



BLACKTHORN TRUST

Pain Management Programme

GP Referral Form

For patients suffering chronic pain unresponsive to pain clinic or secondary care interventions. **PLEASE CHECK THE CRITERIA BELOW**

Aims

- To reduce levels of pain, insomnia, anxiety, depression and exhaustion
- To strengthen self-confidence, kindle motivation, broaden outlook & experience
- To encourage greater independence through activity and exercising new skills in a supportive environment
- To reduce levels of medication, especially opiates

Patient Eligibility

- Resident within West Kent
- The Condition has been fully investigated
- The condition has proven unresponsive to hospital or pain clinic interventions and with no planned follow ups.

Likely Conditions

- Chronic Spinal and joint related pain
- Resistant conditions: fibromyalgia, Migraine, IBS, Reflex Sympathetic Dystrophy Syndrome
- Neuropathic, Ideopathic, Functional pain Disorder

<u>Patients Details</u>	<u>Next Of Kin</u>
Name:	Name:
Date of Birth:	Relationship to Patient:
NHS number	Address:
Address:	Tel No:
Postcode:	
Mob / phone:	
Email address:	

Patients' Health conditions – please tick:

Pain	Mental Health
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Back pain	<input type="checkbox"/> Depression
<input type="checkbox"/> Migraine	<input type="checkbox"/> Isolation/ loneliness
<input type="checkbox"/> Muscular Skeletal Problems	<input type="checkbox"/> Need to develop life/social skills
<input type="checkbox"/> Other	<input type="checkbox"/> Need for meaningful activity
	<input type="checkbox"/> Need for re- orientation
	<input type="checkbox"/> Lacking confidence
	<input type="checkbox"/> Social anxiety
	<input type="checkbox"/> Low self esteem

Patient's Ethnic Origin – please tick:

<input type="checkbox"/> Asian or Asian British (Includes any Asian background, for example, Bangladeshi, Chinese, Indian, Pakistani)
<input type="checkbox"/> Black, African, Black British or Caribbean (Includes any Black background)
Mixed or multiple ethnic groups (includes any Mixed background)
<input type="checkbox"/> White (Includes any White background)
<input type="checkbox"/> Another ethnic group (Includes any other ethnic group, for example, Arab)
<input type="checkbox"/> Prefer not to say

GP Contact

GP Name _____

Surgery Address _____

Phone _____

Email _____

Date _____ Signature _____

IMPORTANT Patient Information - please attach:

1. Print out of Medical History, including medication
2. Copies of relevant specialist letters, summary, investigations
3. Any particular advice/comment