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 |

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

Patient / client details

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| Name:  Date of Birth:    /    /  Preferred name/s:  Sex:  Male  Female  Title:  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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| 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 |

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| Merri Health Chronic Pain Management Service GP Referral | 🖂 **Email** this form to: [service.access@merrihealth.org.au](mailto: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:**

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| --- | --- | --- | --- |
| 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:** |

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