Patient Referral

FRANKSTON
PAIN MANAGEMENT
Maximising Function | Minimising Pain & Suffering

PATIENT DETAILS: Affix Hospital identification label

Patient Name ..... DOB .....

Patient Address .....

Email.....

Home Phone.....Mobile.....

Funding : ◯ Private ◯ WorkCover ◯ TAC ◯ DVA ◉ Uninsured Interpreter Required

Language .....

These details are required to process referral

Patient Email:.....
Next of Kin (NOK) Name:.....
NOK mobile:.....
NOK Email:.....

DATE: .....

REFERRAL TO:

◯ Next available:
◉ Name.....

REFERRAL PERIOD:

◯ 3 months (specialist)
◯ 12 months (GP)
◉ Indefinite (GP)
◯ Other: .....

DETAILS OF REFERRAL (TICK ALL THAT APPLY):

☐ CRPS ☐ Headache/Facial pain ☐ Neck pain ☐ Shoulder pain
☐ Arm pain ☐ Low back pain ☐ Abdominal Pain
☐ Leg pain ☐ Hip Pain ☐ Knee pain ☐ Widespread pain

ADDITIONAL FEATURES:

☐ Cancer-related pain
☐ Neuropathic features
☐ Sympathetic features
☐ Post-surgical pain

FURTHER CLINICAL DETAILS:

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Please include and up-to-date medication list and allergy status, pertinent blood tests, radiology reports, specialist letters, other relevant investigations and details of pending investigations or specialist reviews.

SERVICES REQUIRED (TICK ALL THAT APPLY):

☐ General Pain Management advice and treatments
☐ Opioid management /addiction medicine
☐ Acute Pain

Interventions:

☐ Nerve & Joint blocks
☐ Sympathetic blocks
☐ Radiofrequency treatments
☐ Platelet Rich Plasma
☐ Prolotherapy

Neuromodulation & Pain Device:

☐ Spinal cord stimulation
☐ Dorsal root ganglion stimulation
☐ Sacral nerve stimulation
☐ Peripheral nerve stimulation
☐ Drug catheter

Therapies:

☐ Magnesium infusion
☐ In Hospital Ketamine infusion
☐ Scrambler Therapy

REFERRER:

NAME: .....
PHONE: .....
FAX: .....
PROVIDER NO: .....

All correspondence & enquiries:

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