NSW GOVERNMENT Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

REFERRAL GUIDE TO ADULT AND PAEDIATRIC CHRONIC PAIN SERVICES

There are a number of publicly funded multi-disciplinary chronic pain services in NSW hospitals providing expert assessment, treatment and access to a range of interventions and self management based 'Pain Programmes' from a biopsychosocial perspective. The services are time-limited and require a referral from a medical practitioner with a provider number.

This is a guide to assist practitioners to navigate the referral system and establish suitability of the client. Once received, referrals will be assessed and prioritized by the Pain Service within your Local health District, according to statewide criteria.

Indications for referral to a Pain Service

Consider referral when the patient has **chronic pain*** and;

- 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 some aspects of life – sleep, self care, mobility, work or school attendance, recreation, relationships and/or emotions

Referrals are particularly encouraged when the patient has:

- exacerbations of chronic pain that resulted in an Emergency Department presentation or hospital admission
- complex psychosocial influences on pain behavior requiring specialised assessment and care
- current or past history of addiction or prescribed medication use that seem to be complicating current management (eg. an **escalating opioid requirement**)
- difficult to control neuropathic pain
- difficult to control cancer pain

***** Pain that is constant, and daily for a period of 3 months or more over the previous 6 months, or where the natural history of the painful condition predicts that this is likely to be the case. Also when episodic severe pain occurs; eg. headache which interferes with daily life.

The Pain Services will require

- Completion of the attached referral form in full where possible

The preference of the Chronic Pain Services is

- To work actively in partnership with the General Practitioner in ongoing management
- To work in close communication with other specialist services who are providing treatment for the same or related problem

Statewide Priority Categories

Priority 1 – Wait time < 4 weeks
Pain interfering with sleep or self-care, or requiring the assistance of another for activities of daily living; Children whose pain interferes with school attendance; Refractory cancer pain; Early neuropathic pain or complex regional pain syndrome (CRPS) < 3 months since onset

Priority 2 – Wait time 4-8 weeks
Pain < 1 year not responding to GP management; frequent pain exacerbations occasioning Emergency Dept. presentations or hospital admissions, neuropathic pain, persistent pain following trauma or surgery, pain associated with marked physical interference or emotional distress, children and elderly

Priority 3 – Wait time 2-3 months
Pain > 1 year not responding to GP management, diagnostic advice, medication optimization, psychological distress, physical interference

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SMR010.730

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Date:

Referred to:

Patient details		
Phone (H)	Phone (W)	Phone (M)
Email		Age >70 ☐ < 16 ☐
Indigenous/ CALD status ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Neither		CALD background Y ☐ N ☐
Country of Birth	Preferred language	Interpreter required Y ☐ N ☐
Medicare card no ☐☐☐☐☐☐☐☐☐☐	Medicare expiry date ☐☐ / ☐☐☐☐	

Referring Medical Officer's details		
Family Name	Given Name	
Organisation/practice name		Provider number
Address		Post code
Phone	Fax	Email

Nominated General Practitioner's details	Should be identified if not referring medical officer	
Family Name	Given Name	
Organisation/practice name		Provider number
Address		Post code
Phone	Fax	Email

Will the patient require prior approval from an insurer to attend a clinic Y ☐ N ☐	Insurer: Claim no:

Reason for referral. Please tick the relevant box(es)

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 - 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; eg. escalating opioid requirement	☐

NO WRITING

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Difficult to control neuropathic pain is suspected ☐

Difficult to control cancer pain ☐

Persistent pain following trauma or surgery where there is concern regarding transition to chronic pain ☐

Location of Pain……..

Impact of Pain ……. ☐

Comment:

Priority category **1** ☐ **2** ☐ **3** ☐ **(See Referral Guide)**

Patient History	
Relevant Clinical history (please attach relevant correspondence to referral)	
Background surgical and imaging history **(please attach relevant reports)**	
Current treatment from other specialist or allied health service providers for the same pain problem? Aware and supportive of referral? Please provide details	Y ☐ N ☐ Y ☐ N ☐
History of assessment by another pain service or rehabilitation service for pain management in the last 2 years Name of Service: Please attach relevant correspondence	Y ☐ N ☐
Current medications (include dosage, route, frequency and include analgesics)	

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Allergies/adverse reactions	Y ☐ N ☐
Psychiatric history? Please describe	Y ☐ N ☐
Psychological stressors? Please describe	Y ☐ N ☐
Have any addiction services been involved? Please provide details	Y ☐ N ☐ Y ☐ N ☐
Could the patient have difficulty accessing information/services?	
Impaired cognitive function?	Y ☐ N ☐
Visual or hearing impairment?	Y ☐ N ☐
Difficulty reading and or accessing forms?	Y ☐ N ☐
Difficulty travelling?	Y ☐ N ☐
Comment:	
Has the patient consented to the referral?	Y ☐ N ☐
Does the patient require an advocate/parent/guardian to be involved in consultations and management? If yes: Relationship to patient: Name: Contact details: Has carer strain been identified?	Y ☐ N ☐ Y ☐ N ☐
Would you like the relevant pain service to contact you for telephone advice as soon as practical?	Y ☐ N ☐

*Referral to parallel services such as Addiction Medicine, Psychiatry and Mental health may be essential

Thank you for your time in completing this referral

Name of person completing the form: Date:

Referral to:

Print Name: _____ Designation: _____

Signature: _____ Date: _____

NO WRITING