

REFERRAL FORM

Greenwich Hospital Pain Clinic

PO Box 5084, Greenwich, Sydney NSW 2065 Fax No. 9903 8269



REFERRAL TO: PROF PHILIP SIDDALL DR AMANDA JOHNS

PATIENT DETAILS PLEASE INDICATE IF HAMMONDCARE OR LTCS REFERRAL

Surname:	Given Names:	DOB:
Address:		
Tel (mobile or daytime number):		
Facility if within HammondCare:	Participant No. if Lifetime Care:	

REFERRING DOCTOR (or CASE MANAGER IF LTCS REFERRAL)

Name:	(Or referring Dr's stamp here)
Address:	
Telephone: Fax:	
Signature: Date: / /	
Provider No.:	

LOCATION OF PAIN

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CAUSE OF PAIN (UNDERLYING PATHOLOGY IF KNOWN)

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CURRENT PAIN MEDICATIONS INCLUDING DOSE

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PREVIOUS PAIN MEDICATIONS

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CURRENT OR PREVIOUS TREATMENT FOR MOOD DYSFUNCTION

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MAIN REASON/S FOR REFERRAL ARE:

Medical assessment only Telehealth Medication advice Opioid reduction Pain management program
Multidisciplinary assessment (med, physio, clin psych) * Physiotherapy * Clinical psychology * Hydrotherapy *

* NB. Patients referred for these services require Private Health Insurance or a referral under the Enhanced Primary Care Program or the Lifetime Care and Support Scheme.

Other reason for referral:

ANY OTHER RELEVANT INFORMATION (Please also forward relevant specialist's reports and imaging)

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