

**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.**

**Please email this form back to us at** **epunft.pimhs.eput@nhs.net**

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| **Details of the Parent/ Caregiver & Infant being referred \*** |
| **Parent** First name | \* | Surname | \* | Date of Birth | \* |
| **Child** First name | \* | Surname | \* | Date of Birth/ Estimated Due Date | \* |
| Address &Postcode | \* | Premature? | \*  |
|  | Sex |  |
| Phone Number | \* |
| Parent NHS no:\* | \* | Child NHS no:\* | \* |
| Does the parent consent to text message contact: Yes 🞎 No 🞎 |
| **Referrer Details \*** |
| Name of Referrer  | \* | Consent obtained from family? Yes 🞎 No 🞎  |
| Date of Referral | \* | Consent obtained from family to contact other Professionals involved? Yes 🞎 No 🞎  |
| Role & Agency | \*\* | Tel no:\* |
| Best day/ time to contact  | \* | Email:\* |
| **GP & Health Visitor details** |
| GP’s Name & Address | \* | Health Visitor /MidwifeName & Number | **\*** |
| Child already attending children’s 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/ Caregiver | \* | \* |  | \* |  |
| \* | \* |  | \* |  |
| Siblings  |  |  |  | \* |  |
|  |  |  | \* |  |
| Others |  |  |  | \* |  |
| **Sexuality & Gender \*** |
| **Parent Gender Identity** |
| Female 🞎 | Male 🞎 | Trans-woman 🞎 | Trans-man 🞎 | Non-binary 🞎 | Other/ Prefer not to say 🞎 |
| Does the parent identify as the sex they were assigned at birth?Yes 🞎 No 🞎 Prefer not to say 🞎 |
| **Parent Sexual Orientation**  |
| Straight/ heterosexual 🞎 | Gay/ Lesbian/ Same sex 🞎 | Bisexual 🞎 | Other/ Prefer not to say 🞎 |
| **Nationality \*** |
| Nationality of the family i.e. what country are they from?  |  |
| Main language spoken at home |  |
| Interpreter required and for whom? Yes 🞎 No 🞎\* | 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** | **Other Ethnic Group** |
| Bangladeshi 🞎 | Caribbean 🞎 | British 🞎 | White & Asian 🞎 | Arab 🞎 |
| Indian 🞎 | African 🞎 | Irish 🞎 | White/ Black African 🞎  | Chinese 🞎 |
| Pakistani 🞎 | Other (please specify) 🞎 | Other (please specify) 🞎 | White/ Black Caribbean 🞎 | Other 🞎 |
| **If answered OTHER please specify below:** **\*** | Prefer not to say 🞎 |
| **Mental Health Services Involvement \*** |
| \*Are there any current mental health difficulties? Yes 🞎 No 🞎 Previous & current mental health presentation/ condition/ diagnoses/ identified risks: |
| Are Adult Mental Health Services involved with the family? Yes 🞎 No 🞎  | Team name: |  |
| Name of Mental Health Keyworker/ Care Co: \* | Contact telephone/ email:\* |
| **\*Is the infant or any other child in the household currently (or have been) subject to a:**  |
| **Child in Need Assessment?** Yes 🞎 No 🞎  | \* Name of child:  |
| **Child Protection Plan?** Yes 🞎 No 🞎  | \* Name of child:  |
| **Local Authority Care?** Yes 🞎 No 🞎  | \* Name of child:  |
| **Name of allocated Social Worker:** \* | **Contact telephone/ email:**\* |
| **Is a TAF in place for this child and/or other children?** Yes 🞎 No 🞎  |
| **Are there any current and/or historical safeguarding concerns?** Yes 🞎 No 🞎 Please provide details if yes |
| **Details of other agencies/ professionals involved** |
| Name |  | Name |  |
| Role |  | Role |  |
| Agency & Address |  | Agency & Address |  |
| Contact No. |  | Contact No. |  |
| E-mail  |  | E-mail  |  |
|  **Reason for Referral – Please give a brief description of the parent infant concerns (see referral guidance for additional prompts & support completing the form)\*** |
| **Voice of referred parent/ caregiver. What are their concerns for their relationship with the baby?** *(feelings about the relationship, motivation to change, capacity to think about the infant’s experience, any history of relational difficulties, etc)*\***Voice of the infant. How is the infant experiencing these difficulties?** *(their behaviour, communication, temperament, bodily functions, development, etc)*\* \* Have you seen the infant? 󠄀 Yes 🞎 No 🞎 **Voice of the other parent/ caregiver. How are they experiencing these difficulties?** \*  |
| **\*What are the hopes and concerns of the referred parent for this referral?**  |
| \* |
| **Any other information to share?** |
|  |

