

Northern Adelaide Local Health Network  
**Northern Pain Rehabilitation Service**  
 Referral Information Requirements

*Thank you for the referral of your patient. To enable appropriate triaging of the referral, please attach a relevant summary of the patient's medical history, including medications and allergies, investigations and treatments undertaken and relevant psycho-social issues.*

**Please note: No appointment can be offered to your patient until the required information is received.**

The Northern Pain Rehabilitation Service is a multidisciplinary service providing a sociopsychobiomedical approach to management of persistent pain. This incorporates a specialised assessment, multi-disciplinary pain programs, pharmacological optimisation and non-pharmacological therapies. This service does not currently offer interventional procedures. The service believes in evidence based use of opioid medication. Active substance abuse issues should be referred to DASSA.

<p><b>Conditions treated by our service include:</b></p> <p><b>Neuropathic pain</b> i.e. CRPS / post herpetic neuralgia / peripheral / central neuropathies</p> <p><b>Visceral pain</b> i.e. IBS / chronic pancreatitis / recalcitrant angina</p> <p><b>Musculoskeletal conditions</b> Back pain / hip pain / knee pain / neck pain</p> <p><b>Headaches and facial pain</b></p> <p><b>Persistent pain without obvious organic pathology</b></p>	<p><b>Our service DOES NOT PROVIDE:</b></p> <p><b>Third party compensation</b> i.e. Return to Work SA</p> <p><b>Addiction treatments</b></p> <p><b>Validation of inappropriate opioid prescription</b></p> <p><b>Management of acute mental health issues</b></p> <p><b>Second opinion after previous assessment by other pain service, public or private</b></p>
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**Patient details**

First name: ..... Surname: .....

DOB: .....

Address: .....

Phone: (H)..... (W)..... (M) .....

Email: .....

Country of Birth: .....Language if Interpreter required:.....

Alerts to infections status, allergies or communicable disease:

**Referrer details**

First name: ..... Surname: .....

Provider Number: .....Clinic: .....

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Phone: ..... Fax: .....

**Please return details via fax to: 08 7321 4170**