

Referral Form- Paediatric Chronic Pain Service

Women’s and Children’s Health Network

72 King William Road, North Adelaide SA 5006

Tel: 0481900577 Fax: 81616246

**Dear \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*[Note: All patients referred to the multidisciplinary chronic pain service are seen by a specialist doctor at their initial appointment. Dr Kirsten Ball and Dr Nick Mills are the doctors for this service.]*

Please find attached completed Paediatric Chronic Pain Service referral for:

**PATIENT DETAILS**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

UR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REFERRING PRACTIONERS DETAILS**

Referring Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Period of referral (circle) 3 months; 12 months; 18 months; Indefinitely

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| **REFERRAL TO PAEDIATRIC CHRONIC PAIN SERVICE**  **NB:** All fields must be completed to enable processing of referrals. | | | | | | PATIENT LABEL  UR Number:  Surname:  Given Name:  D.O.B: Sex: | |
| **PATIENT DETAILS** | | | | | | | |
| Family name: | | | Given names: | | | | |
| Sex: | DOB: | | Date of Referral: | | | | |
| Address: | | | | | | | |
| Aboriginal and or Torres Strait Islander Status:  □ Aboriginal  □ Torres Strait Islander  □ Both Aboriginal and Torres Strait islander  □ Neither  Aboriginal Health Service and Contact: | | | | | CALD: □ Yes □ No  Country of Birth:  Interpreter required: □ Yes □ No  If yes, language: | | |
| Medicare card no: | | | | | Medicare expiry date: | | |
| Will the patient require prior approval from an insurer to attend a clinic? □ Yes □ No  If yes, Insurer: Claim no: | | | | | | | |
| Parent/guardian name: | | | | | | | |
| Relationship to patient: | | | | | | | |
| Address (if different than patient): | | | | | | | |
| Phone (H): | | Phone (W): | | | | | Phone (M): |
| **REFERRER’S DETAILS** | | | | | | | |
| Name: | | | | | Provider number: | | |
| Organisation/practice name: | | | | | Address: | | |
| Phone: | | Email: | | | | | Signature: |
| **CONSULTANT IN CHARGE OF CARE** | | | | | | | |
| Name: | | | | | Provider number: | | |
| Organisation/Practice name: | | | | | Address: | | |
| Phone: | | Email: | | | | | Signature: |
| **NOMINATED GENERAL PRACTITONER’S DETAILS (IF NOT REFERRING MEDICAL OFFICER)** | | | | | | | |
| Name: | | | | Provider number: | | | |
| Organisation/practice name: | | | | Address: | | | |
| Phone: | | Fax: | | | | | Email: |

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| **REFERRAL TO PAEDIATRIC CHRONIC PAIN** **SERVICE**  **NB:** All fields must be completed to enable processing of referrals. | PATIENT LABEL  UR Number:  Surname:  Given Name:  D.O.B: Sex: |
| **REASON FOR REFERRAL (Please tick all relevant boxes)** | |
| □ All reasonable investigations have been completed  □ Reasonable management in the primary care or hospital sector has been tried with insufficient success  □ Pain has significant impact on life e.g. sleep, self-care or pain necessitating the assistance of others; pain impacting mobility, work or school attendance, recreation, relationships and/or emotions  □ Pain exacerbations have resulted in extreme distress or repeated hospital presentations/admissions  □ There seem to be complex psychosocial influences relating to pain behaviour requiring specialized assessment and care  □ Current drug management is not resolving pain or leading to improved quality of life e.g. escalating opioids requirements but inadequate relief  □ Duration of pain for greater than 3 months | |
| **PATIENT MEDICAL HISTORY** | |
| Relevant clinical history: | |
| Background surgical and imaging history (please attach relevant reports): | |
| Is the patient and others involved in their care aware and supportive of referral: □ Yes □ No  Comments: | |
| Please outline current or previous treatments from other specialist or allied health service providers for the same problem including name and service provider details. | |
| Current medications (include dosage, route, frequency and include analgesics): | |
| |  |  | | --- | --- | | **REFERRAL TO PAEDIATRIC CHRONIC PAIN** **SERVICE**  **NB:** All fields must be completed to enable processing of referrals. | PATIENT LABEL  UR Number:  Surname:  Given Name:  D.O.B: Sex: |   Previous pain medications and reasons for stopping them: | |
| Allergies and adverse reactions: | |
| Please outline the history of any previous assessment by another pain or rehabilitation service for pain management (Please attach any relevant correspondence): | |
| Please outline any psychiatric or psychological history including name of treating practitioner and past and present treatments. | |
| Does the patient have any other issues the Chronic Pain Service should be aware of? Eg. developmental, learning or communication difficulties, current level of support required (eg. full-time assistance), use of aids (eg. wheelchair). | |