**REFERRAL TO PRIVATE FACIAL PAIN CLINIC**

Please post or email this completed referral pro forma using the contact details above

Please note that this document has been created using Windows 10 – therefore the checkbox system may not function with older versions of Word

|  |  |
| --- | --- |
| **Date** |  |

**Name and Contact Details of Referring Clinician**

|  |  |
| --- | --- |
| **Referring Clinician’s Name** |  |
| **Position** |  |
| **Address** |  |
| **Post Code** |  |
| **Telephone Number** |  |
| **Fax Number** |  |
| **Email address** |  |

**Patient Details**

|  |  |
| --- | --- |
| **Patient’s Name** |  |
| **Title** e.g. Mr, Mrs, Miss etc. |  |
| **Date of Birth** |  |
| **Gender** |  |
| **Address** |  |
| **Post Code** |  |
| **Telephone Number** |  |
| **Email address (mandatory)** |  |
| **Is English the patient’s 1st language?** | Yes [ ]  | No [ ]  | If no, then please note that if an interpreter is required the patient is responsible for arranging this |

**Please note that Dr. McMillan is unable to accept telephone communications from patients or referring clinicians. All contact must be made via email -** roddymcmillan@nhs.net

|  |  |
| --- | --- |
| **General Medical Practitioner’s Name** |  |
| **Address** |  |
| **Post Code** |  |
| **Telephone Number** |  |

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| **Has a dental cause for the pain been excluded?**(Please note that the facial pain clinic only reviews patients who have had a dental cause for their symptoms formally excluded by a dentist)  | Yes [ ]  | No [ ]  |
| **Has an ear nose and throat cause for the pain been excluded?**(Facial pain associated with cardinal nasal (blockage, discharge) and /or ear (blockage, discharge, deafness, tinnitus, vertigo) symptoms should be referred for an ENT opinion and have any such causes excluded prior to coming to the facial pain service) | Yes [ ]  | No [ ]  |

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| **What is the provisional diagnosis?** |  |

**CHARACTER OF PAIN**

|  |  |
| --- | --- |
| **When did the pain first start?** |  |
| **Timing of pain** | [ ]  | **Continuous** |
| [ ]  | **Episodic / paroxysmal (episodes of pain with pain free periods in between)** |
| **What does the pain feel like to the patient? E.g. dull, aching, sharp, stabbing, burning** |  |

**LOCATION OF PAIN**

Please check the boxes that best correspond to the location of the pain

|  |
| --- |
| RightLeft[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  |

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| **Other details relevant to the location of the facial pain****Please specify:** |  |
| **Any other chronic pains affecting other parts of the body?** **If yes, please provide details:** |  |

**CURRENT / PAST MEDICATIONS AND TREATMENTS FOR PAIN**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Medication name** | **Current****(yes/no)** | **Dose** | **Duration of use** | **Effective** **(yes/no)** | **Adverse effects** |
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| **OTHER TREATMENTS FOR PAIN** (e.g. occlusal splints, dental restorations, endodontics, extraction, physiotherapy, osteopathy, alternative medicine, acupuncture, low intensity laser, TENS, homeopathy, chiropractor, hypnosis) **Please specify:** |
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| **PREVIOUS CONSULTATIONS FOR PAIN** (e.g. GP, oral surgeon, neurologist, physician, psychiatrist, ENT surgeon, neurosurgeon, psychologist, pain specialist, counsellor, rheumatologist)**Please specify:** |
|  |

**MEDICAL AND PSYCHOLOGICAL HISTORY**

|  |  |  |  |
| --- | --- | --- | --- |
| **MEDICAL ISSUE** | **YES** | **NO** | **DETAILS** |
| Previous operations / hospital admissions | [ ]   | [ ]   |  |
| Cardiac / hypertension | [ ]  | [ ]  |  |
| Respiratory  | [ ]  | [ ]  |  |
| Dermatological | [ ]  | [ ]  |  |
| Diabetes / other endocrine  | [ ]  | [ ]  |  |
| Gastrointestinal | [ ]  | [ ]  |  |
| Liver / Hepatitis | [ ]  | [ ]  |  |
| Renal | [ ]  | [ ]  |  |
| Musculoskeletal / other pains | [ ]  | [ ]  |  |
| Neurological / migraines | [ ]  | [ ]  |  |
| Mental health | [ ]  | [ ]  |  |
| Other medical issues (please give details) | [ ]  | [ ]  |  |
| Allergy | [ ]  | [ ]  |  |

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| **CURRENT MEDICATIONS****Please list:** |
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| **RELEVANT FAMILY / SOCIAL HISTORY THAT COULD INFLUENCE PAIN AND THE PATIENT’S ABILITY TO MANAGE PAIN** **Please specify:** |
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| **ANY OTHER RELEVANT DETAILS?****Please specify:** |
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| **SIGNATURE OF REFERRING CLINICIAN** |  |

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