Monash Health Referral Guidelines
PAIN MANAGEMENT CLINIC
(STATE-WIDE HEALTH INDEPENDENCE PROGRAM)

EXCLUSIONS

Services not offered by Monash Health

Interventional pain management
Chronic pain secondary malignancy
TAC and Work Cover clients not accepted

REFERRALS ACCEPTED FOR

PERSISTENT OR CHRONIC PAIN

MULTIPLE PRESENTATIONS FOR EXACERBATIONS OF PAIN DESPITE ADEQUATE TREATMENT IN PREVIOUS 12 MONTHS

AT RISK OF FUNCTIONAL OR PSYCHOLOGICAL DETERIORATION

AT RISK OF MEDICATION DEPENDENCE

WILLING TO EXPLORE LIVING WELL WITH PAIN AND WILLING TO LEARN TO SELF-MANAGE ONGOING PAIN.

NOTE SUITABLE FOR

- Patients who are currently not willing to explore living well with pain
- Patients who are not willing to learn to self-manage ongoing pain
- Patients already referred to another pain service for the assessment, or treatment of, the identifiable cause of pain
- Patients currently undertaking another chronic pain management program
- Patients who have already completed a multidisciplinary, comprehensive chronic pain management program or service for the same identifiable cause of pain where their clinical symptoms, or their readiness to undertake a chronic pain management program, remains unchanged
- Patients who only want an intervention such as an injection or dry needling
- Patients who want to receive services as a compensable patient should not be referred to health service that only provides publicly funded services.

CONTACT US

Medical practitioners

To discuss complex & urgent referrals contact:
Pain Management Clinical Lead
Specialist Clinics
T: 9265 1401

Submit a referral

(email referrals preferred)

Use GP Referral Form
https://monashhealth.org/wp-content/uploads/2018/06/gp_referral_template_Dec_15.docx
E: icareaccess@monashhealth.org
T: 9265 9151
F: 9554 9151

Head of unit:	Program Director:	Last updated:
Dr. Mark Adams	Clin Assoc Prof Georgia Soldatos	7/6/2021

MonashHealth

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PRIORITY

All referrals received are triaged by **Monash Health clinicians** to determine **urgency of referral.**

EMERGENCY

For emergency cases please do any of the following:
- send the patient to the Emergency department OR
- Contact the on call registrar OR
- Phone 000 to arrange immediate transfer to ED

URGENT

The patient has a condition that has the potential to deteriorate quickly with significant consequences for health and quality of life if not managed promptly.

ROUTINE

The patient's condition is unlikely to deteriorate quickly or have significant consequences for the person's health and quality of life if the specialist assessment is delayed beyond one month

REFERRAL

How to refer to Monash Health

Mandatory referral content

Demographic:
- Full name
- Date of birth
- Next of kin
- Postal address
- Contact number(s)
- Email address
- Medicare number
- Referring GP details
- including **provider number**
- Usual GP (if different)
- Interpreter requirements

Clinical:
- Reason for referral
- Pain history, onset, location, nature of pain
- Duration of pain
- Management to date and response to treatment
- Comprehensive past medical history and results of previous investigations
- Current medications and medication history if relevant (including non-prescription medicines, herbs and supplements
- History of alcohol, recreation or injectable drugs and prescription medicine misuse
- Functional status
- Psychosocial status and cognitive function
- Diagnostics as per referral guidelines

Preferred referral content

- Details of functional impairment
- Psychiatric history
- Whether the person has symptoms of, or has been diagnosed with, post-traumatic stress disorder (PTSD)
- Details of any current behaviours that may impact on the person's ability to participate in a chronic pain management program (e.g. behaviours of concern, level of alcohol intake, cognition issues, reliance on a carer, mental health issues)
- Whether the person has been identified as having high-risk circumstances (multiple provider episodes, high-risk drug combinations, or opioid dose threshold) through SafeScript

Click here to download the Pain Clinic referral form

Head of unit: Dr. Mark Adams

Program Director: Clin Assoc Prof Georgia Soldatos

Last updated: 7/6/2021

PERSISTENT OR CHRONIC PRIMARY PAIN

WHEN TO REFER?

