

UR NUMBER

SURNAME

GIVEN NAMES

DATE OF BIRTH

Please fill in if no Patient Label available App.27/2/26 Print Code:17541

INTEGRATED PAIN SERVICE REFERRAL

To: Dr Gayathri Aravinthan
Head of Unit Persistent Pain Service
Bayside Health Peninsula Care Group Integrated Pain Service

Patient Name: **Date of Birth:**/...../.....

Address:

Email: **Phone:**

GP:

Interpreter Required: No Yes **Preferred Language:**

I am referring the above patient to Integrated Pain Service for specialist pain assessment, opinion and management.

Reason for Referral:

For this referral to proceed you must be able to answer the following:

The patient has...

- persistent or chronic pain (longer than 3 months duration) that impacts on function including daily activities, work, study, school or carer role;
 No Yes
- had an adequate trial treatment (e.g. physiotherapy, psychology, medical management) for this pain condition in previous 12 months;
 No Yes
- a risk of functional or psychological deterioration, or medication dependence
 No Yes
- a willingness to engage in a multi-disciplinary pain management program focussed on living well with pain and active self-management strategies
 No Yes

For patients answering **no** to any of these questions consideration will be given to access a medical only pathway within our service.

Please identify if the patient has any of the following:

CRPS duration:

post herpetic neuralgia

Please also note that referral to a public hospital H.I.P. chronic pain service is not appropriate if they are currently undertaking another chronic pain management program or if they have previously completed a pain management program for the same issue and nothing else has changed.



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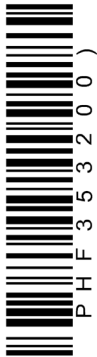
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**INTEGRATED PAIN SERVICE
REFERRAL cont.**



Required Information: Please attach copies of relevant correspondence, medical reports, imaging, and pathology reports.

1. Diagnosis: *(impression, if available)*

2. Pain history: onset, location, nature of pain and duration:

3. Past Medical History: *(can be included in attached health summary)*

4. Psychological status and cognitive function:

5. Details of previous pain management including the course of treatment(s) and outcome of treatment(s) and whether there has been any change in readiness to participate in a pain management program:

6. History of alcohol, recreational or injectable drugs, or prescription medicine misuse:

7. Current and complete medication history: *(can be included in attached health summary)*

8. Any further relevant information (include any potential safety issues):

9. Is this referral related to a WorkCover or TAC claim No Yes

Note: Patients who want to receive services as a compensable patient should not be referred to health service that only provides publicly funded services.

Please attach copies of relevant correspondence, medical reports, imaging, and pathology reports.

Referrer Name: Provider Number:

Signed: Date:

Phone:

**Please complete all fields and send to
Bayside Health Peninsula Care Group
ACCESS fax 91255862**