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| **FIONA STANLEY HOSPITAL**  **REFERRAL TO THE**  **MOTHER AND BABY UNIT**  WARD\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  DOCTOR\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | SURNAME | UMRN | | | | | | |
| GIVEN NAMES | DOB | | | GENDER | | | |
| ADDRESS | | | | POSTCODE | | | |
|  | TELEPHONE | | | | | | |
| **Who can refer to MBU?**  Health professionals.  **Eligibility criteria for referral:**   * Women with severe mental health problems who are the primary carer for their baby or babies, who are not walking and under 12 months, requiring inpatient mental health treatment. * Substance abuse and alcohol use is **not** tolerated on the ward and women with substance and alcohol dependencies will only be considered following completion of withdrawal and detox. * Medical clearance from infectious disease and illness and a minimum of 48 hours symptom free.   **Referral:**   1. Assess mother for severe mental health issue & eligibility for referral to MBU. Telephone the MBU on **08 6152 7866** to discuss the referral. 2. Complete attached form and Fax to: **08 6152 4867** or email to [FSH.MHMotherBabyUnit@health.wa.gov.au](mailto:FSH.MotherBabyUnit@health.wa.gov.au) 3. The referral will be discussed with the multi-disciplinary team and referrer informed of the outcome. 4. The expected admission list will be reviewed periodically. To ensure that your referral is appropriately prioritised, MBU request regular updates regarding the mental health status of your client, especially when the clinical status of the client changes. This can be done via Fax or telephone.   **Waiting for admission:**   * MBU will prioritise referrals according to clinical need. For example: Women with severe mental health problems and who are breast feeding young babies have a higher priority for admission. * When a bed becomes available a MBU staff member will contact you and your patient. * During the waiting period MBU takes no responsibility for the setting up of alternative supports, however, recommend the following services:   **Support services:**  Women, children, fathers, partners and their families need ongoing support whilst waiting for admission. The following services have been identified as providing support and referral to community services, (please note that this list is not exhaustive):   * Emergency Departments of general hospitals * MHERL 1300 555 788 for emergency situations or after hours * Crisis Care 08 223 111 or 1800 199 008 TTY 08 9325 1232 * General Practitioner can discuss further community based services such as referral to a Clinical Psychologist under a *Mental Health Care Plan.* * NGALA 08 9368 9368 or 1800 111 546 (country callers) | | | | | | | | **MR 416 REFERRAL TO THE MOTHER AND BABY UNIT** | |
| **FIONA STANLEY HOSPITAL**  **REFERRAL TO THE**  **MOTHER AND BABY UNIT**  WARD\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  DOCTOR\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | SURNAME | | | UMRN | | | | |
| GIVEN NAMES | | | DOB | | | GIVEN NAMES | |
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|  | | | | TELEPHONE | | | |
| **Email to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Receipt of this form does not imply that referral has been accepted. MBU staff will contact you for  further information and discussion of status of the referral.  **Date of Referral:** \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_  **Referrer Details**   |  |  |  |  | | --- | --- | --- | --- | | Name: |  | | | | Designation: |  | | | | Signature: |  | | | | Service: |  | | | | Contact address: |  | | | | Suburb |  | | | | Postcode |  | | | | Telephone: |  | Mobile: |  | | Fax: |  |  |  |   **Patient Details**  Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of Birth: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_  CALD 🞎 Interpreter needed? 🞎 ATSI 🞎 Disability 🞎  Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Suburb: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone: Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  GP: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Practice \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Next of Kin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Children Details**   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **#** | Child Name | DOB | Hospital of Birth | \* Sex | Breast feeding | |  | 1. | / / |  | **M** of **F** | **Y** of **N** | |  | 2. | / / |  | **M** of **F** | **Y** of **N** | |  | 3. | / / |  | **M** of **F** | **Y** of **N** | |  | 4. | / / |  | **M** of **F** | **Y** of **N** |   Are there any concerns about the admitted baby’s physical or mental health?  No  Yes  Comment: | | | | | | | | | |
| **FIONA STANLEY HOSPITAL**  **REFERRAL TO THE**  **MOTHER AND BABY UNIT**  WARD\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  DOCTOR\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | SURNAME | | | UMRN | | | | |
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| ADDRESS | | | | | | POSTCODE | |
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| **Risk Assessment**  Circle the relevant box for each domain. (For explanation of categories, please see Appendix A)   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **RISK OF HARM TO SELF** | None | Low | Moderate | Significant | Extreme |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **RISK OF HARM TO OTHERS**  **(INCLUDING BABY)** | None | Low | Moderate | Significant | Extreme |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **LEVEL OF PROBLEM WITH**  **FUNCTIONING** | None/Mild | Low | Significant impairment  in one area | Significant impairment  several areas | Extreme impairment |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **LEVEL OF SUPPORT**  **AVAILABLE** | No problems /  Highly Supportive | Moderately  Supportive | Limited Support | Minimal | No support in all  areas |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | **ATTITUDE AND**  **ENGAGEMENT TO**  **TREATMENT** | No Problem /  Very Constructive | Moderate  Response | Poor Engagement | Minimal  Response | No Response |  |  |  |  |  |  | | --- | --- | --- | --- | --- | | **OVERALL ASSESSMENT**  **OF RISK** | **LOW** | **MEDIUM** | **HIGH** | **EXTREME** |   **Mental Health Assessment**   |  |  |  | | --- | --- | --- | | Has a Mental Health Care Plan been completed with this client? Y  N   If yes, please attach most recent copy  Is the client currently taking Psychiatric Medication? Y  N  | | | | **Medication:** | **Dose:** | **Prescribing Dr. & contact number** | | 1. |  |  | | 2. |  |  | | 3. |  |  | | **Does the Client have any current physical health issues or co-morbidities:**  **Y**  **N**  (If yes, please provide a detailed description below including medication.) | | | |  | | | |  | | | |  | | | |  | | | |  | | | |  | | | |  | | | | Does the client have any current drug or alcohol dependencies or known substance abuse:  **Y**  **N**  (if yes, please describe below) | | | |  | | | |  | | | |  | | | |  | | | |  | | | |  | | | | | | | | | | | | |
| **FIONA STANLEY HOSPITAL**  **REFERRAL TO THE**  **MOTHER AND BABY UNIT**  WARD\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  DOCTOR\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | SURNAME | | | UMRN | | | | |
| GIVEN NAMES | | | DOB | | | GIVEN NAMES | |
| ADDRESS | | | | | | POSTCODE | |
|  | | | | TELEPHONE | | | |
| **Presenting Issues**   |  | | --- | | Please describe presenting issues, their history and rationale for inpatient treatment. Note the  patient must be suffering from an acute treatable moderate to severe mental health illness. | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  | |  |   **Current Mental State**   |  |  | | --- | --- | | **Appearance:** |  | |  |  | | **Behaviour:** |  | |  |  | |  |  | |  |  | | **Mood and Affect:** |  | |  |  | |  |  | | **Speech:** |  | |  |  | | **Cognition:** |  | |  |  | | **Thoughts:** |  | |  |  | |  |  | |  |  | | **Perception:** |  | |  |  | |  |  | | **Insight and Judgment:** |  | |  |  | |  |  | | | | | | | | | | |
| **FIONA STANLEY HOSPITAL**  **REFERRAL TO THE**  **MOTHER AND BABY UNIT**  WARD\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  DOCTOR\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | SURNAME | | | UMRN | | | | |
| GIVEN NAMES | | | DOB | | | GIVEN NAMES | |
| ADDRESS | | | | | | POSTCODE | |
|  | | | | TELEPHONE | | | |