**Please complete the following checklist:**

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| **Parent-infant relationship risk factors** |
| **Parent factors** | **Caregiver one - Name:** | **Caregiver two - Name:** |
| History / current anxiety or depression | [ ]  | [ ]  |
| History / current alcohol and / or drug misuse | [ ]  | [ ]  |
| Serious medical condition | [ ]  | [ ]  |
| Learning Disability | [ ]  | [ ]  |
| Single teenage parent without family support | [ ]  | [ ]  |
| Past criminal or young offender’s record | [ ]  | [ ]  |
| Previous child has been in foster care or adopted | [ ]  | [ ]  |
| Violence reported in the family | [ ]  | [ ]  |
| Acute family crisis or recent significant life stress | [ ]  | [ ]  |
| Ongoing lack of support / isolation | [ ]  | [ ]  |
| Inadequate income / housing | [ ]  | [ ]  |
| Previous child has behaviour problems | [ ]  | [ ]  |
| Parent has experienced loss of a child | [ ]  | [ ]  |
| Parent experienced episodes of being in care as a child | [ ]  | [ ]  |
| Current / historical experience of abuse, neglect or loss | [ ]  | [ ]  |
| Chronic maternal stress during pregnancy or ambivalence about the pregnancy (unplanned or rigorous planning)  | [ ]  | [ ]  |
| Disappointment or unrealistic expectation around the parent-infant relationship | [ ]  | [ ]  |
| Other (please describe) | [ ]  | [ ]  |

**Observations**

|  |  |  |
| --- | --- | --- |
| **Factors observed in parent-infant relationship** | **Caregiver 1:** | **Caregiver 2:** |
| Lack of sensitivity to baby’s cries or signals | [ ]  | [ ]  |
| Negative / ambivalent / indifferent feelings towards baby | [ ]  | [ ]  |
| Physically punitive / rough towards baby | [ ]  | [ ]  |
| Lack of vocalisation to baby | [ ]  | [ ]  |
| Lack of eye-to-eye contact/ Infant is observed to avoid eye contact/looking at caregivers face  | [ ]  | [ ]  |
| Infant has poor physical care (e.g. dirty or unkempt) | [ ]  | [ ]  |
| Does not anticipate or encourage child’s development | [ ]  | [ ]  |
| Lack of consistency in caregiving | [ ]  | [ ]  |
| Infant does not seek support from caregiver when distressed/anxious/hurt | [ ]  | [ ]  |
| Infant becomes excessively distressed or appears not to notice when put down by caregiver and/or caregiver becomes briefly unavailable | [ ]  | [ ]  |
| **Infant factors** | **Infant:** |   |
| Developmental delays | [ ]  |   |
| Exposure to harmful substances in utero | [ ]  |   |
| Traumatic birth | [ ]  |   |
| Congenital abnormalities / illness | [ ]  |   |
| Very difficult temperament / extreme crying / hard to soothe | [ ]  |   |
| Very lethargic / nonresponsive / unusually passive  | [ ]  |   |
| Low birth weight / prematurity | [ ]  |   |
| Resists holding / hypersensitive to touch | [ ]  |   |
| Severe sleep difficulties | [ ]  |   |
| Failure to thrive / feeding difficulties / malnutrition | [ ]  |   |
| Infant shows lack of interest in others/objects  | [ ]  |  |
| Infant shows limited range of feelings e.g. infant rarely/never shows ordinary negative feelings | [ ]  |  |