Hertfordshire Partnership NHS
University NHS Foundation Trust

Community Perinatal Team (CPT)

Professional Referral Form

This form is to be used for antenatal and postnatal outpatient referrals from professionals.

Patient details / sticker			**Details of referrer** *(Please print legibly. We can not accept referrals without referrer details)*
Name:			**Name:**
DOB: __ / __ / __	**NHS Number:**		**Profession:**
Address:			**Address:**
Phone number: *(Essential as all referrals receive telephone triage):*			**Phone number:**
GP Details:			**Date of referral:**
Ethnicity:	**Marital status:**	**Employment status:**	Routine ☐ or **Urgent** ☐ (Routine referrals have telephone triage within 2 working days. Please call CPT if referral is urgent):
Religion:	**Accommodation type:**		

What are the concerns about the patient's mental health? *(Please tick all relevant boxes)*

Previous postpartum psychosis	☐	**Bipolar Disorder**	☐
Severe depression	☐	**Obsessive Compulsive Disorder**	☐
Moderate depression	☐	**Personality Disorder**	☐
Severe anxiety disorder	☐	**Eating Disorder**	☐
Moderate anxiety disorder	☐	**PTSD incl Birth Trauma**	☐
Psychosis / Schizophrenia	☐	**Recurrent self harm**	☐

Other *(please provide details)*:

Are these problems: **Current** ☐ **Previous** ☐ **Both** ☐

Details of any psychiatric medication:

(Women with mild depression, not on medication or who are at present successfully managed on medication should be seen in primary care and offered the HPFT Wellbeing Service as appropriate.)

Please provide details of the concerns: *(if you need more space, please continue on a seperate sheet of paper)*

Are they currently open to a mental health team? *(If 'yes' please state which team)*

No ☐ Yes ☐ Name of team: _____

Have there been any other previous mental health problems including in the perinatal period

No ☐ Yes ☐ Details: _____

Is there a family history of mental health problems:

No ☐ Yes ☐ Details: _____

Are there any safeguarding concerns / has a safe guarding referral been made

No ☐ Yes ☐ Details: _____

What are the expectations of what the CPT can offer the patient or you as a professional?

Have you referred to any other services as well (including The Wellbeing team)?

No ☐ Yes ☐ Name of service: _____

For Antenatal Referrals:	**For Postnatal Referrals:**
Hospital baby to be delivered in:	**Date of birth of baby:**
Expected date of delivery:	**Where was baby born:**
Current gestation:	**Mode of delivery:**
Number of previous Pregnancies: ____ Miscarriage: ____ TOP: ____ Live: ____	**Number of other children:**

☐ Interpreter is required for the assessment and if so what language: _____

☐ Consent given to share information with other health professionals e.g. Midwife / Health Visitor / GP

Please email completed referrals from an nhs.net account to: *herts.cpt@nhs.net*

Or post to: Community Perinatal Team, 15 Forest Lane, Kingsley Green, Harper Lane, Radlett, Herts, WD7 9HQ

To discuss referrals please call the team on: *0300 124 0939*