Perinatal Mental Health for Referral by GPs : Midwives :Allied Health :Child and Family Health Teams.

Early Years Outreach Clinic Referral Fax to 1300452059

Patient Contact Details:

Name: **DOB:**

Address:

Phone/ mobile: **Medicare No.**

Person for contact: **Consent:** (Patient to sign)

Referrer Details

Name: **Telephone Number:** **Fax Number:**

Address:

GP Provider Number: **(If referral by GP)**

Provisional Diagnosis:

Reason for referral:

Medication:

Relevant Mental Health history:

Obstetric history: (include EDB or Last Child DOB)

Antenatal Care Provider:

Other services involved:

Additional Information:

Mental State Examination

Appearance: (Age, gender, race/ethnic background, build, apparent health, level of hygiene, mode of dress, physical abnormalities.)

Behaviour: (Eye contact, cooperativeness, motor activity, abnormal movements, expressive gestures.)

Speech: (Articulation disturbances, rate (rapid, pressured, slow, retarded), volume (loud, quiet, whispered), quality (poverty of speech, monotonous, mutism).

Mood & Affect: (Mood (subjective); affect (objective) e.g. elevated, depressed, labile, angry, irritable, blunted, flattened, euphoric, incongruent, anxious.)

Thoughts: (Amount or speed of thought; Poverty of thought, pressure of thought; slow or hesitant thinking. Repetition of same thoughts, thought blocking, concrete thinking, irrelevance.

Cognition: (Level of consciousness/alertness; memory; orientation (time, place, person); concentration; abstract ideas.)

Perceptual Disturbances: (Hallucinations: auditory, visual: olfactory: gustatory: tactile. Depersonalization: derealisation.)

Insight & Judgement: (Capacity to organize & understand problem, symptoms or illness; knowledge of medication; amenable to & compliance with treatment; impaired judgment.)

EPNDS: _____

Signature: _____ **Date:** _____