Living Well with Persistent Pain

Northern Program – Fax: 8289 1255
Centre-West Program – Fax: 8440 5299

phn ADELAIDE
An Australian Government Initiative
connecting you to health

Referral form

PATIENT DETAILS

Date of Referral:		Date of Birth:	Gender:
Title:	Surname:	First Name:	Middle Name:
Address:			
Daytime contact number: Home:		Work:	Mobile:

PATIENT PRESENTATION

Clinical History:
Current Medication List:

PAIN MEDICATION HISTORY

Medication previously tried:

PAIN INVESTIGATIONS HISTORY

Previous investigations and tests conducted

PAIN MANAGEMENT HISTORY

Has the patient previously visited a pain clinic or participated in a pain management program? **Yes / No** ***If yes, where and when:*** What other pain management strategies have been tried?

RISK ASSESSMENT

Suicidal ideation	**Yes…./….No**	Suicide intent	**Yes…./….No**
Current suicidal plan	**Yes…./….No**	Risk to others	**Yes…./….No**
Guide to above risk assessment outcome: If **YES** to one or more of the above questions, please contact your local mental health service provider to consider options for this patient before referring to the Living Well with Persistent Pain program.			
Other comments			

As the referring GP, I agree to:

- ☐ Support my patient to implement their goals and management plans identified with the Care Coordinator, including any referrals to allied health.
- ☐ Encourage my patient to attend the education program
- ☐ Provide additional patient history as required
- ☐ Respond to requests for additional referrals, including HMRs as required

As part of the program, I would like my patient to access a GP with a special interest to assist with:

- ☐ Opioid or other deprescribing
- ☐ Second opinion – please provide more detail
  _____
- ☐ Medical advice for ongoing management
- ☐ Not required

The patient meets all of the following eligibility criteria:

- ☐ Over 18 and living in the northern or central-western Adelaide suburbs
- ☐ Experiencing chronic or persistent pain which has lasted for more than 3–6 months
- ☐ Diagnosed with chronic or persistent pain and any other biological causes (e.g. cancer) fully addressed or ruled out
- ☐ Not suitable for surgical or urgent pain specialist interventions
- ☐ Not in a palliative care situation
- ☐ Able to benefit from improved self-management strategies and skills to optimise ongoing care
- ☐ Suitable for and willing to participate in group education. ***A commitment to attendance is required to enter and remain in the program.***
- ☐ Able to understand written and spoken English
- ☐ Willing to give ongoing informed consent for the collection of de-identified evaluation data.

REFERRING DOCTOR/ORGANISATION DETAILS

A GP Sign off is mandatory for this referral to be accepted

Please stamp/insert details:

Doctor's Signature:_____

Date: _____

This referral is valid for 12 months.

On the receipt of this referral, the patient may be placed on a waiting list and contacted with details of the Living Well with Persistent Pain Program.

Referrals are addressed upon receipt with all considered equally.

PATIENT CONSENT:

I understand that this referral is for the provision of pain management services, which include an assessment, the development of a plan for treatment, and education sessions. I agree to be a part of this process with the knowledge that:

- ☐ My medical history will be shared with the necessary health service providers where relevant
- ☐ The information collected is private and will be kept confidential unless agreed upon
- ☐ My GP has explained to me the reasons for participating in this program
- ☐ I understand that my treatment will be monitored and communicated between my treatment team including my GP
- ☐ All personal information gathered will remain confidential and secure with my treating team.

Name: _____

Signature:_____

Date:_____