Initial GP Work Up

- Functional status
- Psychosocial status and cognitive function
- Diagnostics as per referral guidelines
- Determine and document persistent or chronic pain (> 3 months duration) with symptoms that impact on daily activities including impact on work, study, school or carer role
- Document presentations for exacerbations of pain despite adequate treatment in previous 12 months (exercise and analgesia)
- Determine risk of functional or psychological deterioration, or medication dependence
- Determine whether patient is willing to explore living well with pain and is willing to learn to self-manage ongoing pain

Emergency

- Rapidly progressive neurological symptoms leading to weakness or imbalance
- Suspected cauda equina syndrome (e.g. leg weakness, loss of bowel or bladder control).

Urgent

- Patients with a previous trauma or injury with suspected stage one complex regional pain syndrome (CRPS).

BACK

PERSISTENT OR CHRONIC SECONDARY MUSCULOSKELETAL PAIN

WHEN TO REFER?

Initial GP Work Up

- Functional status
- Psychosocial status and cognitive function
- Diagnostics as per referral guidelines
- Determine and document persistent or chronic pain (> 3 months duration) with symptoms that impact on daily activities including impact on work, study, school or carer role
- Document presentations for exacerbations of pain despite adequate treatment in previous 12 months (exercise and analgesia)
- Determine risk of functional or psychological deterioration, or medication dependence
- Determine whether patient is willing to explore living well with pain and is willing to learn to self-manage ongoing pain

Emergency

- Rapidly progressive neurological symptoms leading to weakness or imbalance
- Suspected cauda equina syndrome (e.g. leg weakness, loss of bowel or bladder control)
- Fever with acutely painful, hot, swollen joints

BACK

PERSISTENT OR CHRONIC VISCERAL PAIN

Initial GP Work Up

- Functional status
- Psychosocial status and cognitive function
- Diagnostics as per referral guidelines
- Determine and document persistent or chronic pain (> 3 months duration) with symptoms that impact on daily activities including impact on work, study, school or carer role
- Document presentations for exacerbations of pain despite adequate treatment in previous 12 months (exercise and analgesia)
- Determine risk of functional or psychological deterioration, or medication dependence
- Determine whether patient is willing to explore living well with pain and is willing to learn to self-manage ongoing pain

WHEN TO REFER?

Emergency

- Rapidly progressive neurological symptoms leading to weakness or imbalance
- Suspected cauda equina syndrome (e.g. leg weakness, loss of bowel or bladder control).
- Suspected systemic infection

BACK

PERSISTENT OR CHRONIC SECONDARY HEADACHE OR OROFACIAL PAIN

Initial GP Work Up

Persistent or chronic headache or orofacial pain including the following information:

- Onset, characteristics and frequency of headache
- Details of any previous neurology assessments or opinions
- Functional status
- Psychosocial status and cognitive function
- Diagnostics as per referral guidelines
- Determine and document persistent or chronic pain (> 3 months duration) with symptoms that impact on daily activities including impact on work, study, school or carer role
- Document presentations for exacerbations of pain despite adequate treatment in previous 12 months (exercise and analgesia)
- Determine risk of functional or psychological deterioration, or medication dependence
- Determine whether patient is willing to explore living well with pain and is willing to learn to self-manage ongoing pain

WHEN TO REFER?

Emergency

Headache with:

- sudden onset or thunderclap headache
- severe headache with signs of systemic illness (fever, neck stiffness, vomiting, confusion, drowsiness, dehydration)
- severe disabling headache
- severe headache associated with recent head trauma.
- Headache suggesting temporal arteritis (focal neurological symptoms, altered vision, elevated erythrocyte sedimentation rate and C-reactive protein in patients > 50 years of age).

BACK

PERSISTENT OR CHRONIC NEUROPATHIC PAIN

Initial GP Work Up

- Functional status
- Psychosocial status and cognitive function
- Diagnostics as per referral guidelines
- Determine and document persistent or chronic pain (> 3 months duration) with symptoms that impact on daily activities including impact on work, study, school or carer role
- Document presentations for exacerbations of pain despite adequate treatment in previous 12 months (exercise and analgesia)
- Determine risk of functional or psychological deterioration, or medication dependence
- Determine whether patient is willing to explore living well with pain and is willing to learn to self-manage ongoing pain

WHEN TO REFER?

