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| **Chronic Pain Referral ProformaYork and Scarborough Hospitals**Send via RSSUnder 18s not accepted unless previously assessed in specialist paediatric pain service |

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| Date of Referral | <Today's date> | Referring GP | <Sender Name> |
| Patient Name | <Patient Name> | Address |  |
| Address | <Patient Address> |  |
|  |
| Postcode | <Patient Address> | Postcode |  |
| DOB | <Date of Birth>  | Practice phone |  |
| Age | <Patient Age> | Practice email |  |
| Gender | <Gender> | Hospital No |       |
| Home number | <Patient Contact Details> | NHS No | <NHS number> |
| Mobile number | <Patient Contact Details> |  |  |
| Email addressFreetext | <Patient Contact Details>      | Ethnicity | <Ethnicity> |
| Occupation |       | Interpreter required | No [ ]  | Yes [ ]  |
|  |  | Language? | <Main spoken language> |

Referrers, please indicate which pain service you require from the service guidance below. *There is only a need to provide the details following the arrows to the boxes on the right for that service requested*.

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| **General History and relevant documentation:** |
| What is reason for referral? (use dropdown list)Other please detail |       |
| Please provide relevant history detail about reason for referral (including that in right side box in the guidance below) |       |
| What are the patient’s expectations **do you think**? |       |
| What are **your** expectations? |       |
| Has the patient previously been seen in a York Pain clinic?Have they been seen in other pain services?Please send with the referral all relevant correspondence from previous pain services and detail what this is | No [ ]  Yes [ ] No [ ]  Yes [ ]       |
| Any known mental health issues?If Yes please detail and particularly comment on any that might prevent attendance or engagement with treatment | No [ ]  Yes [ ]       |
| Is there any specific relevant history of trauma or surgery? If Yes please detail | No [ ]  Yes [ ]       |
| Specific medical history the team should note: |       |
| Past analgesic use, **dose reached**, **form** and **reason for not continuing** with them. *This really helps with future management.* |
| Paracetamol |       |
| NSAIDs (which ones?) |       |
| Neuropathic (gabapentin, pregabalin, amitriptyline etc) |       |
| Opiates – oral and topical (codeine, dihydrocodeine, tramadol, buprenorphine, morphine, fentanyl etc) |       |
| Other (capsacin, nefopam, lidocaine patch etc) |       |
| What examination have you done and what were your findings? |       |
| What is your patient’s BMI? | <Numerics> |
| Is your patient a current smoker? | <Numerics>  |
| How many units of alcohol does your patient drink per week? | <Numerics>  |

**Patient Questionnaire for Pain Clinic**

Patients will be asked to complete a questionnaire about their pain to help triage them to the most appropriate part of our service. It is helpful if this is received prior to triage.

The questionnaire will be sent to the patient by the Pain service. It is helpful if GPs can provide the patient’s email address with the referral

We simply ask that GPs confirm they have told patients to complete the questionnaire and give them their NHS number as that is used with their name and date of birth to marry up referrals and questionnaires.

Yes [ ]  I have informed the patient of the above

**Patient’s Summary Problem List**

**<Problems(table)>**

**Current Repeat Medication List**

**<Medication(table)>**

**Allergies & Sensitivities**

**<Allergies & Sensitivities(table)>**

**Service guidance**

* Duration of symptoms
* Associated motor loss – New?
* MRI already done or ordered?
* How many weeks of physiotherapy undertaken?
* Inflammatory markers normal or not?

Spinal pain with or without radiculopathy

* If fibromyalgia the likely cause, please refer for rheumatology OT via Rheumatology.
* If not confident of diagnosing or excluding fibromyalgia please discuss with rheumatology via A&G first

Chronic widespread pain

* Previously seen by other specialists?
* Send relevant correspondence please

Chronic abdominal or pelvic pain

Possible Chronic Regional Pain Syndrome

* Budapest criteria score (see below)
* Any physiotherapy

Chronic Neuropathic/ post- surgical pain

* Estimated Prognosis
* Known to palliative care

Cancer Pain

* Opioid risk assessment tool score
* Attempted wean in primary care
* History of substance misuse
* Current illicit substance misuse

Opiate dose greater than 120 mg morphine equivalent

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| **Budapest Criteria for Chronic Regional Pain Syndrome** (Harden et al, Pain. 150(2):268-274, 2010) |
| All of the following statements must be met:1. The patient has continuing pain, which is disproportionate to any inciting event
2. The patient has at least one symptom in three of the four following categories:
3. The patient has at least one sign in two or more of the following categories
4. No other diagnosis can better explain the signs and symptoms
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|  | Categories | Symptoms of | Signs  |
| 1 | Sensory | Hyperesthesia and/or allodynia | Evidence of allodynia (to light touch and/or deep somatic pressure and/or joint movement) and/or hyperalgesia (to pinprick) |
| 2 | Vasomotor | Temperature asymmetry and/or skin colour changes and/or skin colour asymmetry | Evidence of the symptoms |
| 3 | Sudomotor / oedema | Oedema and/or sweating changes and/or sweating asymmetry | Evidence of the symptoms |
| 4 | Motor/trophic | Decreased range of motion and/or motor dysfunction (weakness, tremor, dystonia) and/or trophic changes (hair, nail, skin) | Evidence of the symptoms |