|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Referral form** | | | | | | | | | | | | | | | | | | | | |
| **Referrer’s responisbility** | | | | | | | | | | | | | | | | | | | | |
|  | **Consent obtained from client to be referred?** | | | | | | | | | | | | | | | | | | | |
|  | **Is the child under 12 Months of age?** | | | | | | | | | | | | | | | | | | | |
|  | **I have informed the client of potential wait of 3+ weeks for an appointment** | | | | | | | | | | | | | | | | | | | |
| Note: Clients will be notified within 7 working days from receipt of referral | | | | | | | | | | | | | | | | | | | | |
| **MOTHERS DETAILS** | | | | | | | | | | | | | | | | | | | | |
| **Name** | |  | | | | | | | **DOB** | | | | |  | | | | **NHI** |  | |
| **Address** | |  | | | | | | | | | | | | **Ethnicity** | | | |  | | |
| **Phone** | |  | | | | | **Email** | | | |  | | | | | | | | | |
| **Babys details and other children** | | | | | | | | | | | | | | | | | | | | |
| **Name** | |  | | | | | | **DOB** | |  | | | **NHI** | | |  | | **Ethnicity** | |  |
| **Other children’s name** | | |  | | | | | | | | | | **Age** | | |  | | **Gender** | |  |
|  | | |  | | | | | | | | | | **Age** | | |  | | **Gender** | |  |
|  | | |  | | | | | | | | | | **Age** | | |  | | **Gender** | |  |
| **Partners deTAILS** | | | | | | | | | | | | | | | | | | | | |
| **Name** | |  | | | | | | | | | | | | **Ethnicity** | | | |  | | |
| **Other household members?** | | | | |  | | | | | | | | | | | | | | | |
| **Reason for referral** *(please write clearly and provide as much information as possible)* | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **Please tick if any of the following are present** | | | | | | | | | | | | | | | | | | | | |
|  | **Involvement with DHB** | | | | | | | | | | | | | |  | | **Mood changes** | | | |
|  | **Psychiatric history** | | | | | | | | | | | | | |  | | **Grief/loss** | | | |
|  | **Limited support networks** | | | | | | | | | | | | | |  | | **Medical Issues** | | | |
|  | **Concerned about relationship with baby** | | | | | | | | | | | | | |  | | **Anxiety** | | | |
|  | **Unexpected outcome of pregnancy, labour or delivery** | | | | | | | | | | | | | |  | | **Parenting alone** | | | |
|  | **Other Mental Health Supports** | | | | | | | | | | | | | |  | | **Interest in group support** | | | |
|  | **External stressors** *(please state below)* | | | | | | | | | | | | | |  | | **Trauma** *(please state below)* | | | |
|  | | | | | | | | | | | | | | | | | | | | |
| **Referrer’s details** | | | | | | | | | | | | | | | | | | | | |
| **Name** | |  | | | | | | | | | **Designation** | | |  | | | | | | |
| **Phone** | |  | | **Fax** | |  | | | | | **Email** |  | | | | | | | | |
| **Signed** | |  | | | | | | | | | **Date** |  | | | | | | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **(Office use only) Case Manager assigned** | | | | | | | |
| **Case manager** |  | **Date** |  | **Time** |  | **Venue** |  |

Please **email this referral to the below email address**

maternalwellbeing@plunket.org.nz