



FS304680

Women and Newborn Health Service
King Edward Memorial Hospital

REFERRAL TO THE MOTHER AND BABY UNIT

Med Rec. No:

Surname:

Forename:

Gender: D.O.B.

AFFIX LABEL HERE

Referrer Details

Date of Referral:	Time of Referral:
Name:	Designation:
Referral Agency:	Contact Person: <i>(if not referrer)</i>
Address:	Mobile:
Fax:	Email:

Mother's Details

Given Name(s):	Family Name:
Date of Birth:	Email:
Address:	Phone number(s):
Homeless / At risk of homelessness? <input type="checkbox"/> Yes <input type="checkbox"/> No	Country of Birth:
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Other:	
Year of arrival: <input type="checkbox"/> N/A	Interpreter required? <input type="checkbox"/> Yes <input type="checkbox"/> No
Aboriginal or Torres Strait Islander Status: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Preferred Pronoun for Mother: <input type="checkbox"/> She / her <input type="checkbox"/> He / him <input type="checkbox"/> They / them <input type="checkbox"/> Unknown	
Is the mother a current inpatient? <input type="checkbox"/> Yes <input type="checkbox"/> No Location:	
Height:	Weight: BMI:
Private Health Insurance with hospital admission cover? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Overseas visitor without Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Mental Health Act Status: <input type="checkbox"/> Voluntary <input type="checkbox"/> Involuntary	
Is client aware of referral? <input type="checkbox"/> Yes <input type="checkbox"/> No Is client accepting of referral? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Baby's Details / Expected Due Date

First Name:	Last Name:
Date of Birth:	Gender:
Immunisation Status:	Country of Birth:
Mode of feeding: <input type="checkbox"/> Breast <input type="checkbox"/> Formula <input type="checkbox"/> Solids <input type="checkbox"/> Weaning	
Is father of the baby involved in care? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Father / Co-Parent First Name:	Father / Co-Parent Last Name:
Address: (if different to mothers)	
Mobile:	

DO NOT WRITE IN BINDING MARGIN

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Any concerns regarding baby's physical health? (If yes, please state below) Yes No

Any concerns regarding baby's mental health? (If yes, please state below) Yes No

Inability to calm Avoiding eye contact Eating difficulties Sleeping difficulties

Other:

Other Children

First Name	Last Name	Age / DOB	Gender	Who has parental responsibility?	Who will be caregiver during admission?

Please state name and contact details for who else is actively involved in the children / family's care:
(e.g. family / friends)

Please state name and contact details of others who live in the same house:

Infectious Disease Status

Baby is free of infectious disease symptoms for ≥ 48 hours? Yes No

Mother is free of infectious disease symptoms for ≥ 48 hours? Yes No

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Referral Details

Does the mother have any of the following:

Advance Health Directive

Nominated Support Person – Name:

Mobile:

Physical health problems / Comorbidities (including perinatal)

(e.g. thyroid problems, anaemia/low iron, hypertension, pain, gestational diabetes)

Yes No Unknown

Mental Health Assessment

Has a Mental Health Care Plan or assessment been completed with this client? Yes No

If yes, please attach most recent copy

Reason for Referral to Mother Baby Unit – *Note the patient must be suffering from an acute treatable moderate to severe mental health illness*

(Include referrer's rationale for inpatient treatment, onset, duration, triggers, mental state and current social circumstances)

Relevant mental health history:

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Prescribed current medication for mother

Medication	Dose	Prescribing Doctor & Contact Number

Substance Use

Substance	Current – Amount / Frequency	Past
Nicotine / Vaping		
Alcohol Use		
Other substances (please list)		

Additional comments:

(Including any dependence on prescription medications including benzodiazepines / opioids etc)

Concerns with Parent-Child relationship

- Problems bonding with baby
- Lacks confidence with practical baby care
- Feeding Sleeping Settling Nappy changes Bathing Identifying baby's cues
- Other:

Risk Factors

- At risk of harm to self At risk of harm to baby PSOLIS alerts
- Criminal offences At risk of harm to others

Strengths and protective factors *(insight, good social support, resilience)*

Goals of Admission:

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Please outline your intended care plan until admission (*if accepted for admission*)

Legal, Court Orders

Custody arrangements: Formal Informal No Unknown

Are there any Family and Domestic Violence Concerns and/or Violence Restraining Orders in place?

Yes No Unknown

Are there current child protection concerns? (If yes, please specify below) Yes No Unknown

Have any child protection notifications been made Yes – Date: _____ No Unknown

Previous involvement with Child Protection? Yes No Unknown

Please state nature of involvement below:

Child Protection Orders: Yes No Unknown

Name of Child Protection Office:

Address:

Email:

Telephone:

Professional Networks

Mental Health Service

Are Adult Mental Health Service involved with the family? Yes No Unknown

Mental Health Service and Team Name:

Community MH Case Manager:

Consultant Psychiatrist:

Telephone:

Address:

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General Practitioner

GP Name:

GP Clinic:

Telephone:

Address:

Other Services – Current or Planned Post-Discharge

Service	Name	Contact Details
Child Health		
NDIS		
Family Support Services		
Private Psychologist		
Other:		

Referrer

Name:

Designation:

Signature:

Date:

Any Additional Comments:

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