Persistent Pain Program Referral Form

PATIENT DETAILS

Date of Referral:		Date of Birth:	Gender: M / F
Title:	Surname:	First Name:	Middle Name:
Address: :			
Daytime contact number: Home:		Work:	Mobile:

Patient presentation

Clinical History:

PAST HISTORY

Has the patient previously visited a pain clinic or participated in in pain management program? YES/NO

If so, Where , When

The patient has met ALL the following criteria to be eligible for the program (please tick):

The patient has persisting pain which has lasted for more than 3-6 months

The patient is not suitable for surgical or urgent pain specialist interventions

The patient is not a palliative care patient

The patient requires improved self-management strategies and skills to optimise ongoing care

The patient is able to participate in group education

Able to give voluntary, informed consent for the ongoing collection of audit data.

REFERRING DOCTOR/Organisation DETAILS

A GP Sign off is mandatory for this referral to be accepted

Please stamp/insert details:

Doctor's Signature_____

Date_____

REFERRING ALLIED HEALTH PROFESSIONAL DETAILS (if this applies)

Please stamp/insert details:

AH Signature:_____

Date:_____