REFERRAL FORM

Main reason for patient referral: ______________________

BACKGROUND INFORMATION

Has the patient had pain for longer than 12 weeks?

☐ Yes ☐ No

Is the patient currently on sick leave?

☐ Yes ☐ No

Is the pain having a significant impact on the patient's life and functioning?

☐ Yes ☐ No

Has the patient been assessed / treated within secondary care before (e.g. a rheumatologist, neurologist)?

☐ Yes ☐ No

CONTACT DETAILS:

Referrer

Name ______________________ Position ______________________

Address ______________________ Phone ______________________

Patient

Name ______________________ Phone ______________________

Address ______________________

Patients GP (if not referrer)

Name ______________________ Practice ______________________

Address ______________________ Phone ______________________

BRIEF PAIN HISTORY:

Pain related diagnosis / diagnoses ______________________

____

Pain location(s) ______________________

____

Approximate pain duration ______________________

____

CHRONIC PAIN

CHANGE PAIN®
Taking care of pain

BRIEF PAIN HISTORY:

Present Pain Level

No Pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Pain as bad as you can imagine

Pain medication(s) / dosage currently prescribed ______________________________

____

Previous/ongoing (or planned) interventions and surgeries ______________________________

____

Other relevant medical history ______________________________

____

IMPACT OF PAIN:

Need for improvement in the following areas:

	not at all	a little	very much
Sleep	☐	☐	☐
General Activity	☐	☐	☐
Ability to work	☐	☐	☐
Relations with other people	☐	☐	☐
Mood	☐	☐	☐
Side effects	☐	☐	☐

OTHER RELEVANT INFORMATION:

Other relevant information (e.g. communication needs, concerns) ______________________________

____

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REFERRAL COMPLETED BY:

Name: ______________________________ Position: ______________________________

Signature: ______________________________ Date: ______________________________

(if sent by fax or post)

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