Aronui Ora – Maternal Mental Health

 Ground Floor, Building 15

 Greenlane Hospital, Private Bag 92189

 Auckland 1142

 DDI: 6234671

 Fax: 6309957

 Freephone: 0800 43 43 44

***ARONUI ORA REFERRAL FORM***

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| --- |
| **Client Name:**  |
| **DOB:** |
| **NHI:** |
| **Address:** |
| **Phone number:** |
| **Baby DOB or EDD:** |
| **GP name & ph/fax number:****Address details:** |
| **Ethnicity:** |
| **Preferred first language? (Interpreter required? Yes/no)** |
| **Marital Status:** |
| **Family circumstances / people in household including DOB/age of other children:** |
| **Referrer Name and designation:****Ph & fax number:****Address details:** |
| **LMC (if different from referrer):****Ph & fax number:****Address details:** |

**Is the client in the second trimester of pregnancy or less than one year post-partum?**

Yes / No (See Inclusion criterion A1)

**Does the client have a current moderate to severe mental health disorder during pregnancy, perinatal or early post-partum period ? Please describe your observations of their symptoms (changes in mood, behaviours, thinking, sleep, mood, appetite, functioning)**

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**Do you have acute safety concerns for mother and/or baby? Yes/No**

Please give details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Does the client have a current post-partum psychosis? Yes /No**

**Has the client had a previous post-partum psychosis? Yes/No**

**Does the client have a diagnosis of bipolar disorder? Yes/No**

**Is the client experiencing any social issues? Yes / No (e.g. poverty, lack of suitable housing)**

If these issues are present please also refer to **Women’s Health Social Worker** and/or other social agencies such as **Family Start.**

Please give details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Ha**ve you completed a family violence screen? Yes / No**

If no screen has been completed, please complete if possible prior to making a referral. If there is Family Violence please also refer to appropriate agencies such as CYFS / SHINE / Womens’ Refuge.

Outcome of screen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is the client having difficulties in her bond / relationship with her baby? Yes / No**

If the client does not have mental health concerns but the primary issue is related to bonding, please consider referral to the Koanga Tupu (Infant Mental Health Team) at the Kari centre or other relevant community agencies which address attachment between parent and child.

Please give details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Does the client abuse alcohol or other substances? Yes / No**

If there is A&D use or it appears to be the primary issue, please also refer to Community Alcohol and Drug Services (CADS), and/or the CADS Pregnancy & Parental service.

Please give details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Does the client report relationship issues with her partner and/or father of the baby?**

**Yes / No**

If these issues are apparent please consider referral to an appropriate community agency for relationship counseling such as Family Court Counselling; Relationship Services, Family Works, Procare Psychology, Home & Family Counselling.

Please give details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has there been previous or current involvement with CYFS? Yes / No**

Please give details of the involvement / name & contact details of any current CYFS worker involved with the family: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What do you and your client hope to achieve from this referral?**

**Signature:**  **Date:**