Community Chronic pain management program

Referral form

Personal information		
☐ Mr ☐ Ms ☐ Mrs ☐ Other _____	Surname:	First name:
Marital status:	Gender:	DOB:
Aboriginal and/or Torres Strait Islander: ☐ Yes ☐ No ☐ Both		
Address:		
Phone:	Email:	
GP details		
Name:	Practice:	
Does the participant consent to the Chronic Pain team contacting their GP? ☐ Yes ☐ No		
Does the participant need support with reading/writing? ☐ Yes ☐ No		
Criteria		
Does the participant meet ALL of the following criteria? • Participant identified by their GP as having chronic pain • Pain persisting longer than 3 months or beyond the normal healing time of an injury, resulting in declining functional and psychological wellbeing • Independently mobile • Self-motivated and willingness to complete set tasks at home. • Ability and preparedness to attend all sessions within the 6-week program (2-3 hours/session)		☐ Yes ☐ No (please indicate which one/s) ……..... …… …… …… ……
Does the participant meet any of the following criteria, which would exclude them from the program? • Worker's compensation or third-party insurance claims • Unstable or excessive Opioid usage • Inability to participate in a group setting. • Presence of significant or unstable mental health disorders • Significant disability		☐ No ☐ Yes (please indicate which one/s) ……..... …… …… ……
CCPMP involves guided self-help material, does the participant understand and are they willing to engage within the model.		☐ Yes ☐ No
Current presenting issues and relevant medical history:		

Source of referral	
Name:	Agency:
Address:	
Role:	Email:

Referring agent signature: _____

Referral date: _____

Please send completed referral via one of the below methods and our team will be in touch:

Email: chronicpain@marathonhealth.com.au

Argus: clinicsargus@marathonhealth.com.au

Post/in person: 106, Talbragar street, Dubbo, NSW, 2830