TO MY GP

You are reading this because I believe I am experiencing **postnatal depression**.

This document was downloaded from **www.thepostnatalproject.com**. I hope it is helpful in assessment and planning of my treatment.

I would like this information to accompany the Edinburgh Postnatal Depression scale.

NAME:

DATE OF BIRTH:

BABY'S NAME:

BABY'S DATE OF BIRTH:

HISTORY

I have a history of depression or mental illness

◯ Yes

Provide details

_____

_____

_____

◯ No

◯ I don't know

If you answered yes
I received the following treatment

☐ Medication

☐ Counselling

☐ Hospitalisation

☐ Natural medicine

☐ Other _____

☐ Other _____

My family has a history of depression

◯ Yes

◯ No

◯ I don't know

In the past, I have seen the following professionals/services:

☐ **GP**

Name:_____

Date:_____

This was helpful ◯ Yes ◯ No

☐ **Psychologist**

Name:_____

Date:_____

This was helpful ◯ Yes ◯ No

☐ **Mental Health Nurse**

Name:_____

Date:_____

This was helpful ◯ Yes ◯ No

☐ **Social Worker**

Name:_____

Date:_____

This was helpful ◯ Yes ◯ No

☐ **Counsellor**

Name:_____

Date:_____

This was helpful ◯ Yes ◯ No

☐ **Psychiatrist**

Name:_____

Date:_____

This was helpful ◯ Yes ◯ No

☐ **Accident & Emergency Staff**

Name:_____

Date:_____

This was helpful ◯ Yes ◯ No

☐ **Other**

Name:_____

Date:_____

This was helpful ◯ Yes ◯ No

☐ **Other**

Name:_____

Date:_____

This was helpful ◯ Yes ◯ No

SYMPTOMS

I am experiencing the following symptoms:	Not at all	Last 2 weeks	Everyday
Low mood	☐	☐	☐
Abrupt mood swings	☐	☐	☐
Appetite changes	☐	☐	☐
Being nervous or panicky	☐	☐	☐
Panic attacks (racing heart, palpitations, shortness of breath)	☐	☐	☐
Persistent, generalised worry	☐	☐	☐
Having little or no interest in things I previously enjoyed or found brought me joy	☐	☐	☐
Insomnia (unrelated to nights feeds/wakings)	☐	☐	☐
Feeing angry, irritable or resentful	☐	☐	☐
Feeling unable to cope	☐	☐	☐
Withdrawing from social contact	☐	☐	☐
Not looking after myself	☐	☐	☐
Decreased energy and feeling exhausted	☐	☐	☐
Having thoughts of harming myself or my baby, ending my life or wanting to escape	☐	☐	☐
Other	☐	☐	☐
Other	☐	☐	☐

Additional information:

SUICIDAL IDEATION

I feel I am at risk of suicide/harming myself

◯ Yes

◯ No

Details:

_____

_____

_____

I have a plan to complete suicide

◯ Yes

◯ No

Details:

_____

_____

_____

I intend to act on my plan to complete suicide

◯ Yes

◯ No

Details:

_____

_____

_____

The people who know about my thoughts of suicide/harm to self are

_____

_____

_____

I have thoughts of harming my baby

◯ Yes

◯ No

Details:

_____

_____

_____

I feel that the hospital would be an appropriate and safer place for me right now

◯ Yes

◯ No

Details:

_____

_____

_____

PREDISPOSING FACTORS

I believe the following issues are contributing:	✓
A stressful/complicated pregnancy/birth	☐
A past history of depression/anxiety and/or antenatal depression/anxiety	☐
A family history of mental illness	☐
Lack of support from partner or marital problems	☐
Lack of practical, financial, social, emotional support	☐
Life stresses (moving house, starting work, major illness, loss of a loved one)	☐
Domestic violence	☐
Drug use (either myself, my partner or someone close to me)	☐
Problems with the baby's health	☐
Difficulties breastfeeding	☐
Difficulties in close/family relationships	☐
Single parenthood	☐
An unsettled baby (difficulty with feeding or sleeping)	☐
Motherhood different to what was expected	☐
Previous miscarriage/stillbirth	☐
History of child abuse	☐
Young maternal age	☐
Sleep deprivation	☐
Other	☐

If I could describe my pregnancy using three words

_____

_____

_____

If I could describe my birth using three words

_____

_____

_____

If I could describe my recovery using three words

_____

_____

_____

At the moment, my biggest concern is

_____

_____

_____

I feel I need support with

☐ Feeding

☐ Sleep

☐ General health checks for my baby

☐ General health checks for myself

continued on next page

- [ ] My own mental health
- [ ] My partner's mental health
- [ ] Caring for my baby's needs
- [ ] Other

_____

I would like more information on

- [ ] Mother and baby units
- [ ] Local mental health services
- [ ] Medication
- [ ] Medication and breastfeeding
- [ ] Mental health care plans

I would like a referral for

- [ ] Psychologist
- [ ] Counsellor
- [ ] Psychiatrist
- [ ] Mother and baby unit
- [ ] Blood test for organic screening (iron, thyroid, etc)
- [ ] Specialist in: _____
- [ ] Lactation consultant
- [ ] Paediatrician
- [ ] Other

_____

I would like a fortnightly appointment with you or other professional currently involved in my care/treatment

◯ Yes

◯ Not required

I need to debrief with the midwife about my birth

◯ Yes

◯ Not required

I would like information about accessing my file

◯ Yes

◯ Not required

I would like to complete a form which gives the following support people authority to discuss my treatment, symptoms and progress with you:

Name:_____Phone:_____

Name:_____Phone:_____

Name:_____Phone:_____

DATE: **SIGNED:**

_____