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| Logo | ***PAIN CLINIC REFERRAL FORM******Concord Hospital*** ***RPA Hospital******Fax No: CRGH: 9767 7841******Fax No: RPAH: 9515 9831*** |  |
| Name: |  |
| Address: |  |
| E-mail |  |
| Phone: |  |  |
| Date of Birth: |  |  |
| ATSI | Aboriginal | Torres Strait Islander | Neither |
| CALD Status Yes/No | Language Spoken at Home | Interpreter Required | Yes/No |

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| **Referring GP Details**  |
| GP Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Phone No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Fax No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| e-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| ***Reason for referral- Please tick the relevant box(es)*** |
| All reasonable investigations pertaining to pain have been carried out |  |
| Reasonable and accessible management in the primary care sector has been carried out |  |
| Pain has significant impact on life* Sleep, self-care necessitating the assistance of others
* Mobility, work, school attendance, recreation, relationship and/or other emotions
 |  |
| Emergency Department presentations or hospital admissions for pain  |  |
| Complex psychosocial influences relating to pain behaviour requiring specialised assessment and care  |  |
| History of addiction or prescribed medication use complicating current management e.g. escalating opioid requirement |  |
| Difficult to control neuropathic pain  |  |
| Difficult to control cancer pain |  |
| Persistent pain following trauma or surgery where there is concern regarding transition to chronic pain |  |
| Location of pain:……………………………………………………………………………………..Impact of Pain:……………………………………………………………………………………… |
| Priority Category  | Wait Time <8 weeks  | Wait time 2-6 months  | Wait time 6-12 months  |

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| ***Please ensure specialist reports/summaries/investigations relevant to the patient’s pain condition are attached*** |

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| **Patient history** |
| Relevant clinical history |
| Background surgical and imaging history (please attach relevant reports)  |
| Current treatment from other specialist or allied health professional for the same problem? Aware and supportive of referral?Please provide details | Yes/No |
| History of assessment by another pain service or rehabilitation service for pain management in the last 2 years?Name of Service:Please attach relevant correspondence | Yes/No |
| Current Medications (include dosage route, frequency and include analgesics) |  |

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| --- | --- |
| Psychiatric history?Please describePsychological stressorsPlease describeHave any addiction services been involved?Please provide details | Yes/No |
| Has the patient consented to the referral? | Yes/No |
| Does the patient require an advocate/parent/guardian to be involved in consultations and managementIf yes: Relationship to patient:………………………………………………………….Name:……………………………………………………………………………………..Contact Details:…………………………………………………………………………………..Has carer strain been identified? | Yes/No |
| Would you like the relevant pain service to contact you for telephone advice as soon as possible? | Yes/No |

\*Referral to parallel services such as addiction medicine, psychiatry and mental health may be essential

GP Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **OFFICE USE ONLY** | Referral received: | Triage date: | Triage officer name: | Signature |
| **URGENCY** |
|  | Category 1(<30 days) |  | Category 2(<90 days) |  | Category 3(<365 days) |  | GP contact/phone advice |
|  | Inappropriate referral |  | Further information required; (Specify)............................................................................................... |
| **SERVICE TYPE:** |
|  | Medical Consultation (specify):. |  | Multidisciplinary team review (specify): |
|  |  |  |  |
|  | Allied Health (specify) |  | Pain Management Program (specify) |
|  |  |  |  |
|  | Orientation – education program: (specify) |  | Other (specify) |
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