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):**

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

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🖂 **Email** this form to: service.access@merrihealth.org.au Or 🖷 **Fax** this form to: **(03) 9495 2599**

**Call 1300 637 744 for assistance**