Returning Officer: ……..
Tel: ……..
Please email to: referrals@360.org.au OR
Fax to (08) 9279 8221

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:_____

On the receipt of this referral, the patient will be contacted with details of the Persistent Pain Program for review with an initial service assessment. Our case management reviews will be held at our office at 360 Health + Community, 14-16 Commodore Drive, Rockingham. The self-management education sessions will be held at 360 Health + Community, 14-16 Commodore Drive, Rockingham. Patients will be provided with a calendar of dates of our next program. Please provide your patient with the *Patient Information Sheet* for further information. Patients can also call us directly to enquire further on, Tel: 08 6595 8800

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