**Referral Form Pain Management**

Patients should not be referred until all appropriate investigations have been completed. PLEASE DO NOT REFER PATIENTS TO THE PAIN SERVICE WITH UNINVESTIGATED RED FLAGS.

If a patient is currently on a surgical pathway for the condition they are being referred for, we would request that they complete this surgical pathway before referral to our service.

We do not accept referral for acute pain (< 3 months duration) or malignant pain.

Patients requiring acute mental health support for current suicide risk should be referred to mental health services.

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| Contact Details for the services |
| Southwest Hampshire Pain Management Service‘Live Your Best Life’Supported Self-Management |
| Email | PainService@southernhealth.nhs.uk |
| Address | Hythe Hospital, Beaulieu Road, Hythe, SO45 4ZB |
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| Patient’s details | Patient’s background and culture |
| Name | Full Name  | Ethnicity | Ethnic Origin       |
|  |  | 1st language | Main Language       |
| DOB | Date of Birth  | Age | Age  | Interpreter required? Interpreter required       |
| Sex | Gender(full) | Military Veteran?       |
| Address & postcode | Home Full Address (stacked)  | Referrer details |
|  |  | Referring Clinician  |       |
|  |  | Address | Organisation Name Organisation Full Address (stacked)  |
| NHS No | NHS Number  |  Tel no | Organisation Telephone Number  |
| Hospital No | Hospital Number       |  Email | Organisation E-mail Address       |
| Home tel  | Patient Home Telephone  | Referral date | Short date letter merged  |
| Work tel | Patient Work Telephone  | Date received |       |
| Mobile tel | Patient Mobile Telephone  |  |  |
| Email | Patient E-mail Address       |  |  |
| Preferred contact method | Home | **[ ]**  | Work  | **[ ]**  | Mobile | **[ ]**  | E-mail | **[ ]**  |

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| **Social Information** |
| Social Context | Transport Issues **[ ]**  | Has a Carer **[ ]**  | Is a Carer **[ ]**  | Lives Alone **[ ]**  |
| Next of Kin |       |
| Relationship to Patient |  | Telephone No |       |

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| **Reason for referral** |
| **Current Episode of Pain:** **Duration of current symptoms:** | **3-12months [ ]**  | **1-3 years [ ]**  | **3 years + [ ]**  |
| **Is the patient off work due to pain?** | **Yes [ ]**  | **No [ ]**  | **N/a [ ]**  | **If yes, for how long?** |
| **Pain Presentation and Significant Past Medical History:** |
| **Psychological Factors:** |
| **Pain Medications Tried:** |
| **Expectation of Referral (Referrer and Patient):** |
| **Other relevant information (e.g., Family History / Allergies):** |
| Has the patient previously been referred to this or another pain service? Yes [ ]  No [ ]  Please attach a GP Summary with this referral including Past Medical History, Current Medication, Relevant Investigations/ Imaging/ Blood Tests.GP Summary attached (please tick to confirm) Yes [ ]  Please ensure that the patient understands our service supports people to self-manage their long-term pain condition and is not an investigative/ diagnostic service.Please ensure that simple first line pain medications and any other appropriate treatments (e.g., physiotherapy) have been tried prior to referral. |