Peninsula Health

REFERRAL
INTEGRATED PAIN SERVICE

FAX: 9784 2309

PHONE: 1300 665 781

UR NUMBER ....

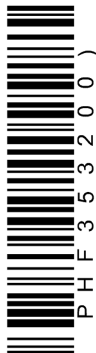
SURNAME ....

GIVEN NAMES ....

DATE OF BIRTH ....

Please fill in if no Patient Label available

App.30/10/18 Print Code:17541



Attention: Head of Unit - Dr T. Weaver

Client Details:

Client Name: .... Date of Birth: ..../........../..........

Address: ....

Telephone – Home: .... Mobile: .... Work: ....

e-Mail: ....

Financial Status: ☐ Worksafe ☐ TAC ☐ DVA ☐ Public Medicare No. ....

General Practitioner Details:

Name: .... Phone: .... Fax: ....

Address: ....

Primary Clinical Concern:

☐ Disabling pain (please state duration): ....

☐ Complex Regional Pain Syndrome (please state duration): ....

☐ Shingles or Post Herpetic Neuralgia ☐ Cancer Pain ☐ Other (please describe): ....

Reason For Referral and Pain History:

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Past Medical / Surgical History:

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Are there any 'Red Flag' Symptoms / Signs:

☐ Age >60 or <20yrs

☐ Fevers / Chills / Systemic Illness / Weight loss

☐ Trauma (minor trauma in elderly)

☐ Signs of Neurological involvement

☐ IV Drug use

It is mandatory that you include copies of relevant correspondence, medical reports, x-ray reports, pathology reports and a list of current and past medications for this referral to progress.
Please encourage patients to bring images to their appointment.

....	....	....	....
Signature	Print Name	Provider No.	Date

Please provide referrer details if not GP - Name: .... Role/Specialty: ....

Phone: .... Fax: ....

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MR/353200

30/10/18 Print Code:17541 Ref Link / GP Liaison