Persistent Pain Program Referral Form

Please fax Completed referral form to (08) 9458 0555

Office Use Only; Patient Code:_____

PATIENT CONSENT
I (the patient), give consent to participate in the Persistent Pain Program for Arche Health Ltd staff to access my medical information and share with contracted allied health professionals who are contributing to my care. I understand that my medical information will remain confidential.

Patient Signature		**Date**	

PAST HISTORY
Has the patient previously visited a pain clinic or participated in in pain management program? YES/NO
If so, Where , When

PATIENT DETAILS		
Date of Referral:	**Date of Birth:**	**Gender**: M / F
Title: **Surname:**	First Name:	Middle Name:
Address:		
Daytime contact number: Home:	Work:	Mobile:

PATIENT PRESENTATION

Clinical History:

□ Back Pain	□ Rheumatoid Arthritis	□ Fibromyalgia
□ Neck Pain	□ Osteoporosis	□ Migraine
□ Osteoarthritis	□ Complex Regional Pain Syndrome	□ Endometriosis

Other medical information: _____

□ **Current Treatment/Therapy *(please attach GPMP and TCA)***

□ **Current medications *(please attach current Medication list to referral form)***

The patient has met ALL the following criteria to be eligible for the program (please tick):

- □ The patient has persisting pain which has lasted for more than 3-6 months
- □ The patient is not suitable for surgical or urgent pain specialist interventions
- □ The patient is not a palliative care patient
- □ The patient requires improved self-management strategies and skills to optimise ongoing care
- □ The patient is able to participate in group education
- □ Able to give voluntary, informed consent for the ongoing collection of audit data.
- □ Can Understand English

REFERRING DOCTOR/Organisation DETAILS

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

Please stamp/insert details:

Doctor's Signature_____

Date_____

On the receipt of this referral, the patient will be contacted with details of the Persistent Pain Program for review with an initial service assessment.

Unit 4/1140 Albany Highway, Bentley WA 6102
T: (08) 9458 0505 F: (08) 9458 8733
E: t.pereyra@archehealth.com.au au W: www.archehealth.com.au