Health Care Professional Referral Form

This form is for recognised health care professionals (midwives, health visitors, nurses, GP's, paediatricians etc.) to refer families where one member has post-natal depression (or is at high risk of developing this after birth), bonding issues, or a child with serious illness or disability.

We at the Sheffield Sling Surgery will assist with the safe use of a sling, which can help with building bonds, as well as allowing parents to be hands free, making life more manageable. If the family is in financial hardship (such as in receipt of healthy start vouchers) we will provide free support. Please notice that we are a not-for-profit enterprise and are mainly staffed by volunteers.

Please ensure you've read the referral guidelines before completing this form.

NB We only accept referrals where the person referred has given their consent.

Referee’s Information

|  |  |  |
| --- | --- | --- |
| Name | First |  |
| Last |  |
| Age of child (or estimated due date) |  |
| Email address |  |
| Telephone number | Mobile |  |
| Landline |  |
| Address (including postcode) |  |
| Preferred method of contact | Email / Phone / Text / Letter |

Details of referral

|  |
| --- |
| Please provide details of any other agencies currently involved with the family |
|  |
| Can you describe briefly why you are referring and provide any other information that you think will be useful when we are assessing which of our services will be most appropriate? (e.g. relationship / attachment difficulties with the baby; mental health history, type of illness/disability, including prognosis if relevant) |
|  |
| Are there any safeguarding issues (adult and child) with which we need to be aware? |
|  |
| Do you feel the family are in financial hardship and would be unable to afford to contribute to our running costs for example in receipt of healthy start vouchers? We are a not-for-profit mainly staffed by volunteers.  | Yes / No |

## Referred by

|  |  |
| --- | --- |
| NameDate |  |
| Job Role: | Health Visitor / Midwife / Doctor / Nurse / Other (please give details) |
| Verbal consent obtained from parents | Date …………………………………... |
| Your contact details (phone / email) |  |