**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**](mailto: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**: | | | | | |
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| **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