	STANDARD FORM **Pain Management Referral Form**	

P A I N R E F E R R A L F O R M

Contact Details:

Name: …………………………………………… Date of Referral: …………………………..……

Age: ……………………………………………… Date of Birth:……………………………….…..

Address:………………………………………… Telephone; (H) ………………………………......

…………………………………………………… (W) ………………………………..

Referrer:……………………………………….. Doctor: ……………………………………….

Address: ……………………………………… Address: ……………………………………..

……………………………………………….. ……………………………………………...

Phone: ………………………………………… Phone: …………………………………………

Funding: Private / Workcover / CTP / ADF / DVA / Other Insurer

Diagnosis and Date of Onset: …………………..………..……………………………………..…

………………………………………………………………………………………………………..

Relevant Medical History; ……………………………………………………………………….

………………………………………………………………………………………………………..

Current Medications; ……………………………………………………………………………..

Attitude towards Referral: ………………………………………………………………….

Forward Report to: ……………………………………………………………………………….

………………………………………………………………………………………………………..

Contact Process: Contact client directly for appointment / Contact referrer for further direction / other: ……………………………………………………………………………..

NB: ALL REFERRALS MUST BE ACCOMPANIED BY A MEDICAL CERTIFICATE STATING THAT THE CLIENT IS MEDICALLY FIT TO UNDERTAKE THE PAIN MANAGEMENT COURSE.

PAIN REFERRAL FORM

Physical Status:

Visual: ……………………………………………………………………………..

……………………………………………………………………………..

Hearing: ……………………………………………………………………………………………

Communication: ……………………………………………………………………………………

Needs Interpreter: Yes No (Circle)

Non-English Speaking Background: Yes No (Circle)

Physical Function:
Comment on which part/parts of the body the client reports the pain?

……

……

Any other comments relevant to their physical condition?

……

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Perceptual/Cognitive Function: (Circle)

- Not impaired
- Impaired Give details: …………………………………………………………………………

………..

Psychiatric Condition: (Circle)

- Not present
- Present Give details; ………………………………………………………………………….

………

DOCTOR'S APPROVAL:

I, Dr …………………………….. of ………….……………………..(Medical Practice) give approval for ………………….………..(Client / Patient Name) to undertake a Pain Management Course with a Multi-Disciplinary team of health professionals from North Queensland Therapy Services.

Signed …………………….. Date ………………………………