HAWKE'S BAY
District Health Board
Whakawāteatia

Fill in only if patient label is unavailable

Name: ..... DoB: .....

NHI: ..... Phone: .....

Address: .....

.....

REFERRAL FOR MATERNAL MENTAL HEALTH SERVICE

Referral to secondary Maternal Mental Health Service

Date of referral: .....

Referral source: □ Community □ GP □ Lead Maternity Carer (LMC) .....

□ Senior Medical Officer (SMO) □ DHB Midwife □ Inpatient ward location: .....

Referrer name: ..... Referrer Contact details: .....

Referrer relationship to person: .....

Key support person (family/friend) Name: .....Phone number: .....

GP name/phone number: .....

Confirmed patient knowledge and agreement for referral:

□ Yes □ No If no, please provide reason: .....

Reason for Referral

□ Assessment and management plan .....□ Other, please state: .....

Screening tool score:

Edinburgh Postnatal Depression Score (EPDS)

Please note intent & plan if answered 1, 2 or 3 of EPDS questionnaire number 10 .....

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Current mental health symptoms:

Please record general description of mental status observations:

Appearance .....

Behaviour/facial expression .....

Speech .....

Mood (scale of 10: 1=not worth living, 10= very happy) .....

Sleep .....

Thought form/content (jumbled/coherent/on track) .....

Perception - Is the woman experiencing any Hallucinations (auditory, visual, taste, touch, smell) illusions, distortion of senses, misinterpretation of true sensations? .....

Effect on current functioning - Is the woman able to carry out her normal day to day tasks, including personal/self-cares etc? .....

Judgment and Insight - Client's knowledge of problem and need for treatment, reasoned, poor or impaired judgment (is she aware of the consequences of not being treated) .....

Bonding with baby/pregnancy .....

Duration of mental health symptoms .....

- What keep woman going (as described by woman) .....
- Risk Concerns .....

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NHI number: _____

Past medical/social history

MATERNITY HISTORY:

Expected Date of Delivery: .....

LMC: .....

GP name: .....

Agencies involved in care: .....

Other Children: .....

Support People: .....

MENTAL HEALTH HISTORY: (please attach Mental Health Service risk alerts, relapse prevention plan and comprehensive assessment if available)

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Practitioners / Agencies involved in care: .....

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SOCIAL HISTORY:

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Alcohol, Tobacco and Drug History: .....

Family Violence History: .....

MEDICAL HISTORY: .....

.....

Medications:

.....

..... Chart attached to referral: ☐ Yes ☐ No

Referral outcome (for completion by MMH Services):

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.....

Referrer informed ☐ Yes ☐ No Date : .....

Name of person contacting referrer:

PERSON COMPLETING THE FORM:

Name:..... Designation:.....

Signature:..... Date:.....

- **For urgent mental health crisis concerns, please contact the Emergency Mental Health Service on 0800 112 334**
- Please fax referral form and copy of completed EPDS tool to: HBDHB internal ext 2277 / external: 06 873 4885