**INFANT MENTAL HEALTH SERVICE**

**REFERRAL FORM**

**Infant Mental Health Service**

Hunslet Health Centre

24 Church Street

Hunslet

Leeds

LS10 2PT

**🕿 0113 84 30841**

***NOTE: You must discuss the case with an***

***IMHS clinician before the referral can be processed.***

**SystmOne Users:**

TASK User Group ‘IMH Administration’ to inform referral is on S1

**External Services:**

E-mail Referral Form to: [leedsimh@nhs.net](mailto:leedsimh@nhs.net)

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| **REFERRAL INFORMATION** | | | | | | | | | | |
| **Discussed with IMHS clinician (name)**: | | | | | **Date of Referral**: | | | | | |
| **Has the parent/carer consented to this referral?** NOTE: We cannot accept referrals for direct work without the parent / primary caregiver’s consent | | | | | | | **Yes** |  | **No** |  |
| **FAMILY DETAILS** | | | | | | | | | | |
| **Primary Carer’s Name**: | |  | | **Child’s Name**: |  | | | | | |
| **DOB**: | |  | | **DOB**:  **(Or EDD)**: |  | | | | | |
| **NHS No.** | |  | | **NHS No.** |  | | | | | |
| **Relationship to Child**: | |  | | **Gender**: |  | | | | | |
| **Ethnicity**: | |  | | **Ethnicity**: |  | | | | | |
| **Address**: | |  | | **Address**:  **(If Different)** |  | | | | | |
| **Postcode**: | |  | | **Postcode**: |  | | | | | |
| **Mobile No**. | |  | | **Home / other No.** |  | | | | | |
| **Communication requirements**: | | (e.g. Interpreter, Easyread) | | | | | | | | |
| **OTHER FAMILY MEMBERS (if applicable)** | | | | | | | | | | |
| **Name:** | | **DOB:** | | **Relationship (i.e. parent / sibling):** | | | | | | |
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| **REFERRERS DETAILS** | | | | | | | | | | |
| **Name:** | |  | | **Service:** |  | | | | | |
| **Role:** | |  | | **Contact Tel No. / mobile:** |  | | | | | |
| **Address:** | |  | | **Email:** |  | | | | | |
| If this referral is not within our identified referral route **(e.g. from FDAC / Baby Steps)** please confirm you have discussed the referral with your supervisor? YES / NO | | | | | | | | | | |
| **OTHER PROFESSIONALS INVOLVED:** | | | | | | | | | | |
| **Service/role:** | | **Name:** | **Base & address:** | | | **Tel and Email:** | | | | |
| GP **(must include)** | |  |  | | |  | | | | |
| Health Visitor  (if not referrer) | |  |  | | |  | | | | |
| *Social Worker*  *(if applicable)* | |  |  | | |  | | | | |
| *Family Outreach Worker* | |  |  | | |  | | | | |
| *Mental Health Service (if applicable)* | |  |  | | |  | | | | |
| *Other(s)* | |  |  | | |  | | | | |
| **INFANT VOICE:**  It is important that the IMHS considers the infant’s experience of the relationship. It is helpful to have professional observations of the infant and parent-infant relationship. We may ask you to gather this information (i.e., liaise with 0-19 service) where the infant has not been seen. | | | | | | | | | | |
| **Please share your observations of infant what the infant is telling us e.g. how does the infant present, how do they respond to their caregiver, what might they say if they could put their experiences into words.**  **OR where an Early Attachment Observation (EAO) has been completed, please give details from the *two minute EAO observation*:** | | | | | | | | | | |
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| **EAO - Where completed, please provide the information from the screening questions:** | | | | | | | | | | |
| **What is the best thing about your relationship with your baby?** Answer: | | | | | | | | | | |
| **What is your biggest fear about your relationship with your baby?**  Answer: | | | | | | | | | | |
| **Describe your relationship with your baby in 3 words**: Answer: | | | | | | | | | | |
| **EAO completed on:** |  | | | | | | | | | |
| **EAO completed by:** |  | | | | | | | | | |
| **REASON FOR REFERRAL:**  *E.g., What are the concerns of the parent/caregiver? What are your concerns?* | | | | | | | | | | |
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| **Please specify any safeguarding concerns for this infant and family (and for staff/home visiting) and plans to manage risks:** | | | | | | | | | | |
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| **PREVIOUS AND ONGOING SUPPORT:**  *E.g., listening visits, Understanding Your Baby leaflet/course, HENRY, parent support groups.*  *\*\*Where there are parental mental health concerns, please include ongoing plans for support\*\** | | | | | | | | | | |
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| **Thank you for your referral.**  Our Referral Management Group will review the referral and you will be updated with the final decision within 1-2 weeks. | | | | | | | | | | |
| Referral Form Updated: August 2023 | | | | | | | | | | |