**Perinatal Support Service – Referral Form**

**Areas Covered: Little Horton/Bowling & Barkerend/ Bradford Moor**

|  |
| --- |
| **PLEASE NOTE FAILURE TO SUPPLY ALL THE INFORMATION ASKED FOR WILL RESULT IN YOUR REFERRAL BEING RETURNED.** |

What Is Family Action Perinatal Support Service?

‘Perinatal’ means the time around a baby’s birth. The Perinatal Support Service offers support to families where mum or mum to be is struggling with their emotional health and wellbeing or where they have been diagnosed with a low to moderate level perinatal mental illness (anxiety related disorders or depression). Sometimes a lack of bonding with infant is also an issue. We can work around addressing social isolation which can make mums and pregnant women vulnerable to developing a perinatal mental health issue. If dad is primary carer for an infant and has mental health issues and would like support please state this and speak to us further about his specific needs and situation.

What do we offer?

The service offers volunteer peer support by trained peer mentors who may have lived experiences of perinatal mental health issues. This can involve weekly listening ear/emotional support, help to make changes and/or help to access local services. The service also offers Theraplay groups facilitated by staff trained by the Theraplay Institute which aims to help improve bond between baby and mum. All service users would be offered an assessment to help us work out what is best for each family.

|  |
| --- |
| **Postcode of referred family:****REASON FOR REFERRAL**Maternal mental health [ ]  Are either of the below also evident?Attachment/Bonding issues [ ]  Social Isolation [ ] **WHY HAS THE REFERRAL BEEN MADE?** Professionals: Please provide further information from the ticked boxes above. If possible please attach most recent GAD7/PHQ9 scores and relevant information taken from your most recent assessment: Parent/s/mum to be: please tell us a bit more about your symptoms/struggles here: |
| **Are there any known risks to workers undertaking visits at the family home: Yes: [ ]  No: [ ]** (If yes please provide further details)**Is Domestic Abuse a current or Historical issue? Yes: [ ]  No: [ ]** (If Yes please provide further Information) |

|  |
| --- |
| **FAMILY DETAILS:** |
| **Name of Adult Being Referred: NHS Number: Interpreter Required: Yes** [ ]   **No** [ ]  **Name of Child Being Referred: NHS Number: Please State Language:** |
| **Family Address:** **Postcode:** | **Home Tel No:****Mobile No: Other Contact No:****Email:**  |
| Adult Referred must be over 18 years of age) | **Full Name** | **D.O.B/ E.D.D** (Expected Date of Delivery) | **Gender M/F** | **Relationship in Family** | **School/ Nursery Attended** | **Disability Y/N** (If Y Please State) | **Ethnicity**(\* Please see options table at end) | **Religion**(\* Please see options table at end) | **Sexuality**(\* Please see options table at end) |
| **Adult Referred** |  |  |  |  |  |  |  |  |  |
| **Child Referred** |  |  |  |  |  |  |  |  |  |
| **All Other Household Members** |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |

|  |
| --- |
| **ADDITIONAL INFORMATION & OTHER SERVICE INVOLVEMENT** |
| **Designation:** | **Name:** | **Organisation & Contact Number:** | **Current Involvement:** | **Can They Be Contacted for Further Information?** |
| **G.P** |  |  |  | **YES/NO** |
| **Midwife/Health Visitor**  |  |  |  | **YES/NO** |
| **Social Worker** |  |  |  | **YES/NO** |
| **Other** (Please State) |  |  |  | **YES/NO** |
| **Early Help Plan in Place ?: Yes:** **[ ]**  **No:**  **[ ]** **Child Protection Plan? Yes: [ ]  No: [ ]**  **Looked After Children Plan? Yes: [ ]  No: [ ]**  |

|  |
| --- |
| **REFERRER DETAILS:** |
| **Referrer’s Name:** **Job Title:**  | **Referring Agency:****Date of Referral:** |
| **Referrer’s Address:** **Postcode:** | **Telephone:** **Fax:****Email:** |
| **How did you hear about our service:** Volunteer[ ]  Leaflet [ ]  Better Start [ ]  Health Visitor [ ]  Meeting [ ]  Children Centre [ ]  Other [ ]  **Signature of Referred Person(s): Date:** **Signature of Referrer Person: Date:** **Tick to confirm that the family consent to a referral being made to Family Action Perinatal Support Service** [ ]  |
| **PLEASE RETURN THIS COMPLETED FORM TO: Email to: perinatalsupport****@family-action.org.uk** **If sending this form back in the post please use recorded delivery to: Family Action Perinatal Support Service, The Thornbury Centre, 79 Leeds Old Road, Bradford, West Yorkshire, BD3 8JX. You can make a referral over the phone by calling 01274 505034 or you can fax the completed form back on 01274 668304**  |

|  |  |  |
| --- | --- | --- |
| **\*Ethnicity** | **\*Religion** | **\*Sexuality** |
| * White: English/Welsh/Scottish/Northern Irish/British
* White: Irish
* White: Polish
* White: Slovakian
* White: Romanian
* White: Czech
* White: Gypsy/Roma or Irish traveller
* Other White: (please specify)
* Pakistani
* Indian
* Bangladeshi
* Arab
* Chinese
* Unknown
* Other Asian: (please specify)
* African
* Caribbean
* Other Black: (please specify)
* Mixed White and Black African
* Mixed White and Black Caribbean
* Mixed White and Asian
* Any other mixed/multiple ethnic background: (please specify)
* Any other ethnic background: (please specify)
* Preferred not to say
 | * Christian
* Buddhist
* Hindu
* Jewish
* Orthodox Jewish
* Muslim
* Sikh
* Other (please specify)
* No religion
* Religion not stated
* Not known
* Christian – Catholic
 | * Bisexual
* Heterosexual
* Other (please specify)
* Does not wish to disclose
* Gay/Lesbian
* Questioning
 |