BWCPM Referral Guidelines

Referrals to **Barbara walker Centre for Pain Management (BWCPM)** chronic pain health independence service are subject to **State-wide Referral Criteria (SRC)** for public specialist clinics as outlined by the Department of Health Victoria**.** For more information about the SRC visit https://src.health.vic.gov.au. We may also Medicare Bulk-Bill specialist appointments while your patient attends our clinic.

We accept referrals for persistent or chronic pain:

- that requires complex medication management
- neuropathic pain
- in cancer survivors
- post-surgical or post-traumatic pain
- primary pain
- secondary headache or orofacial pain
- secondary musculoskeletal pain
- visceral pain

Please refer to criteria under each sub-heading at https://src.health.vic.gov.au/specialities

Referral to the service is not appropriate for people who

- are not ready, willing or able to engage in multi-disciplinary pain management approaches about living well with pain, improving function and adopting active self-management strategies
- have already been referred to another service for the assessment, or treatment of, the identifiable cause of pain
- are currently undertaking another chronic pain management program
- have already completed a multidisciplinary, comprehensive chronic pain management program or service for the same identifiable cause of pain where their clinical symptoms, or their readiness to undertake a chronic pain management program, remains unchanged

To ensure we can accept the referral under SRC Guidelines, **please fully complete every section of the referral form** overleaf. If you wish to write your own referral, please include all information requested, including your provider number and address.

Referrals:
Fax to 03 92314660, or
Email to BWCPM@svha.org.au, or
Mail to Barbara Walker Centre for Pain Management, 1st floor, Building D, St Vincent's Hospital Melbourne, 41 Victoria Pde, Fitzroy 3065

Please address the referral to Clinical Director, Dr Aston Wan. Patients will be allocated to any of our pain medicine specialists.

If you believe your patient should be seen urgently, or fast tracked, please state the reason.

To: Dr Harry Eeman,
Barbara Walker Centre for Pain Management
First Floor, Daly Wing
35 Victoria Parade
Fitzroy, Vic. 3065

PH: (03) 9231 4681
Fax: (03) 9231 4660
E: bwcpm@svha.org.au

Referrer Stamp

Dear Dr

RE: **Patient Name:**
Address:
Email:
Phone:
D.O.B: / /
St Vincent's UR (if known):

Interpreter Required ☐ No ☐ Yes Preferred Language: _____

I am referring the above patient to the Barbara Walker Centre for Pain Management for specialist pain assessment, opinion and management.

Reason for Referral:

For this referral to proceed you must be able to answer "yes" to all of the following:
The patient has…

- pain that impacts on function including daily activities, work, study, school or carer role;
  ☐ Yes ☐ No
- had an adequate trial treatment (e.g. physiotherapy, psychology, medical management) for this pain condition in previous 12 months;
  ☐ Yes ☐ No
- a risk of functional or psychological deterioration, or medication dependence
  ☐ Yes ☐ No
- a readiness and willingness to engage in a multi-disciplinary pain management program focussed on living well with pain and active self-management strategies
  ☐ Yes ☐ No

Please also note that referral to a public hospital H.I.P chronic pain service is not appropriate if they are currently undertaking another chronic pain management program or if they have previously completed a pain management program for the same issue and nothing else has changed.

Required Information

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RE: **Patient Name:**
D.O.B: / /

1. Diagnosis (if available):

2. **Pain** history: onset, location, nature of pain and duration:

3. Past Medical History:

4. Psychological status and cognitive function:

5. Details of previous pain management including the course of treatment(s) and outcome of treatment(s) and whether there has been any change in readiness to participate in a pain management program:

6. History of alcohol, recreational or injectable drugs, or prescription medicine misuse:

7. Current and complete medication history:

8. Any further relevant information (include any potential safety issues):

9. Is this referral related to a WorkCover or TAC claim ☐ Yes ☐ No Claim number:

Please attach copies of relevant correspondence, medical reports, imaging, and pathology reports.

Referral valid for
☐ 3 months (specialist referral)
☐ 12 months (GP referral)
☐ Referral Acknowledgement letter required
☐ Telehealth Consult preferred

Referrer Name: Provider Number:
Signed: Date: / /
Ph:

Please complete all fields and send to Barbara Walker Centre for Pain Management. Thank you.
Fax: 03 9231 4660 or Email: BWCPM@svha.org.au