

**PIMHS Referral Form**

**Together with Baby**

**Cherry Trees, St Peter’s Hospital**

**Spital Road, Maldon, Essex**

**CM9 6EG**

**Tel: 01621 866900   
Email:** [epunft.pimhs.eput@nhs.net](mailto:epunft.pimhs.eput@nhs.net)

**Please note: All items marked \* are Mandatory. We are not able to accept referrals without this information.**

**Please email this form back to us at** [**epunft.pimhs.eput@nhs.net**](mailto:epunft.pimhs.eput@nhs.net)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Details of the Parent/ Caregiver & Infant being referred \*** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Parent(s)**  First name | | \* | | | | | | Surname | | | \* | | | | | | Date of Birth | | | | | | | \* | | |
| **Child**  First name | | \* | | | | | | Surname | | | \* | | | | | | Date of Birth/ Estimated Due Date | | | | | | | \* | | |
| Address | | \* | | | | | | | | | | | | | | | Premature? | | | | | | | \* | | |
|  | | | | | | | | | | | | | | | | | Sex | | | | | | |  | | |
| Postcode | | | | | | \* | | | | | | | | | | |  | | | | | | | | | |
| Parent NHS no:\* | | | | | | \* | | | | | | Child NHS no:\* | | | | | | \* | | | | | | | | |
| **Referrer Details \*** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of Referrer | | | | \* | | | | | | | | | | | Consent obtained from family? Yes 🞎 No 🞎 | | | | | | | | | | | |
| Date of Referral | | | | \* | | | | | | | | | | | Tel no:\* | | | | | | | | | | | |
| Role & Agency | | | | \*  \* | | | | | | | | | | | Email:\* | | | | | | | | | | | |
| Address | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| Best day/ time to contact | | | \* | | | | | | | | | | | | | | | | | | | | | | | |
| **GP & Health Visitor details** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| GP’s Name & Address | | \* | | | | | | | | | | Health Visitor /Midwife  Name & Number | | | | | | | | | | **\*** | | | | |
| Child already attending children’s centre? Yes 🞎 No 🞎 | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Who has legal Parental responsibility? | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Family Composition (i.e other parents / carers / siblings / significant others) \*** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name** | | | | | | | | | **Relationship** | | | | **Occupation** | | | | | | | | | | **Living at home? (Y/N)** | | | **Age or DoB** |
| Parent/ Caregiver | \* | | | | | | | | \* | | | |  | | | | | | | | | | \* | | |  |
| \* | | | | | | | | \* | | | |  | | | | | | | | | | \* | | |  |
| Siblings |  | | | | | | | |  | | | |  | | | | | | | | | | \* | | |  |
|  | | | | | | | |  | | | |  | | | | | | | | | | \* | | |  |
| Others |  | | | | | | | |  | | | |  | | | | | | | | | | \* | | |  |
| **Nationality \*** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Nationality of the family i.e. what country are they from? | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| Main language spoken at home | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| Interpreter required and for whom? Yes 🞎 No 🞎  \* | | | | | | | | | | | | | | Language/ dialect required:  \* | | | | | | | | | | | | |
| Are the Family Asylum seekers? Yes 🞎 No 🞎 | | | | | | | | | | | | | | Do they have Refugee Status? Yes 🞎 No 🞎 | | | | | | | | | | | | |
| **Ethnic Group \*** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Asian or Asian British** | | | | | | **Black or Black British** | | | | | **White** | | | | | | | | | | **Mixed** | | | | **Other Ethnic Group** | |
| Bangladeshi 🞎 | | | | | | Caribbean 🞎 | | | | | British 🞎 | | | | | | | | | | White & Asian 🞎 | | | | Arab 🞎 | |
| Indian 🞎 | | | | | | African 🞎 | | | | | Irish 🞎 | | | | | | | | | | White/ Black African 🞎 | | | | Chinese 🞎 | |
| Pakistani 🞎 | | | | | | Other (please specify) 🞎 | | | | | Other (please specify) 🞎 | | | | | | | | | | White/ Black Caribbean 🞎 | | | |  | |
| **If answered OTHER please specify below:**  **\*** | | | | | | | | | | | | | | | | | | | | | Declined to answer 🞎 | | | | | |
| **Mental Health Services Involvement \*** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Are Adult Mental Health Services involved with the family? Yes 🞎 No 🞎  Team name: | | | | | | | | | | | | | | | | | | | |  | | | | | | |
| Name of Mental Health Keyworker/ Care Co:  \* | | | | | | | | | | | | | | | | Contact telephone/ email:  \* | | | | | | | | | | |
| Previous Mental Health presentation/ condition/ identified risks:  \* | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **\*Is the infant or any other child in the household currently (or have been) subject to a:** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Child in Need Assessment?** Yes 🞎 No 🞎  \* Name of child: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Child Protection Plan?** Yes 🞎 No 🞎  \* Name of child: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Local Authority Care?** Yes 🞎 No 🞎  \* Name of child: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name of allocated Social Worker:**  \* | | | | | | | | | | **Contact telephone/ email:**  \* | | | | | | | | | | | | | | | | |
| **Details of other agencies/ professionals involved** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name | | | | |  | | | | | | Name | | | | | | | |  | | | | | | | |
| Role | | | | |  | | | | | | Role | | | | | | | |  | | | | | | | |
| Agency & Address | | | | |  | | | | | | Agency & Address | | | | | | | |  | | | | | | | |
| Contact No. | | | | |  | | | | | | Contact No. | | | | | | | |  | | | | | | | |
| E-mail | | | | |  | | | | | | E-mail | | | | | | | |  | | | | | | | |
| **Reason for Referral – Please give a brief description of the parent infant concerns (see referral guidance for additional prompts & support completing the form)\*** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Voice of referred parent/ caregiver. What are their concerns for their relationship with the baby?** *(feelings about the relationship, motivation to change, mentalizing the infant’s experience, any history of relational difficulties, etc)*  \*  **Voice of the infant. How is the infant experiencing these difficulties?** *(their behaviour, communication, temperament, bodily functions, development, etc)*  \*  \* Have you seen the infant? 󠄀 Yes 🞎 No 🞎  **Voice of the other parent/ caregiver. How are they experiencing these difficulties?**  \* | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **\*What are the hopes and concerns of the referred parent for this referral?** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| \* | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Any other information to share?** | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |

