

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 LABELUR 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□ NeitherAboriginal Health Service and Contact: | CALD: □ Yes □ NoCountry of Birth: Interpreter required: □ Yes □ NoIf yes, language: |
| Medicare card no: | Medicare expiry date: |
| Will the patient require prior approval from an insurer to attend a clinic? □ Yes □ NoIf 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 LABELUR 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 □ NoComments: |
| 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): |
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| **REFERRAL TO PAEDIATRIC CHRONIC PAIN** **SERVICE****NB:** All fields must be completed to enable processing of referrals. | PATIENT LABELUR 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). |