PATIENT REFERRAL FORM

Patient details

Name

Address

Phone | Mobile

Email | Date of birth

☐ Private Insurance ☐ WorkCover INSURER: .... CLAIM NUMBER: .... ☐ TAC ☐ Uninsured

Chronic primary pain area (Tick all that apply)

Duration: Months: Years:

☐ Back pain
☐ Chronic post-surgical pain
☐ Neck / upper limb
☐ Pelvic / thoracic / abdominal
☐ Chronic sciatica
☐ Osteoarthritis
☐ Headache
☐ Chronic Regional Pain Syndrome (CRPS)
☐ Other:

Clinical notes

Referrer

Name

Provider no | Signature | Date

Address

Referred to:

☐ **Metro Pain Group** (ANY)

☐ **Dr Paul Verrills**
MBBS FAFMM GDMM(Hons) MM(Pain Medicine) FIPP

☐ **Dr Bruce Mitchell**
MBBS FACSM FACSP FASMF MPainMed FIPP

☐ **Dr Neels Du Toit**
MBChB DipSEM FACSP FIPP

☐ **Dr Dan Bates**
BMed BSc(Hons) FACSEP

☐ **Dr Guy Buchanan**
MBBS FANZCA FFPMANZCA FIPP

☐ **Dr Slava Poel**
MBBS FANZCA

☐ **Dr Stephen Nutter**
MBBS FANZCA FACEM MRCS

☐ **Dr Peter Freeman**
MBBS FFARACS FANZCA

☐ **Dr Navid Hamedani**
MD FRACGP FAMAC

☐ **Dr Vishal Bhasin**
MBChB BHB MbiomedE FRNZCGP FRACGP

☐ **Dr Simon Cohen**
BSc MBChb FRACP FFPMANZCA

☐ **Dr Gurbir Kaur**
MBBS, DNB (Anaesthesia), FFPMANZCA

☐ **David Field**
BSocSc(FamSt) MPsych (Clinical) MAPS MCHP

☐ **Jo Rankin**
BAppSci(Physiotheraphy)

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For general enquiries:
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For referrals:
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Remember to bring all information supplied by your referring practitioner including your referral letter, reports, x-rays, MRI, TAC/WorkCover details.

SEND REFERRAL
Email: referrals@metropain.com.au | Fax: 03 9595 6110