Merri Health Chronic Pain Management Program GP Referral

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| Merri Health Chronic Pain Management Service GP Referral |  | **Referral Date:**    /    /    **GP Review Date:**    /    /    **Feedback Requested:** [ ]  Yes [ ]  No |

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

Patient / client details

|  |  |  |
| --- | --- | --- |
| Name:      Date of Birth:    /    /    Preferred name/s:      Sex: [ ]  Male [ ]  FemaleTitle: [ ]  Mr [ ]  Mrs [ ]  Ms [ ]  Miss |  | Address:           Phone:       Work:      Mobile:      Email:       |
| Alternative Contact:       |
| Indigenous Status: |

Reason for patient referral

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|       |

Other notes (eg current services)

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|       |

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| Interpreter required:      Preferred language is:      Pension Card Number:       |  | DVA Number:      Insurance:      Medicare Number:       |

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

Attach ‘Patient Consent Form’ if restrictions apply.

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| Referring doctor:       Patient name:       Date:    /    /      | Page 1 of 2 |

Merri Health Chronic Pain Management Program GP Referral

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| Merri Health Chronic Pain Management Service GP Referral | 🖂 **Email** this form to: service.access@merrihealth.org.au Or🖷 **Fax** this form to: **(03) 9495 2599****Call 1300 637 744 for assistance** |

Clinical information

**Warnings:**

**Allergies:**

**Current Medication:**

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

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| **Past Medical History:**      |

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| **Investigation / Test Results:**      |

|  |  |
| --- | --- |
| Referring doctor:       Patient name:       Date:    /    /      | Page 2 of 2 |