

**PIMHS Referral Form**

**Together with Baby**

**Cherry Trees, St Peter’s Hospital**

**Spital Road, Maldon, Essex**

**CM9 6EG**

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**Please note: All items marked \* are Mandatory. We are not able to accept referrals without this information**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **\*Details of the Parent & Baby being referred** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Parent’s  First name | | \* | | | | | | | | Surname | | \* | | | | | | | | Date of Birth | | | | | | | | \* | | |
| Child’s  First name | | \* | | | | | | | | Surname | | \* | | | | | | | | Date of Birth/ Estimated Due Date | | | | | | | | \* | | |
| Address | | \* | | | | | | | | | | | | | | | | | | Premature? | | | | | | | | \*Yes 🞎 No 🞎 | | |
|  | | | | | | | | | | | | | | | | | | | | Sex | | | | | | | | Male / Female | | |
| Postcode | | | | \* | | | | | | | | | | | | | | | | (Home No.) | | | | | | | | | | |
| Parent’s Tel No. | | | | (Mobile No.) \* | | | | | | | | | | | | | | | | (Alternate phone No.) | | | | | | | | | | |
| Parent NHS no:\* | | | |  | | | | | | | | | | Child NHS no:\* | | | | | | |  | | | | | | | | | |
| GP’s Name & Address\* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Tel. No. | | \* | | | | | | | | | | | | Health Visitor /Midwife  Name & Number | | | | | | | | | | |  | | | | | |
| Fax/E-mail | |  | | | | | | | | | | | |
| Closest Children’s Centre | | | | | | | | | | | | | | | | | | | | | | | | | Child already attending centre? Yes 🞎 No 🞎 | | | | | |
| Who has legal Parental responsibility? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Family Composition (i.e other parents / carers / siblings / significant others)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name | | | | | | | | | | | Relationship | | | | | | Occupation | | | | | | | | | Living at home? (Y/N) | | | Age or DoB | |
| Parent/ Carers | \* | | | | | | | | | | \* | | | | | |  | | | | | | | | | \* | | |  | |
| \* | | | | | | | | | | \* | | | | | |  | | | | | | | | | \* | | |  | |
| Brothers /  Sisters |  | | | | | | | | | |  | | | | | |  | | | | | | | | | \* | | |  | |
|  | | | | | | | | | |  | | | | | |  | | | | | | | | | \* | | |  | |
| Any others |  | | | | | | | | | |  | | | | | |  | | | | | | | | | \* | | |  | |
| Referrer’s Details \* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of Referrer | | |  | | | | | | | | | | | | | | | | Consent obtained from family? \* Must be Yes 🞎 | | | | | | | | | | | |
| Date of Referral | | |  | | | | | | | | | | | | | | | | Tel no: | | | | | | | | | | | |
| Role & Agency | | |  | | | | | | | | | | | | | | | | Email: | | | | | | | | | | | |
| Address | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Best Day/Time to contact\* | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | |
| Nationality | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| What Nationality is the family i.e. what country are they from? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Main Language spoken at home | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |
| Interpreter required and for whom? | | | | | | | | | | | | | | | | | | Language/dialect required: | | | | | | | | | | | | |
| Are the Family Asylum seekers? | | | | | | | | | Yes 🞎 No 🞎 | | | | | | | | | Do they have Refugee Status? Yes 🞎 No 🞎 | | | | | | | | | | | | |
| **Ethnic Group \*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Asian or Asian British | | | | | | | | Black or Black British | | | | | | | | White | | | | | | | | | | | Mixed | | | |
| Bangladeshi | | | | | | 🞎 | | Caribbean | | | | | 🞎 | | | British | | | | | | | | | 🞎 | | White & Asian | | | 🞎 |
| Indian | | | | | | 🞎 | | African | | | | | 🞎 | | | Irish | | | | | | | | | 🞎 | | White & Black African | | | 🞎 |
| Pakistani | | | | | | 🞎 | | Other (please specify) | | | | | 🞎 | | | Other (please specify) | | | | | | | | | 🞎 | | White & Black Caribbean | | | 🞎 |
| Other Ethnic Group | | | | | | | | **If answered OTHER please specify below:** | | | | | | | | | | | | | | | | | | |  | | | |
| Arab | | | | | | 🞎 | |  | | | | | | | | | | | | | | | | | | | Other Ethnic Group | | | 🞎 |
| Chinese | | | | | | 🞎 | | Refused to answer | | | 🞎 |
| **\*Professional Network** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Are Adult Mental Health Services involved with the family? Yes 🞎 No 🞎 | | | | | | | | | | | | | | | | | | | | | | Team Name | | | | | | | | |
| Name of Mental Health Keyworker | | | | | | | | | | | | | | | | | | | | | | Tel. No. | | | | | | | | |
| Current Mental Health presentation/condition/identified risks | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | |
| Previous Mental Health presentation/condition/identified risks | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | |
| Is a Social Work team involved with the child? Yes 🞎 No 🞎 | | | | | | | | | | | | | | | | | | | | | | Team Name | | | | | | | | |
| Name of allocated Social Worker: | | | | | | | | | | | | | | | | | | | | | | Tel. No. | | | | | | | | |
| **Are there any children living in the household who are currently (or have been) subject to a:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Child in Need Assessment | | | | | | | | | | | | | | | | | | | | | | | Yes 🞎 No 🞎 | | | | | | | |
| Child Protection Plan | | | | | | | | | | | | | | | | | | | | | | | Yes 🞎 No 🞎 | | | | | | | |
| Local Authority Care? | | | | | | | | | | | | | | | | | | | | | | | Yes 🞎 No 🞎 | | | | | | | |
| Name of allocated Social Worker | | | | | | | | | | | | | | | | | | | | | | | Tel. No. | | | | | | | |
| **Details of other agencies / professionals involved** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name | | | | |  | | | | | | | | | | Name | | | | | | | | |  | | | | | | |
| Role | | | | |  | | | | | | | | | | Role | | | | | | | | |  | | | | | | |
| Agency & Address | | | | |  | | | | | | | | | | Agency & Address | | | | | | | | |  | | | | | | |
| Contact No. | | | | |  | | | | | | | | | | Contact No. | | | | | | | | |  | | | | | | |
| Fax/ e-mail | | | | |  | | | | | | | | | | Fax/ e-mail | | | | | | | | |  | | | | | | |
| **\*Reason for Referral – Please give a brief description of concerns, including any observations of the parent-child relationship. Use an extra sheet if necessary.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **\*What would you hope to be the outcome of this referral? Use an extra sheet if necessary** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

**\* Please do not post this form, email us instead at** [epunft.pimhs.eput@nhs.net](mailto:epunft.pimhs.eput@nhs.net)