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

» *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

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 ☐ Both Aboriginal and Torres Strait Islander origin ☐ Not stated/unknown ☐ Torres Strait Islander but not Aboriginal origin ☐ Neither Aboriginal or Torres Strait Islander origin		
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

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PPMS REFERRAL FORM

v2.00 - 09\2014

SW218

Queensland Government

Persistent Pain Management Service

Referral

(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

Referral received:	Triage date:	Triage officer name:	Signature:

Urgency: ☐ Category 1 (‹ 30 days) ☐ Category 2 (‹ 90 days) ☐ Category 3 (‹ 365 days) ☐ GP contact / phone advice

☐ Inappropriate referral ☐ Further information required (specify: .....)

Service type: ☐ Medical consultation (specify: .....) ☐ Multidisciplinary team review (specify: .....)

☐ Allied health (specify: .....) ☐ Pain management program (specify: .....)

☐ Orientation - education program (specify: .....) ☐ Other (specify: .....)

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