**Referral Form**

**Name: DOB:**

**MRN/NHS No: Mobile number:**

**Address:**

**Preference for consultation:** Face to face / Telephone **Interpreted needed:** Yes / No

**Date of delivery (should be ≥4wks ≤1yr):**

**Known to Perinatal Mental Health team (Y/N):**

**Inclusion Criteria (Referrals from 4 weeks - 1 year after birth)**

**Pregnancy/ birth or postnatal and**

Confused or unclear about experience **OR** 

Disappointed/ upset or feels a sense of failure about experience **OR** 

Feels traumatised by experience 

 (This list is not exhaustive)

**Exclusion Criteria**

* Birth outside Royal London Hospital (needs to contact hospital where birthed)
* Would like to complain (refer to complaints policy)
* Pregnancy loss (refer to bereavement pathway)

Name of referrer: …………………………… Signature………………………

Designation: ………………………………… Date……………….……………

***Referral forms should be emailed to:*** **BHNT.antenataloutpatients@nhs.net**

**For office use only**

Referral screened by**: ……………………………………………..** Date screened: **……………………**

Decision: Request notes and make appointment in 2 months / referral declined **(please circle)**

Case notes ordered by**: ……………………………………………..** Date ordered**: ……………………….**

**Please check notes are available 1 week before appointment**