Broken Hill GP SUPER CLINIC phn WESTERN NSW An Australian Government Initiative **BROKEN HILL PAIN MANAGEMENT SERVICE REFERRAL**	Family name:	
	Given name:	
	Date of birth:	

To avoid delays for your patients please consider the Screening and Referral Guide for Persistent Pain Management Services prior to referring patients. Please provide as much information as possible

Referral to		
Name:	Kathy Mitchell (Nurse Practitioner)	
Organisation:	Coordinator, Broken Hill Pain Management Program	
Address:	235 Thomas Street, Broken Hill, NSW, 2880	
Phone: (08) 8088 7044	Fax: (08) 8088 7055	Email: painclinic@brokenhillgpsuperclinic.com.au

Patient Details		
Family name:		Given name(s):
☐ Male	☐ Female	Date of birth:
Address:		Postcode:
Post address (if different from above):		
Phone:	Mobile:	Email:
Medicare card number		Number on card:
Expiry date:		

Referring Practitioners Details		
Family name:		Given name(s):
Practice Name:		Provider number:
Address:		Postcode:
Phone:	Fax:	Email:

Nominated Practitioner's details. Should be identified if not the referring practitioner		
Family name:		Given name:
Practice Name:		Provider number:
Address:		Postcode:
Phone:	Fax:	Email:

Reason for Referral	**Y/N**
All reasonable investigations have been completed	
Reasonable and accessible management in the primary care sector has been tried with insufficient success	
Pain has significant impact on life including; sleep, self-care or pain necessitating the assistance of others	
Pain impacting on mobility, work or school attendance, recreation, relationships and/or emotions	
Pain exacerbations have resulted in an Emergency Department presentation or hospital admission	
There seem to be complex psychosocial influences relating to pain behaviour requiring specialised assessment and care	
Current or past history of addiction or prescribed medication use seem to be complicating current management; *e.g. escalating opioid requirement*	
Difficult to control neuropathic pain is suspected	
Other reasons:	

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Patient History		
Relevant Clinical history ***(please attach relevant correspondence to this referral):***		
Background surgical and imaging history ***(Please attach relevant reports):***		
Current medications ***(include dosage, route, frequency and include analgesics):***		
Allergies/adverse reactions:	☐ Yes	☐ No

	Y/N
Psychiatric history? ***Please describe:***	
Psychological stressors? ***Please describe:***	
Have any addiction services been involved? ***Please provide details:***	
Could the patient have difficulty accessing information/services?	
Impaired cognitive function?	
Visual or hearing impairment?	
Difficulty reading and or accessing forms?	
Difficulty travelling?	
Has the patient consented to the referral?	

Pain management services are provided collaboratively with medical, nurse practitioners and allied health input in a coordinated approach. This program may involve up to two multidisciplinary case conferences for each referred patient. Referral to parallel services such as Addiction Medicine, Psychiatry and Mental Health may be required. If so you will receive communication with recommendations for referral
Signature or Stamp Date:

Thank you for your time in completing this referral