SUPPORT KIDS IN PAIN

**Return Referral Form to:**
**Support Kids in Pain**
**Ph: 0434 747 547**
**Fax: (07) 3831 0044**
**Email: referrals@skip.org.au**

# GP / Specialist Referral Form

| Referring GP / Specialist Details | |
|---|---|
| **Date of Referral:** | |
| **GP or Specialist Name:** | |
| **Provider Number:** | |
| **Address:** | |
| **Phone:** | |
| **Fax:** | |
| **Email:** | |
| **Patient Information** | |
| **Child's Name:** | |
| **Date of Birth:** | |
| **Address:** | |
| **Phone:** | |
| **Medicare Number:** | |
| **Private Health Cover:** | |
| **Family Information** | |
| **Parent/Caregiver Name:** | |
| **Home Phone Number:** | |
| **Mobile Phone Number:** | |
| **Email Address:** | |
| **Obtained parental consent for referral? Y / N** | |

| Reason for Referral |
| --- |
| |

| Pain History and Progression; Previously Tried Treatment/s |
| --- |
| |

| **Relevant Investigations** – or attach reports |
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| |

| **Current Medications and Treatment** – or attach medical summary |
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| Medical Summary | |
| --- | --- |
| **Past Medical History:** | |
| **Other Conditions:** | |
| **Allergies:** | |
| **Psychosocial Issues: e.g. school absenteeism, mental health, family** | |
| **Known Family Medical History including pain:** | |

| **Signature:** | **Date:** |
| --- | --- |