**Essex Maternal Mental Health Service**

**By Your Side - Referral For**

**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.

**We recommend that referrals are made at least four weeks after the loss to allow the body and mind time to heal, and to enable us to offer support at the right stage in a person’s journey in line with NICE guidelines. Therefore, we will not accept referrals that are made before 4 weeks have passed since the date of loss. We will accept referrals up to one year after the loss.**

Before making this referral please be aware:

* The woman and/or birthing parent has suffered a perinatal loss, at any gestation. A perinatal loss encompasses miscarriage, planned termination, still birth or neonatal death (in the UK this is the death of a live-born baby that occurs within 28 days of birth).
* By Your Side does not offer care coordination
* If you are concerned about perinatal red flags and/or a individuals’ risk to themselves, others or from others, please contact local Perinatal Mental Health Services - *01245 315637* (North Essex)- PMHS 01702 538170 (South Essex ).
* If the mother and/or birthing parent is physically unwell, please contact their named midwife, health visitor and/or GP
* Consent must be given by the mother and/or birthing parent for this referral and for us to liaise with other professionals to support a seamless experience of care.

If you are unsure about how appropriate the referral is, please review the Eligibility Criteria that can be found on the ‘By Your Side’ webpage on the EPUT website or we welcome questions from you about potential referrals.

\***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 an interpreter?** |  |
| **If interpreter 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?** |  |
| **Sexual 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*\* |  |

**Birthing History**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of GP** |  | **GP Contact No.** |  |
| **GP practice address**\* |  |
| **Name of Health Visitor** |  | **Health Visitor Contact No.** |  |
| **Name of Midwife** |  | **Midwife Contact No.** |  |
| **Birthing Hospital (planned or birthed)** |  |
| **Is the individual known to any MH service?** *If yes, please detail*\* |  |

**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** |  |

|  |  |
| --- | --- |
| **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 physical health experiences following the loss?** *Please provide any relevant physical health information*\* |  |
| **Was there a post-mortem investigation?** *If yes, please provide details* |  |

**Loss History**

|  |  |
| --- | --- |
| **In which pregnancy did the loss occur?** *(e.g. first, second, third)*\* |  |
| **Has the individual experienced a perinatal loss previously?** *If yes, please provide details*\* |  |
| **How would the individual like us to refer to the loss of their baby?** *(e.g. death, loss)*\* |  |
| **Did they know the sex of the baby?** *If yes, please specify male or female* |  |
| **Did they name the baby?** |  |
| **Would the individual like us to refer to baby by name?** *If no, please specify how they would like baby referred to* |  |
| **Was the individual able to hold baby?** |  |
| **Was the individual to take photos or any other memory taking?** |  |
| **Were the family given the option of a ceremony or funeral?** |  |

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| **Please provide a brief description of your current concerns with regards to the moderate to severe distress that has prompted this referral. Please include current presentation, including loss history details if necessary and impact on; \*****(1) mother and/or birthing parent****(2) partner or significant other** **(3) any other children/dependents** |
|  |
| **Please provide the desired outcome from this referral, including goals and preferences of the individual being referred. \*** |
|  |
| **Please provide any additional information including any relevant medical history/obstetric history/mental health concerns including previous service contact** |
|  |

**Thank you for your referral, please send this completed referral form to:** **Epunft.byyourside-maternalmentalhealth@nhs.net**

**The receipt of this referral does not imply the referral is accepted. Please ensure the named individual is made aware of this referral.**