Barwon Health **Barwon Health Pain Management Unit** **Referral** **(FAX NO: 03 4215 1383)**	(Affix identification label here – hospital use only) URN: Family name: Given name(s): Address: Date of birth: Sex: M ☐ F ☐

» Prior to referral, please consider the *Screening and Referral Guide* for Barwon Health Pain Management Services.
» To ensure the accurate categorisation of your patients' referral please provide as much information as possible.

Referral to Barwon Health Pain Management Unit (Director, Dr L Brennan)

Fax Referral to: 03 4215 1383

Patient details

Family name:	Given name(s):	
Gender: Male Female	Date of birth:	
Address:		Postcode:
Postal address (if different from above):		Postcode:
Phone (H):	Phone (W):	Phone (M):
Country of birth:	Preferred language:	Interpreter required? Yes ☐ No ☐
Medicare card number:	Medicare card expiry date:	
Is this TAC/Workcover or DVA? Yes ☐ No ☐	Claim number:	

Referring medical officer details

Family name:	Given name(s):	
Organisation / practice name:		Provider no.:
Address:		Postcode:
Phone:	Fax:	Email:

Nominated general practitioner details (must be identified if not 'Referring medical officer')

Family name:	Given name(s):	
Organisation / practice name:		Provider no.:
Address:		Postcode:
Phone:	Fax:	Email:

Reason for Referral and Pain history (summary of pt needs, date of injury/onset pain/mechanism of injury/ location & nature of pain)

GP expectation from the pain consult/assessment?

Barwon Health Pain Management Unit

Referral

(FAX NO: 03 4215 1383)

(Affix identification label here – hospital use only)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: M ☐ F ☐

Patient history

Relevant medical and surgical history:

History of assessment by another pain service / clinic in the past two years? Yes ☐ No ☐

If *yes*, please provide details:

Current treatment from other specialist services for the same pain problem? Yes ☐ No ☐

If *yes*, please provide details:

History of alcohol / substance abuse and / or medication misuse? Yes ☐ No ☐

If *yes*, please provide details:

History of opiates / drugs of dependence for greater than 8 weeks? Yes ☐ No ☐

If *yes*, do you have a permit? Yes ☐ No ☐

Current medications (include description, dosage, rate, dose quality, frequency, any additional instructions):

Allergies / adverse reactions (include reaction description):

Psychological stressors:

Psychiatric history:

» Please attach specialist reports / summaries / investigations relevant to the patient's pain condition and psychological status (required prior to entry to the service).

This patient's pain has been appropriately assessed and he / she is medically fit to undertake a management program Yes ☐ No ☐

I only require telephone advice to help manage this patient Yes ☐ No ☐

This patient consents to this referral Yes ☐ No ☐

Referring medical officer: Signature: Date: