Queensland Government

Referral to North Queensland Persistent Pain Management Service (NQPPMS)

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

» Prior to referral, please consider the *Screening and Referral Guide for Queensland Health Persistent Pain Management Services*.
» To ensure the accurate categorisation of your patients' referral please provide as much information as possible.

Referral to

Name: ☐ **Dr Matthew Bryant**	☐ **Other:**	
Organisation: **North Queensland Persistent Pain Management Service**		
Address: **The Townsville Hospital, 100 Angus Smith Drive, PO Box 670, Douglas QLD**		Postcode: **4814**
Phone: **(07) 4433 2218**	Fax: **(07) 4433 2223**	Email: **NQPPMS@health.qld.gov.au**

Patient details

Family name:	Given name(s):	
Sex: ☐ Male ☐ Female	Date of birth:	
Address:		Postcode:
Postal Address (if different from above):		Postcode:
Phone (H):	Phone (W):	Phone (M):

Indigenous status: ☐ Aboriginal but not Torres Strait Islander origin ☐ Torres Strait Islander but not Aboriginal origin ☐ Both Aboriginal and Torres Strait Islander origin ☐ Neither Aboriginal or Torres Strait Islander origin ☐ Not stated / unknown

Country of birth:	Preferred language:	Interpreter required? ☐ Yes ☐ No
Medicare card number:	Medicare card expiry date:	

Referring medical officer details

Family name:	Given name(s):	
Organisation / practice name:		Provider no.:
Address:		Postcode:
Phone:	Fax:	Email:

Nominated general practitioner details (must be identified if not 'Referring medical officer')

Family name:	Given name(s):	
Organisation / practice name:		Provider no.:
Address:		Postcode:
Phone:	Fax:	Email:

Relevant medical and surgical history

Attach: ☐ Neurosurgical report ☐ MRI ☐ CT ☐ Neurological report ☐ Nerve conduction studies ☐ Orthopaedic report ☐ Bone mineral density ☐ Rheumatology report ☐ Full blood screening ☐ Completed patient questionnaire ☐ Other:

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URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Reason for referral, pain history and physical examination findings

History of assessment by another pain service / clinic in the past two years? ☐ Yes ☐ No

If *yes*, please provide details:

Current treatment from other specialist services for the same pain problem? ☐ Yes ☐ No

If *yes*, please provide details:

History of alcohol / substance abuse and / or medication misuse? ☐ Yes ☐ No

If *yes*, please provide details:

History of opiates / drugs of dependence for greater than 8 weeks? ☐ Yes ☐ No

If *yes*, have the Drugs of Dependence Unit been notified as per the Controlled Substances Act? ☐ Yes ☐ No

If *yes*, please provide details:

Current medications (include description, dosage, rate, dose quality, frequency, any additional instructions):

Allergies / adverse reactions (include reaction description):

Psychological stressors:

☐ Attach report

Psychiatric history:

☐ Attach report

Cognitive function:

» Please attach specialist reports / summaries / investigations relevant to the patient's pain condition and psychological status (required prior to entry to the service).

This patient's pain has been appropriately assessed and he / she is medically fit to undertake a management program ☐ Yes ☐ No

I only require telephone advice to help manage this patient ☐ Yes ☐ No

This patient consents to this referral ☐ Yes ☐ No

Referring medical officer:	Signature:	Date: