Maternal Mental Health Service
Grnd fl, bldg 14, Greenlane Hospital
Private Bag 92189, Auckland
Ph: 0-9-623 4671 Ph: Internal 26740
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Email: maternalmh@adhb.govt.nz

REFERRAL FORM

Attention Clinicians: ***If you are unsure about your client's suitability or any other aspect of referral please phone us prior to investing your valuable time in completing this form.***

Acceptance criteria:

1. **Women in 2nd trimester of pregnancy until one year postpartum:**
   - ***who are experiencing*** **an episode of mental illness related to perinatal period**
   - ***or who have had*** **previous severe postpartum depression/psychosis**
   - ***or who are*** **currently clients of CMHCs requiring specialist consultation**
2. **Pre-pregnancy consultation for women with mental illness.**

Referred by	Date:
Name:	Phone:
Position/organisation:	
Client's GP:	GP Phone:

Client Details		
	NHI no:	
Client's first name:	Surname:	
Country of birth:	Date of birth:	Age:
Ethnicity:	EDD:	
If interpreter required - language:		
Occupation:	Lives with:	
Benefit status:	Children:	Ages:
Address:		
Telephone:		

Next of kin
Name:
Address:
Telephone:

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Referral Details
Reason for referral:

History of presenting problems:

Specific symptoms:

Sleep:

Appetite:

Mood:

Edinburgh Postnatal Depression Scale score: ___/30 *(Attach completed EPDS to referral form)*

Self harm ☐ Suicidal ☐ Violent ☐ Homicidal/infanticidal ideation ☐

Energy:

Concentration:

Enjoyment of life:

Psychotic symptoms:

Medical/psychiatric history: (severity/treatment)

Family Violence History:

Current medication:

Substance abuse/use:

Additional Information
Relationships with children:

Breastfeeding: Yes / No Infant's state of health:

Contributing stressors:

Social supports/Agencies involved:

Lab tests - include results:

Client's expectations of service
Is client aware of referral? Yes/No
Client's view of referral: Pleased ☐ Ambivalent ☐ Unaccepting ☐