



Queensland Government

Persistent Pain Management Service Referral

(Affix identification label here)

URN:
 Family name:
 Given name(s):
 Address:
 Date of birth: Sex: M F I

Facility:

» Prior to referral, please consider the *Screening and Referral Guide* for Queensland Health Persistent Pain Management Services.
 » To ensure the accurate categorisation of your patients' referral please provide as much information as possible.

Referral to

Name:
 Organisation:
 Address:
 Postcode:
 Phone: Fax: Email:

Patient details

Family name: Given name(s):
 Sex: Male Female Indeterminate Date of birth:
 Address: Postcode:
 Postal address (if different from above): Postcode:
 Phone (H): Phone (W): Phone (M):
 Indigenous status: Aboriginal but not Torres Strait Islander origin Torres Strait Islander but not Aboriginal origin
 Both Aboriginal and Torres Strait Islander origin Neither Aboriginal or Torres Strait Islander origin
 Not stated / unknown
 Country of birth: Preferred language: Interpreter required: Yes No
 Medicare card number: Medicare card expiry date:

Referring medical officer details

Family name: Given name(s):
 Organisation:
 Address: Postcode:
 Phone: Fax: Email:

Nominated general practitioner details (must be identified if not 'Referring medical officer')

Family name: Given name(s):
 Organisation:
 Address: Postcode:
 Phone: Fax: Email:

Reason for referral

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DO NOT WRITE IN THIS BINDING MARGIN





**Persistent Pain Management Service
Referral**

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth:

Sex: M F I

Patient clinical history

Relevant medical and surgical history (include treatments, medications, outcomes, date / time range):

History of assessment by another pain service / clinic in the past two years? Yes No

If yes, please provide details / other relevant information:

Current treatment from other specialist services for the same pain problem? Yes No

If yes, please provide details / other relevant information:

History of alcohol / substance abuse and / or medication misuse? Yes No

If yes, please provide details / other relevant information:

History of opiates / drugs of dependence for greater than 8 weeks? Yes No

If yes, have the *Drugs of Dependence Unit* been notified as per the *Controlled Substances Act*? Yes No

Please provide details / other relevant information:

» Please attach specialist reports / summaries / investigations relevant to the patient's pain condition and psychological status (required prior to entry to the service).

Medications and allergies

Current medications (include description, dosage, rate, dose quality, frequency, any additional instructions):

Allergies / adverse reactions (include reaction description):

Additional information (please provide details of the following information if known)

Psychological stressors:

Psychiatric history:

Cognitive function:

Declaration: I understand that the Persistent Pain Management Service's involvement will be consultative and time-limited. The patient's ongoing care will be provided by me / his or her General Practitioner.

Referring medical officer:

Signature:

Date:

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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: _____)

