REFERRAL FORM

Greenwich Hospital Pain Clinic

PO Box 5084, Greenwich, Sydney NSW 2065 Fax No. (02) 9903 8399

REFERRAL TO: ☐ PROF PHILIP SIDDALL ☐ DR AMANDA JOHNS ☐ DR RAJ ANAND ☐ MS REBECCA McCABE

PATIENT DETAILS PLEASE INDICATE IF HAMMONDCARE ☐ OR icare ☐ REFERRAL

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

REFERRING DOCTOR **(or CASE MANAGER IF icare REFERRAL)**

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

LOCATION OF PAIN

CAUSE OF PAIN (UNDERLYING PATHOLOGY IF KNOWN)

CURRENT PAIN MEDICATIONS INCLUDING DOSE

PREVIOUS PAIN MEDICATIONS

CURRENT OR PREVIOUS TREATMENT FOR MOOD DYSFUNCTION

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 approval from icare.*

Other reason for referral:

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