Merri Health Chronic Pain Management Servoce GP Referral

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| **Referral Date:**    /    /     |

[ ] The client is aware that referral to the pain service requires active engagement. The client is ready to apply pain management principles into practice and is open to a biopsychosocial approach.

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| **Referral to:**Name:      Address:           Phone:      Fax:      Email:       |  | **Referring General Practitioner** (stamp): |

Patient Details

|  |  |  |
| --- | --- | --- |
| Name:      Date of Birth:    /    /    Preferred name/s:      Gender:       Title:       |  | Address:           Phone:       Work:      Mobile:      Email:       |
| Alternative Contact:       |
| Indigenous Status:       |

Reason for patient referral (e.g. what does the patient hope to achieve through this referral?)

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|       |

Description of presenting and underlying pain issues (e.g. pain onset, location, nature and duration, psychological status, details of previous pain management interventions and their outcomes)

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|       |

Other notes (e.g. social, spiritual, diversity, and vulnerable population considerations)

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|       |

Current or previous services (e.g. psychology, psychiatry, physiotherapy, osteopath)

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| --- | --- | --- | --- |
| Type of service  | Organisation | Timeline | Contact details or other information as appropriate |
|       |       |       |       |
|       |       |       |       |
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Referrals sent

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| Type of service  | Organisation | Purpose of referral |
|       |       |       |
|       |       |       |
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| Interpreter required:      Preferred language is:      Pension Card Number:       |  | DVA Number:      Insurance:      Medicare Number:       |

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**Consent to referral and sharing of relevant information:** [ ]  Yes [ ]  No

Attach ‘Patient Consent Form’ if restrictions apply.

Clinical information

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**Warnings:**

**Allergies:**

**History of alcohol, recreational or injectable drugs, or prescription medicine misuse:**

**Current Medication (including non-prescription medicines, herbs and supplements):**

|  |  |  |  |
| --- | --- | --- | --- |
| Drug name | Ltd. elapse | Strength | Dose / frequency / special |
|       |       |       |       |
|       |       |       |       |
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| **Social History:**      |

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| **Comprehensive Past Medical History (including psychiatric e.g. PTSD):**      |

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| **Investigations / Test Results (e.g. neurological or orthopaedic imaging, nerve conduction studies, HbA1c):**       |

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| **Details of any current behaviours that may impact on the person’s ability to participate in a chronic pain management program (e.g. behaviours of concern, level of alcohol intake, cognition issues, reliance on a carer, mental health issues):**       |

 🖷 **Fax** this form to: **(03) 9495 2599**

**Call 1300 637 744 for assistance**

**Important: please be mindful of client privacy and Australian privacy laws when deciding how best to send this information. As this form contains detailed medical history, medication lists or test results, please fax to 03 9495 2599.**

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