

**TURNING POINT ALCOHOL & DRUG CENTRE**

Clinical Services  
54-62 Gertrude Street  
Fitzroy VIC 3065

T 03 8413 8444  
F 03 9486 9766



**CHRONIC PAIN AND ANALGESIA CONSULTANCY REFERRAL**

The Turning Point Chronic Pain and Analgesia Consultancy service provides advice to medical practitioners in the use and management of medications in the treatment of chronic pain. This service provides secondary consults on pain issues, it **does not** provide ongoing pain management, physiotherapy, occupational therapy, physical or occupational rehabilitation programs, or other ancillary services.

Patients referred to this consultancy service will be seen by an Addiction Medicine Physician and a Psychologist, through the Medicare Extended Primary Care (EPC) Program. For patients to be seen a GP Management Plan (Medicare Item 721 or review item 727) and a Team Care Arrangement (Medicare Item 723 or review item 727) needs to be in place (referrals will not be accepted if the appropriate Medicare items are not in place).

<p><b><u>REFERRING DOCTOR</u></b></p> <p>NAME: _____</p> <p>ADDRESS: _____</p> <p>PHONE: _____</p> <p>FAX: _____</p> <p>PROVIDER NUMBER: _____</p> <p>(or stamp if preferred)</p> <p>Has the client previously been seen by this service?</p> <p>YES <input type="checkbox"/> NO <input type="checkbox"/> Year _____</p>	<p><b><u>PATIENT</u></b></p> <p>FIRST NAME: _____</p> <p>SURNAME: _____</p> <p>DATE OF BIRTH: ____ / ____ / ____</p> <p>MALE / FEMALE</p> <p>ADDRESS: _____</p> <p>PHONE: _____ MOBILE: _____</p> <p>MEDICARE NUMBER: □□□□□□□□□□ Ref No <input type="checkbox"/></p> <p>EXPIRY DATE: _____</p> <p>HEALTHCARE CARD NUMBER: □□□□□□□□□□</p> <p>EXPIRY DATE: _____</p>
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**REASON FOR REFERRAL** (tick as many as apply):

- € Difficulty stabilising dose
- € Overuse of medication (prescriptions run out early)
- € Difficult / aggressive / dishonest behaviour
- € Concern about misuse of medication
- € Concern about other substance use (including alcohol)
- € Regulatory requirement (request from DPU)

(Please provide relevant details): \_\_\_\_\_

**MEDICATION:**

MEDICATION	DOSE	PICKUP FREQUENCY (if applicable)

Allergies: \_\_\_\_\_

**PAIN HISTORY:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ALCOHOL & DRUG HISTORY:**

- History of injected drug use
- Previous misuse of pharmaceutical/prescribed medication
- Previous maintenance therapy (methadone or buprenorphine)
- History of use of illicit substances
- History of alcohol dependence

(Please provide relevant details): \_\_\_\_\_

**OTHER RELEVANT MEDICAL HISTORY** (general, mental health issues, acquired brain injury etc):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**OTHER RELEVANT SOCIAL ISSUES:**

- Homelessness / inappropriate housing
- Isolation – difficulty accessing services; poor supports
- Financial difficulties
- Forensic issues
- Other legal problems (e.g. civil cases)

(Please provide relevant details): \_\_\_\_\_

*Further information or copies of relevant documentation may be attached and forwarded with this referral.*

Signature of referring doctor: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Please return completed referral form by:  
fax (03 9486 9766) or post (54-62 Gertrude St, Fitzroy VIC 3065)