SCOTTISH NATIONAL RESIDENTIAL PAIN MANAGEMENT PROGRAMME

REFERRAL FORM v0.1, JANUARY 2015

PATIENT DETAILS M ☐ F ☐		Date of Referral (day/month/year)	
Name:		Referrer's Name:	
Address:		Specialty:	
		Hospital:	Health Board:
		GP Name:	
Postcode:	Age:	GP Practice:	
CHI:			
Patient tel (Day):		Postcode:	GP Tel:
Referrer's e-mail:		Patient has reasonable spoken English? Yes ☐	No ☐

PAIN HISTORY: include details on pain problem, diagnosis and site **OR** tick if enclosing clinic letter(s) ☐

DURATION OF PAIN:	**When last seen in pain clinic?**

Has this patient already attended a pain management programme? Yes ☐ No ☐
If yes, please give details:

Reasons for referring to residential pain management programme (Please tick all relevant boxes):

Excessive distance to local PMP ☐ *(details):*

No PMP in health board ☐

High levels of distress ☐

High levels physical disability ☐

Pain / physical disability preclude travel to local PMP ☐

Failed local PMP ☐

Difficult social circumstances ☐

Chaotic lifestyle ☐

Transport issues in attending local PMP ☐

Requires intensive input which can't be delivered by outpatient PMP ☐

Other reason(s) not mentioned above**:**

ANY OUTSTANDING INVESTIGATIONS / PROCEDURES? **NB** Patients should have ***all*** investigations completed prior to referral
Yes ☐ No ☐ If yes, please give details below.

PSYCHIATRIC DIAGNOSIS / MENTAL HEALTH DIFFICULTIES Yes ☐ No ☐ If yes, please give details.

Currently under care of CMHT? Yes ☐ No ☐ Name of Consultant Psychiatrist;

PREVIOUS INTERVENTIONS & TREATMENTS (Please tick all relevant boxes)

Physiotherapy: **MSK Physio (e.g. primary care, ortho) ☐** **Pain Specialist (comments below) ☐**

Psychology: **Primary Care ☐** **Pain Specialist (comments below) ☐**

Patient Education Classes ☐ **Any difficulties in complying with self-help guidance? Yes ☐ No ☐**

OTHER SIGNIFICANT MEDICAL CO-MORBIDITIES (eg severe cardio-respiratory problems, IDDM, epilepsy)
Yes ☐ No ☐ If yes, please give details.

LEGAL ISSUES PENDING Yes ☐ No ☐ If yes, please give details.

Visual Impairment Yes ☐ No ☐ Hearing difficulties Yes ☐ No ☐ Literacy Problems Yes ☐ No ☐
If yes, please give details of any assistance required i.e. colour of paper, larger font or hearing loop

POTENTIAL BARRIERS TO PARTICIPATION IN RESIDENTIAL PMP (Please tick all relevant boxes)

No obvious barriers ☐ **Pre-contemplative ☐** **Social anxiety ☐** **High levels of distress ☐**

High levels physical disability ☐ **Memory or comprehension problems ☐** **Literacy issues ☐**

Cure-seeking ☐

Difficult social circumstances ☐ **Chaotic lifestyle ☐**

Previous failure to complete PMP ☐

Further comments:

Patients referred will be assessed and discussed in an MDT meeting to decide suitability for the PMP.
If unsure about a particular referral, please feel free to phone and discuss prior to this.
E-mail, post or fax form to

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Please complete all sections, as incomplete forms will be returned for clarification