RHW PERINATAL MENTAL HEALTH (PNMH) SERVICE

REFERRAL FORM FAX to: (02) 9382 6421

Date of referral: ____________________

Name:______________________________ DOB: ____________ **MRN**: ________________

Address: ____

Contact number: ______________________

Antenatal / Postnatal (circle) **Gestation**: ________ **EDC**: ____________________

Infant age: _________ Infant DOB: _____________ Baby born @ RHW YES/NO (circle)

Referrer details:

Name & Role: _____________________ Phone____________ Email: ____________________

Reason for referral: **Is this a referral for MH home-visiting service? Y/N** (circle)

____

____

Recent EPDS: _____/30 Q10: ______ Date of EPDS: ________

Past mental health history: **Past Contact with RHW psychiatry Clinic? YES/NO (circle)**

____

Current Medications: (& recent changes) **Substance use & Medical history:**

________________________________ _____________________________________

________________________________ _____________________________________

Other key health care providers: **GP details (Name, address, phone):**

_______________________________ _____________________________________

Referral Criteria:-

ANTENATAL: all women birthing at RHW

POSTNATAL: birthed at RHW, less than 12 <u>months postnatal</u> AND living in <u>Northern sector SES LHD</u>

****Women living in St Vincent's catchment, are eligible to attend RHW clinics but not for Outreach.***

Updated March 2017