**Referrers Details:**

**GP Name: GP Practice:**

**Phone: Fax:**

**Postal Address:**

**Patient Information:**

**Name: DOB:**

**Phone: Email:**

**Postal Address:**

**Best contact (circle): email / phone Permission to leave a message? Y/N**

**Please note the following are exclusion criteria**:

* Patients undergoing active treatment for cancer, infection or fractures
* Patients receiving high dose opioids (>60mg morphine equivalent per day)
* Workers compensation, third party, and motor accident injury claims

**Patient Pain History:**

Please include any Specialist Reports or Investigations undertaken with this referral as well as a brief summary of their pain history with relevant past medical history and previous treatments.

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**Medication:** Please list the patient’s current medication below or provide in your usual referral letter

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Dose  | Frequency | No of days per week/7 |
|  |  |  |  |
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|  |  |  |  |
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Please return this form to the Chronic Pain Management Program Facilitator in your area, details are available on the ACT&Southern NSW HeathPathways portal [here](https://actsnsw.healthpathways.org.au/13893.htm).