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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 describe  Psychological stressors  Please describe  Have 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 management  If 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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