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| **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. | |

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| **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** | | | |

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| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |  | | | | | | | | | |

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| |  | | --- | | * **Current Treatment/Therapy *(please attach GPMP and TCA)*** | |
| |  | | --- | | * **Current medications *(please attach current Medication list to referral form)*** | |

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| **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 and is >18 years of age. * 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **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.** |