Queensland Government

# QId Collaborative Virtual Integrated Pain Service Referral

**Facility:**

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

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

## Referral to: *Please direct this referral to your local catchment Persistent Pain Service to review*

| | | |
|---|---|---|
| Name: | | |
| Organisation: | | |
| Address: | | Postcode: |
| Phone: | Fax: | Email: |

## Patient details

| | | |
|---|---|---|
| Family name: | Given name(s): | |
| Sex: ☐ Male ☐ Female ☐ Indeterminate | Date of birth: | |
| Address: | | Postcode: |
| Postal address (if different from above): | | Postcode: |
| Phone (H): | Phone (M): | Phone (W): |
| Indigenous status: ☐ Aboriginal but not Torres Strait Islander origin ☐ Torres Strait Islander but not Aboriginal origin ☐ Both Aboriginal and Torres Strait Islander origin ☐ Neither Aboriginal or Torres Strait Islander origin ☐ Not stated/unknown | | |
| Country of birth: | Preferred language: | Interpreter required? ☐ Yes ☐ No |
| Medicare card number: | Medicare card expiry date: | |

## Referring medical officer details

| | | |
|---|---|---|
| Name: | | |
| Organisation/practice name: | | Provider no: |
| Address: | | Postcode: |
| Phone: | Fax: | Email: |

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

| | | |
|---|---|---|
| Name: | | |
| Organisation/practice name: | | Provider no.: |
| Address: | | Postcode: |
| Phone: | Fax: | Email: |

## Reason for referral and pain history

DO NOT WRITE IN THIS BINDING MARGIN

QLD COLLABORATIVE VIRTUAL INTEGRATED PAIN SERVICE REFERRAL

v3.00 - 06/2021

SW1070

Queensland Government

**Persistent Pain Management Service**

# Referral

**Facility:**

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

## 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*, have the Drugs of Dependence Unit been notified as per the Controlled Substances Act? ☐ Yes ☐ No

If *yes*, please provide details:

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

***Allergies / adverse reactions*** (include reaction description):

***Psychological stressors:***

***Psychiatric history:***

***Cognitive function:***

» *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: |
|---|---|---|
| | | |

**OFFICE USE ONLY** *Referrals will be transfered between all QCVIPC provider sites depending on the patients selected pathway*

| | | | | |
|---|---|---|---|---|
| **GC IPPC** | Referral received: | Triage date: | Triage officer name: | Signature: |
| **SC PPMS** | Referral received: | Triage date: | Triage officer name: | Signature: |
| **NQ PPMS** | Referral received: | Triage date: | Triage officer name: | Signature: |

DO NOT WRITE IN THIS BINDING MARGIN