MIDCENTRAL HEALTH

Name: _____

Address: _____

NHI: _____ DOB: _____ __Male / Female

GP _____ Area: _____

OR PATIENT ID LABEL HERE

PERINATAL MENTAL HEALTH REFERRAL FORM

Client Name: **Client Contact No.:**	**Ethnicity:**
Client Address:	
Next of Kin Details: Name: Contact No.:	**Relationship :**
Support Agencies Involved:	**LMC/Carer:**
Referrers Name:	**Signature:**
Designation:	**Organisation:**
Referrer Contact Details:	**Date:**

BINDING MARGIN – NO WRITING

Obstetric	**Medical**	**Mental Health**
Mother ☐ Perinatal Issues Pregnancy: ☐ Normal ☐ Complications Labour: ☐ Normal ☐ Other ☐ Breast feeding Issues ☐ Significant other ☐ Other children **Infant** Sex of infant: ☐ M ☐ F **Gestation/post birth age:……..** ☐ Health issues	☐ Existing health issues ☐ Medications ☐ Smoking History ☐ Substance Use ☐ Allergies	☐ Mood issues ☐ Anxiety ☐ Sleep issues ☐ Appetite issues ☐ Relationship issues ☐ Life stressors ☐ Poor social supports ☐ Family issues ☐ Financial stress ☐ Parenting issues ☐ Bonding/attachments issues
Where ticked above please expand in 'reason for referral' or provide relevant attachments		

NHI_____

Reason for Referral: (eg issues with mood, anxiety, unusual behaviours, issues with delivery, trauma, unusual speech/thought patterns)

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Risk issues/factors: (e.g. Self harm/suicidal – homicidal ideation/thoughts, plans or intent, medical or obstetric)
(If any high risk mental health concerns please contact duty worker or after hours Mental Health Line 0800 653 357)

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☐ **Edinburgh Post Natal Depression Scale attached**
☐ **Additional Information Attached**

Send referral to:

Perinatal Mental Health Service:
Perinatal Mental Health Service: Phone: Consult/Liaision – 0275740222
Primary Care Email: incomingfaxes@thinkhauora.nz
Acute/Crisis Email: MHEmergencyResponseReferral@midcentraldhb.govt.nz

BINDING MARGIN – NO WRITING

Edinburgh Postnatal Depression Scale (EPDS)

J.L. Cox, J.M. Holden, R. Sagovsky,
Department of Psychiatry, University of Edinburgh

HOW ARE YOU FEELING?

Your Name

_____

Your Address

_____

_____

Your baby's age

_____

As you have recently had a baby, we would like to know how you are feeling. Please UNDERLINE the answer which comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

Here is an example, already completed:
I have felt happy:
Yes, all the time Yes, most of the time
No, not very often No, not at all.

This would mean "I have felt happy most of the time" during the past week. **Please complete the other questions in the same way.**

IN THE PAST 7 DAYS:

1. I have been able to laugh and see the funny side of things:
As much as I always could
Not quite so much now
Definitely not so much now
Not at all.

2. I have looked forward with enjoyment to things:
As much as I ever did
Rather less than I used to
Definitely less than I used to
Hardly at all.

3*. I have blamed myself unnecessarily when things went wrong:
Yes, most of the time Yes, some of the time
Not very often No, never

4. I have been anxious or worried for no good reason:
No, not at all Hardly ever
Yes, sometimes Yes, very often

5*. I have felt scared or panicky for no very good reason:
Yes, quite a lot Yes, sometimes
No, not much No, not at all

6*. Things have been getting on top of me:
Yes, most of the time I haven't been able to cope
Yes, sometimes I haven't been coping as well as usual
No, most of the time I have coped quite well
No, I have been coping as well as ever.

7* I have been so unhappy that I have had difficulty sleeping:
Yes, most of the time Yes, sometimes
Not very often No, not at all

8*. I have felt sad or miserable:
Yes, most of the time Yes, quite often
Not very often No, not at all

9*. I have been so unhappy that I have been crying:
Yes, most of the time Yes, quite often
Only occasionally No, never

10*.The thought of harming myself has occurred to me:
Yes, quite often Sometimes
Hardly ever Never

BINDING MARGIN – NO WRITING

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