

**PIMHS Referral Form**

**Together with Baby**

**Cherry Trees, St Peter’s Hospital**

**Spital Road, Maldon, Essex**

**CM9 6EG**

**Tel: 01621 866900
Email:** epunft.pimhs.eput@nhs.net

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

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| **\*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** |
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**\* Please do not post this form, email us instead at** epunft.pimhs.eput@nhs.net