FS304680

Women and Newborn Health Service
King Edward Memorial Hospital

# REFERRAL TO THE WNHS MENTAL HEALTH SERVICE MOTHER AND BABY UNIT

Med Rec. No: ..........
Surname: ..........
Forename: ..........
Gender: .......... D.O.B. ..........

AFFIX LABEL HERE

## Referrer Details

| | |
|---|---|
| Date of Referral: | Time of Referral: |
| Name: | Designation: |
| Referral Agency: | Contact Person: *(if not referrer)* |
| Address: | Mobile: |
| Fax: | Email: |

## Mother's Details

| | |
|---|---|
| Given Name(s): | Family Name: |
| Date of Birth: | Email: |
| Address: | Phone number(s): |
| Homeless / At risk of homelessness? ☐ Yes ☐ No | Country of Birth: |

Preferred Language: ☐ English ☐ Other:

| | |
|---|---|
| Year of arrival: ☐ N/A | Interpreter required? ☐ Yes ☐ No |

Aboriginal or Torres Strait Islander Status: ☐ Yes ☐ No ☐ Unknown

Preferred Pronoun for Mother: ☐ She / her ☐ He / him ☐ They / them ☐ Unknown

Is the mother a current inpatient? ☐ Yes ☐ No Location:

| | | |
|---|---|---|
| Height: | Weight: | BMI: |

Private Health Insurance with hospital admission cover? ☐ Yes ☐ No

Overseas visitor without Medicare? ☐ Yes ☐ No

Mental Health Act Status: ☐ Voluntary ☐ Involuntary

Is client aware of referral? ☐ Yes ☐ No Is client accepting of referral? ☐ Yes ☐ No

## Baby's Details / Expected Due Date

| | |
|---|---|
| First Name: | Last Name: |
| Date of Birth: | Gender: |
| Immunisation Status: | Country of Birth: |

Mode of feeding: ☐ Breast ☐ Formula ☐ Solids ☐ Weaning

Is father of the baby involved in care? ☐ Yes ☐ No ☐ Unknown

| | |
|---|---|
| Father / Co-Parent First Name: | Father / Co-Parent Last Name: |

Address: (if different to mothers)

Mobile:

DO NOT WRITE IN BINDING MARGIN

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Any concerns regarding baby's physical health? (If yes, please state below) ☐ Yes ☐ No

Any concerns regarding baby's mental health? (If yes, please state below) ☐ Yes ☐ No
☐ Inability to calm ☐ Avoiding eye contact ☐ Eating difficulties ☐ Sleeping difficulties
☐ Other:

## Other Children

| First Name | Last Name | Age / DOB | Gender | Who has parental responsibility? | Who will be caregiver during admission? |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Please state name and contact details for who else is actively involved in the children / family's care:
*(e.g. family / friends)*

Please state name and contact details of others who live in the same house:

## Infectious Disease Status

Baby is free of infectious disease symptoms for ≥ 48 hours? ☐ Yes ☐ No

Mother is free of infectious disease symptoms for ≥ 48 hours? ☐ Yes ☐ No

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## Referral Details

**Does the mother have any of the following:** ☐ Advance Health Directive

☐ Nominated Support Person – Name: Mobile:

**Physical health problems / Comorbidities (including perinatal)**
(e.g. thyroid problems, anaemia/low iron, hypertension, pain, gestational diabetes)
☐ Yes ☐ No ☐ Unknown

**Mental Health Assessment**
Has a Mental Health Care Plan or assessment been completed with this client? ☐ Yes ☐ No
If yes, please attach most recent copy

**Reason for Referral to Mother Baby Unit –** ***Note the patient must be suffering from an acute treatable moderate to severe mental health illness***
(Include referrer's rationale for inpatient treatment, onset, duration, triggers, mental state and current social circumstances)

**Relevant mental health history:**

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## Prescribed current medication for mother

| Medication | Dose | Prescribing Doctor & Contact Number |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## Substance Use

| Substance | Current – Amount / Frequency | Past |
|---|---|---|
| Nicotine / Vaping | | |
| Alcohol Use | | |
| Other substances (please list) | | |

Additional comments:
*(Including any dependence on prescription medications including benzodiazepines / opioids etc)*

**Concerns with Parent-Child relationship**

☐ Problems bonding with baby
☐ Lacks confidence with practical baby care
☐ Feeding ☐ Sleeping ☐ Settling ☐ Nappy changes ☐ Bathing ☐ Identifying baby's cues
☐ Other:

**Risk Factors**

☐ At risk of harm to self ☐ At risk of harm to baby ☐ PSOLIS alerts
☐ Criminal offences ☐ At risk of harm to others

**Strengths and protective factors** *(insight, good social support, resilience)*

**Goals of Admission:**

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Please outline your intended care plan until admission *(if accepted for admission)*

## Legal, Court Orders

Custody arrangements: ☐ Formal ☐ Informal ☐ No ☐ Unknown

Are there any Family and Domestic Violence Concerns and/or Violence Restraining Orders in place?

☐ Yes ☐ No ☐ Unknown

Are there current child protection concerns? (If yes, please specify below) ☐ Yes ☐ No ☐ Unknown

Have any child protection notifications been made? ☐ Yes – Date: ☐ No ☐ Unknown

Previous involvement with Child Protection? ☐ Yes ☐ No ☐ Unknown

Please state nature of involvement below:

Child Protection Orders: ☐ Yes ☐ No ☐ Unknown

Name of Child Protection Office:

Address:

Email: Telephone:

## Professional Networks

**Mental Health Service**

Are Adult Mental Health Service involved with the family? ☐ Yes ☐ No ☐ Unknown

Mental Health Service and Team Name:

Community MH Case Manager:

Consultant Psychiatrist: Telephone:

Address:

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## General Practitioner

| GP Name: | |
|---|---|
| GP Clinic: | Telephone: |
| Address: | |

## Other Services – Current or Planned Post-Discharge

| Service | Name | Contact Details |
|---|---|---|
| Child Health | | |
| NDIS | | |
| Family Support Services | | |
| Private Psychologist | | |
| Other: | | |

## Referrer

| Name: | Designation: |
|---|---|
| Signature: | Date: |

**Any Additional Comments:**

To discuss this referral further, please call the Mother and Baby Unit on 6458 1799.
Please email completed form to: WNHS.MHS.MBU@health.wa.gov.au

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