**INFANT MENTAL HEALTH SERVICE**

**REFERRAL FORM**

Infant Mental Health Service

Middleton Health Centre

Middleton Park Avenue

Middleton

Leeds

 LS10 2PT

**🕿 0113 84 30841**

**E-mail Referral Form to:**

**leedsimh@nhs.net**

**NOTE: You must have discussed the case with a member of the IMH Team before the referral can be processed**

|  |  |
| --- | --- |
| **Discussed with from IMHS (name)**:  | **Date**:  |
| **Has the parent consented to this referral? Please mark with an X**NOTE: We cannot accept referrals for direct work without the parent / primary caregivers consent | **Yes** |  | **No** |  |
| **Primary Carer Name**: |  | **Child’s Name**: |  |
| **DOB**: |  | **DOB (Or EDD)**: |  |
| **NHS No.** |  | **NHS No.** |  |
| **Relationship to Child**: |  | **Gender**: |  |
| **Ethnicity**: |  | **Ethnicity**: |  |
| **Address**: |  | **Address**:**(If Different)** |  |
| **Mobile No**. |  | **Mobile No**.**(If Different)** |  |
| **Home No**. |  | **Home No**.**(If Different)** |  |
| **GPs Name**: |  |
| **Surgery Address**: |  |
| **HV / Midwife**: |  |
| **Address**: |  |
| **Cluster**: |  |
| **Other Professionals**: | **Name** | **Contact No.** | **Email** |
| **Social Workers**: |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **Other Key Workers**: |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **OTHER FAMILY MEMBERS**:(Specify Spouse / Partner / Children as applicable) |
| **NAMES**: | **DOB**: | **RELATIONSHIP**: |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **REFERRERS DETAILS** |
| **Referred By**: |  | **Date of Referral**: |  |
| **Job Title**: |  | **Contact Tel No**. |  |
| **Base / HC**: |  | **Mobile No**. |  |
| **Address**: |  | **Email**: |  |
| **For completion by Health Visitor only**:**Early Attachment Observation (EAO)**Please give the following details from the when the EAO was completed at the 6-8 week visit: |
| **Date EAO completed**:  |
| **EAO completed by**:  |
| **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:  |
| Please give details from the two minute EAO observation: |
| **REASON FOR REFERRAL**: (Please continue over if necessary) |
|  |

Referral Form Updated: December 2020