PERSISTENT PAIN PROGRAM:
TURNING PAIN INTO GAIN REFERRAL FORM

Incomplete referral form may result in processing delays and impact on the client's care coordination
Please sign and submit the completed form to info@blackswanhealth.com.au or fax to 9201 0033
Please refer to the Black Swan Health website for eligibility and exclusion criteria

BINDING MARGIN – NO WRITING

Date of referral:__ /___/ 20___

1. CLIENT DETAILS

Title: ____________________ *Gender:* ☐ *Male* ☐ *Female* ☐ *Other*

Last Name: ____________________________ *First name(s):* _________________________

*D.O.B:*___/_____/ _______ *Access issues:* ________________________

Address: ____

Mobile: ____________ *Home:* ______________ *Email:* ______________________________

*Emergency contact / Next of Kin name:*_________________________*Phone:* ________________

Is the client of Aboriginal and/or Torres Strait Islander descent? ☐ *Yes* ☐ *No*

2. REFERRER DETAILS

☐ *GP (Skip to Section 3 – GP details)* ☐ *Specialist*

*Referrer name:*__________________________ *Position:* ____________________________

Address: ____

*Suburb:*________________________________ *Postcode:* __________

Phone: ______________ *Fax:* _____________ *Email:* _____________________________

3. GP DETAILS

GP's name: _____________________________ *GP Stamp:*

GP's practice: ____________________________

Address: ________________________________

*Suburb:*__________________*Postcode:* _______

Phone: ______________ *Fax:* _____________ *Email:* _______________________________

4. REFERRAL INFORMATION

Diagnosis (please tick as appropriate) *Date of diagnosis (if known):*__ /___/ ____

☐ *Back pain* ☐ *Fibromyalgia* ☐ *Osteoarthritis*

☐ *Complex regional pain syndrome* ☐ *Migraine* ☐ *Osteoporosis*

☐ *Endometriosis* ☐ *Neck Pain* ☐ *Rheumatoid Arthritis*

☐ *Other (please specify):* ________________________________

PERSISTENT PAIN PROGRAM:
TURNING PAIN INTO GAIN REFERRAL FORM

BINDING MARGIN – NO WRITING

Current treatment or therapy (or attach): ____

____

Current medications (or attach): ____

____

Relevant medical history: ____

Current treatment: ____

Has the client been hospitalised in the last 12 months? ☐ *Yes* ☐ *No*

If Yes, please provide details (e.g. number of admissions, length of stay): ____________________

____

5. CONSENT TO REFERRAL

Please tick the appropriate boxes below. Black Swan Health is only able to accept referrals where the client / guardian has consented to the referral, either verbally or in writing.

☐ *I consent to be referred to Black Swan Health*

Client / guardian signature: ______________________________ *Date:__ /___/ 20___*

Print Name: ______________________________

☐ *I confirm my client has been assessed and meets the eligibility criteria for a referral to Black Swan Health*

☐ *I have obtained verbal consent from the client / legal guardian to refer and provide their personal health information to Black Swan Health for further assessment*

Referrer's signature: ______________________________ *Date:__ /___/ 20___*

Print Name: ______________________________

OFFICE USE ONLY – leave blank
Unique client number (Black Swan Health to generate): ______________________________

The Persistent Pain Program is supported by funding from the Australian Government under the PHN Program, delivered by Black Swan Health, using the Turning Pain Into Gain, Painwise Program, © Joyce McSwan

Black Swan Health Limited *(ABN 64 169 929 677)*
t: *08 9201 0044* **f:** *08 9201 0033* **e:** *info@blackswanhealth.com.au*
Corporate office: 137-151 Main Street, Osborne Park, WA 6017
Service locations: Osborne Park | Joondalup | Midland | Fremantle
www.blackswanhealth.com.au