NHS
Somerset
NHS Foundation Trust

Somerset Community Pain Management Service Referral Form

PATIENT DETAILS		
Name of Patient	**NHS Number**	**D.O.B. (N.B. This service is for people aged 18 and over)**
Home Address	**Preferred contact number**	**Email address**
Does the patient consent to receiving information via email (e.g. letters, links for appointments, handouts etc.)	**Yes**	**No**

DETAILS OF REFERRER	
Name of Referrer	**G.P. practice name/address or referring clinician name/service**

INFORMATION REGARDING THE PATIENT'S PAIN			
What is the MAIN reason for referral? (please tick ONE option)	Support with pain management		
	Opiate reduction support		
	Diagnostic injection		
	Palliative care		
	Other (please specify)		
Does the patient have an existing pain diagnosis or diagnoses?	**Yes – please specify which:**		**No**
Whereabouts is the pain? (please specify all locations, e.g. widespread, lower back, neck and shoulder etc.)			
Other medical conditions			
What medication/s and dose/s is the patient currently prescribed?			

Has the patient been fully investigated for causes of their pain eg fibromyalgia blood screen (we are not a diagnostic service)	**Yes**	**No**	**Pending**
Has the patient attended any other specialist appointments in relation to their pain with the following services/ previously attended ours or another pain clinic?	**Yes - please tick all that apply**		**No**
	Rheumatology Service		
	Neurology Service		
	OASIS Service		
	Physiotherapy Service		
	CRPS Service, Bath		
	Other pain service		
	Rosa Burden Centre		
	Other (please specify)		
Has the patient been signposted to the 'Live Well with Pain' interactive Ten Footsteps Programme? Please add details if completed	**Yes**	**No – please provide details - https://livewellwithpain.co.uk/ten-footsteps-programme/**	
INFORMATION REGARDING THIS REFERRAL			
Date of referral			
Has the patient requested or agreed to be referred to the Pain Service?	**Yes**	**No**	
Has the patient been signposted to our website https://www.somersetpain.co.uk/?	**Yes**	**No**	
Has the patient received previous mental health support?	**Yes (please specify when/where/which service/s this was with if known)**	**No**	**Unsure**
In your view is the patient's mental health stable at present?	**Yes**	**No – please consider referral to Talking Therapies Service, Open Mental Health or Community Mental Health Service in the first instance**	
What type/s of appointment is the patient able to attend? Please tick all that apply. (Our first appointment is a group video)	**Telephone**	**Video**	**Face-to-face**
Does the patient have any hearing/ reading or writing difficulties or need an interpreter (if yes please specify)	**Yes**	**No**	**Unsure**

Thank you for taking the time to complete this referral form. Please email to PainService@SomersetFT.nhs.uk