (within 28 days of birth)** |  |
| **Ectopic pregnancy** |  |
| **Termination of Pregnancy due to medical reasons** |  |
| **Termination of Pregnancy** |  |
| **Death of baby(ies) (after 28 days of birth)** |  |

|  |  |
| --- | --- |
| **Date of perinatal loss** *(this can be an approximate)*\* |  |
| **At which stage of pregnancy did the loss occur** (eg. 16+2 weeks)\* |  |
| **Are there any further or ongoing physical health experiences following the loss?** *Please provide any relevant physical health information*\* |  |
| **Was there a post-mortem investigation?** *If yes, please provide details* |  |

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| --- |
| **Please provide a brief description of your current concerns that have prompted this consultation request:\*** |
|  |
| **Please provide the desired outcome from this consultation:\*** |
|  |
| **Please provide any additional information including any relevant medical history/obstetric history/mental health concerns including previous service contact** |
|  |

**Thank you for your consultation request, please send this completed consultation form to:** [**Epunft.byyourside-maternalmentalhealth@nhs.net**](mailto:Epunft.byyourside-maternalmentalhealth@nhs.net)