Queensland Government

Children's Health Queensland Hospital and Health Service

Referral to Queensland Interdisciplinary Paediatric Persistent Pain Service

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

Please direct an acutely unwell child to the Emergency Department

REFERRAL DATE: **REFER TO:**

REFERRER DETAILS

Name: **Designation:**

Provider no: **Ph:** **Signature:**

Team/specialty:

Hospital/practice:

Why are you referring this patient?

Pain history (location, character, duration, onset)

Function (school attendance, sleep, physical activity, mood)

DO NOT WRITE IN THIS BINDING MARGIN

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Name DOB UR No

Medication (adverse drug reactions, current medications, previously trialled analgesics)

Other practitioners involved in patient's care (Doctors, Allied Health, alternative medicine)

Past medical history

Psychosocial history (mental health, history of abuse, history of bullying, relationship issues, developmental issues)

Physical examination

Investigations

DO NOT WRITE IN THIS BINDING MARGIN

SUBMIT FORM

QUEENSLAND INTERDISCIPLINARY PAEDIATRIC PERSISTENT PAIN SERVICE

Ph: **3068 4499**
Email: **QCH-persistentpain@health.qld.gov.au**