| **Current Supports and Services**  ◦ Psychiatrist  ◦ Psychologist  ◦ GP  ◦ Family  ◦ Partner  ◦ Mental Health Nurse/Clinician  ◦ Adult Mental Health Service  ◦ Other   |  | | --- | |  | |  | |  | |  |    Please outline your intended ongoing plan of care with this client until admission to MBU:   |  | | --- | |  | |  | |  | |  |   Has consent been granted from the client for this referral? **Y**  **N**   **Legal, Court Orders**  Are there any current Forensic or Legal issues (incl. child protection orders): **Y**  **N**   (If yes, please provide details below and attach copy of any orders)   |  | | --- | |  | |  | |  | |  |   To the best of your knowledge have any child protection notifications been made: **Y**  **N**   Is the client aware of child protection issues?: **Y**  **N**   **DCP Case Manager** (if applicable):  **Name: Phone: Office Location:**  The MBU is a tertiary referral centre and does not have an acute response service.  If you require urgent acute or crisis intervention please call the  **Mental Health Emergency Response Line (MHERL) ON 1300 555 788**  or your nearest hospital emergency department.  **Risk Assessment Guide over page** | | | | | | | | | |
| **FIONA STANLEY HOSPITAL**  **REFERRAL TO THE**  **MOTHER AND BABY UNIT**  WARD\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  DOCTOR\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | SURNAME | | | UMRN | | | | |
| GIVEN NAMES | | | DOB | | | GIVEN NAMES | |
| ADDRESS | | | | | | POSTCODE | |
|  | | | | TELEPHONE | | | |
| **Risk Assessment Guide**  Risk of harm to self/others   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **0. None** (no  thoughts or action of  harm). | **1. Low** (Fleeting  thoughts of harming  themselves or harming  others but no  plans/current low  alcohol or drug use). | **2. Moderate** (current  thoughts/distress/past  actions without intent  or plans/moderate  alcohol or drug use). | **3. Significant**  (current thoughts/past  impulsive  actions/recent  impulsivity/some  plans, but not well  developed/increased  alcohol or drug use). | **4. Extreme** (Current  thoughts with  expressed  intentions/past  history/plans/  unstable mental illness/  high alcohol  or drug use,  intoxicated/violent to  self/others/means at  hand for harm to  self/others). |   Level of problem with functioning   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **0. None/Mild** (No  more than everyday  problems/slight  impairment when  distressed). | **1. Moderate** (Moderate  difficulty in  social/occupational or  school  functioning/reduced  ability to cope  unassisted). | **2. Significant**  **Impairment in one**  **area** (either social,  occupational or  school functioning). | **3. Serious impairment**  **in several areas**  (Social, occupational or  school functioning). | **4. Extreme**  **Impairment**  (inability to function in  almost all areas). |   Level of support available   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **0. No**  **problems/Highly**  **Supportive** (all  aspects/most aspects  highly supportive/self/  family/professional/  effective involvement). | **1. Moderately**  **Supportive** (Variety of  support available, able  to help in times of  need). | **2. Limited Support**  **(few sources of help,**  **support system has**  **incomplete ability to**  **participate in**  **treatment).** | **3. Minimal** (few  sources of support  and not motivated). | **4. No support in all**  **areas.** |   Attitude and Engagement to treatment   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **0. No problem/Very**  **Constructive**  (Accepts illness and  agrees with treatment/  new client). | **1. Moderate**  **Response** (Variable/  ambivalent response to treatment). | **2. Poor Engagement**  (Rarely accepts  diagnosis). | **3. Minimal Response**  (Client never  cooperates willingly). | **4. No Response**  (Client has only been  able to be treated in  an involuntary  capacity). |  |  | | --- | | Disclaimer: The advice and information contained herein is provided in good faith as a public service. How the accuracy of  any statements made is not guaranteed and it is the responsibility of readers to make their own enquiries as to the accuracy,  currency and appropriateness of any information or advice provided. Liability for any act or omission occurring in reliance on  this document or for any loss, damage or injury occurring as a consequence of such act or omission is expressly disclaimed | | | | | | | | | | |