Emergency

- Rapidly progressive neurological symptoms leading to weakness or imbalance
- Suspected cauda equina syndrome (e.g. leg weakness, loss of bowel or bladder control).

Urgent

- Immediately contact the ophthalmology registrar to arrange an urgent ophthalmology assessment for:
- Facial shingles with eye involvement.

Routine

Neuropathic pain related to any of the following:

- post-herpetic neuralgia
- trigeminal neuralgia
- peripheral nerve injury (e.g. brachial plexopathy)
- peripheral neuropathies (e.g. diabetic neuropathy)
- multiple sclerosis
- spinal cord injury
- post-stroke
- complex regional pain syndrome

BACK

PERSISTENT OR CHRONIC SECONDARY MUSCULOSKELETAL PAIN

Initial GP Work Up

- Pain history: onset, location, nature of pain and duration
- Details of surgery or trauma (date and where surgery / treatment was supplied)
- Functional status
- Psychosocial status and cognitive function
- Diagnostics as per referral guidelines
- Determine and document persistent or chronic pain (> 3 months duration) with symptoms that impact on daily activities including impact on work, study, school or carer role
- Document presentations for exacerbations of pain despite adequate treatment in previous 12 months (exercise and analgesia)
- Determine risk of functional or psychological deterioration, or medication dependence
- Determine whether patient is willing to explore living well with pain and is willing to learn to self-manage ongoing pain

WHEN TO REFER?

Routine

- Persistent or worsening post-surgical or post-traumatic pain (where post-operative complications have been treated or excluded)

PERSISTENT OR CHRONIC PAIN IN CANCER SURVIVORS

Initial GP Work Up

- Functional status
- Psychosocial status and cognitive function
- Diagnostics as per referral guidelines
- Determine and document persistent or chronic pain (> 3 months duration) with symptoms that impact on daily activities including impact on work, study, school or carer role
- Document presentations for exacerbations of pain despite adequate treatment in previous 12 months (exercise and analgesia)
- Determine risk of functional or psychological deterioration, or medication dependence
- Determine whether patient is willing to explore living well with pain and is willing to learn to self-manage ongoing pain

WHEN TO REFER?

Emergency

- Rapidly progressive neurological symptoms leading to weakness or imbalance
- Suspected cauda equina syndrome (e.g. leg weakness, loss of bowel or bladder control)
- Suspected systemic infection

Routine

- Persistent or chronic pain following cancer treatment (e.g. chemotherapy-induced peripheral neuropathy, abdominal visceral pain, neural injury) with all of the following:
  - >3 months duration with symptoms that impact on daily activities including impact on work, study, school or carer role
  - ongoing or escalating analgesia needs despite adequate trial of treatment in previous 3 months (exercise and analgesia)

PAIN THAT REQUIRES COMPLEX MEDICATION MANAGEMENT

Initial GP Work Up

- Functional status
- Psychosocial status and cognitive function
- Diagnostics as per referral guidelines
- Determine and document persistent or chronic pain (> 3 months duration) with symptoms that impact on daily activities including impact on work, study, school or carer role
- Document presentations for exacerbations of pain despite adequate treatment in previous 12 months (exercise and analgesia)
- Determine risk of functional or psychological deterioration, or medication dependence
- Determine whether patient is willing to explore living well with pain and is willing to learn to self-manage ongoing pain

WHEN TO REFER?

Emergency

- Rapidly progressive neurological symptoms leading to weakness or imbalance
- Suspected cauda equina syndrome (e.g. leg weakness, loss of bowel or bladder control)
- Central nervous system, autonomic and neuromuscular symptoms suggestive of serotonin syndrome
- Symptoms of respiratory depression, unconsciousness and pupillary miosis suggestive of opioid toxicity

Routine

- The person has been identified as having high-risk circumstances through SafeScript (multiple provider episodes, high-risk drug combinations, or opioid dose threshold) with both:
  - persistent or chronic pain (> 3 months duration) with symptoms that impact on daily activities including impact on work, study, school or carer role
  - open to exploring living well with pain and learning to self-manage ongoing pain

BACK