**Please complete the following checklist:**

|  |  |  |
| --- | --- | --- |
| **Parent-infant relationship risk factors** | | |
| **Parent factors** | **Caregiver one - Name:** | **Caregiver two - Name:** |
| History / current anxiety or depression |  |  |
| History / current alcohol and / or drug misuse |  |  |
| Serious medical condition |  |  |
| Learning Disability |  |  |
| Single teenage parent without family support |  |  |
| Past criminal or young offender’s record |  |  |
| Previous child has been in foster care or adopted |  |  |
| Violence reported in the family |  |  |
| Acute family crisis or recent significant life stress |  |  |
| Ongoing lack of support / isolation |  |  |
| Inadequate income / housing |  |  |
| Previous child has behaviour problems |  |  |
| Parent has experienced loss of a child |  |  |
| Parent experienced episodes of being in care as a child |  |  |
| Current / historical experience of abuse, neglect or loss |  |  |
| Chronic maternal stress during pregnancy or ambivalence about the pregnancy (unplanned or rigorous planning) |  |  |
| Disappointment or unrealistic expectation around the parent-infant relationship |  |  |
| Other (please describe) |  |  |

**Observations**

|  |  |  |
| --- | --- | --- |
| **Factors observed in parent-infant relationship** | **Caregiver 1:** | **Caregiver 2:** |
| Lack of sensitivity to baby’s cries or signals |  |  |
| Negative / ambivalent / indifferent feelings towards baby |  |  |
| Physically punitive / rough towards baby |  |  |
| Lack of vocalisation to baby |  |  |
| Lack of eye-to-eye contact |  |  |
| Infant has poor physical care (e.g. dirty or unkempt) |  |  |
| Does not anticipate or encourage child’s development |  |  |
| Lack of consistency in caregiving |  |  |
| **Infant factors** | **Infant:** |  |
| Developmental delays |  |  |
| Exposure to harmful substances in utero |  |  |
| Traumatic birth |  |  |
| Congenital abnormalities / illness |  |  |
| Very difficult temperament / extreme crying / hard to soothe |  |  |
| Very lethargic / nonresponsive / unusually passive |  |  |
| Low birth weight / prematurity |  |  |
| Resists holding / hypersensitive to touch |  |  |
| Severe sleep difficulties |  |  |
| Failure to thrive / feeding difficulties / malnutrition |  |  |