Pain Management Centre (PMC) - Outpatient Referral Form

1. Patient name	
Date of birth	
Address	
NHS number	
GP practice	

2a. Is patient a resident of Camden & Islington?	Yes *If yes go to question 3* No
2b. If No, which pain clinic have they been seen at? *	Name of Pain clinic and Consultant:

** GP or referrer – please ask GP to refer to local pain clinic to enable partnership working local to the patients home. Patients must be seen by a local pain specialist to allow access to UCLH specialist pain service.* For best practice for the management of chronic pain: *http://bps.mapofmedicine.com/evidence/bps/index.html*

3. Type of pain	**Tick**	Free text
Spinal pain	☐	
Other musculoskeletal pain e.g. shoulder, knee	☐	
Abdominal and/or pelvic pain	☐	
Complex regional pain syndrome (CRPS)	☐	
Pain associated with a neurological condition	☐	
Pain associated with a rheumatological condition	☐	
Joint Hypermobility Syndrome	☐	
Pain associated with sickle cell disease	☐	
Pain following cancer	☐	
Other, please state	☐	
Facial pain special consideration *	☐	
Headache special consideration *	☐	

Facial pain referrals should be directed in the first instance to
www.uclh.nhs.uk/OurServices/ServiceA-Z/EDH/MAXMED/FPAIN/Pages/refer.aspx
Headache referrals should be directed in the first instance to
www.uclh.nhs.uk/OurServices/ServiceA-Z/Neuro/hsnhnn/THS/Pages/refer.aspx

Referrer confirms that they will institute maps of medicine care pathways and pharmacological interventions or ask GP to do so. Tick as appropriate:

Care map	**Tick**
Chronic pelvic pain (for men and women)	☐
Chronic widespread pain, including fibromyalgia	☐
Initial assessment and early management of pain	☐
Low back and radicular pain	☐
Neuropathic pain	☐

4. Past pain medications tried	**Maximum dose taken**	**Duration of use**	**Effective Y/N**
Amitriptyline			
Nortriptyline			
Gabapentin			
Pregabalin			

Duloxextine			
Opioid			
Other (s)			

5. Past pain interventions	**Specify type (s)**	**Duration of use**	**Effective Y/N**
Nerve block			
TENS			
Acupuncture			
Physiotherapy			
Osteopathy			
CBT			
Pain management programme			
Other			

5. Previous consultations	**Name**	**Hospital**	**Current Y/N**
Neurologist			
Rheumatologist			
Gynaecologist			
Urologist			
Gastroenterologist			
Neurosurgeon			
Psychologist			
Physiotherapist			
Psychiatrist			
Other			

Please attach correspondence or scan to email with online referral form

6. Past Medical History Include diagnoses or enter ‘nil’ to confirm none	

6. Past Psychiatric History Include diagnoses or enter ‘nil’ to confirm none. Please include if patient currently seeing mental health services	

7. Current medication and doses or enter ‘nil’	
Allergies : List/ Nil	

8. Relevant family/ social history	
