**Referral to Positive Birth Service**

**Criteria for Referral**

* Previous LSCS to discuss mode of Delivery.
* No Previous LSCS requesting LSCS e.g. Significant anxiety related to pregnancy/ birth.

**Addressograph:-**

**Woman’s telephone number…………………………………………………………………….**

**EDD………………………………………………. Parity……………………………………………….**

**Named Midwife…………………………………………………………………………………………..**

**Brief Summary of details relating to the referral**

**Please attach a copy of Perinatal Mental Health screening tool.**

**Please return forms to Positive Birth Service ANC Salisbury NHS Foundation Trust.**