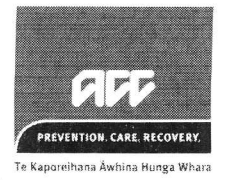


Provider referral for pain management



Complete this form to refer a client to the ACC Pain Management service.

When you've finished, please return this completed form and any relevant records and reports to the appropriate ACC Pain Management service provider.

1. Client details

Client name:

ACC claim number:

Date of birth:

NHI number:

Email address:

Phone number:

Mobile phone:

Work phone:

Residential address:

Postal address (if different from above):

Known barriers or special considerations

Please note details, eg if a barrier, note any existing or recommended support

Cultural or language considerations

Substance abuse

Other health issues

On current medication

Other:

Other:

2. Referrer details

Referrer name:

Scope of practice:

Date of referral:

Phone number:

Email address:

Preferred method of contact, eg phone, email:

3. ACC contact details (if known)

ACC contact person:

ACC branch:

Contact phone number:

Email address:

4. Why I'm making this referral

Please let us know why you're making this referral for the Pain Management service. Include advice on how the clients current pain concern is linked to covered injury(s)

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Orebro score:

Orebro form attached:

Yes

No

5. Service level required

Please let us know the type of service required.

Service level	The Pain Management Service supplier will contact ACC to seek approval
<input type="checkbox"/> Community services	Please send a copy of all reports to ACC
<input type="checkbox"/> Tertiary services	Please provide all supporting medical information available
<input type="checkbox"/> Group education	Please send a copy of any reports

6. Injury details

Injury description:

Date of injury:

Read code	Description	Side	Site

How did this injury happen (mechanism of injury)?

7. Injury management and rehabilitation

Describe the management and rehabilitation provided to date.

Type and number of treatments:

Current assistance:

Current daily activities:

Barriers or obstacles to return to work:

Relevant client specific issues:

8. Relevant contact details

Please list who was involved with this client's rehabilitation.

Role	Contact person's name	Phone number	Email address
Treating General Practitioner (GP)			
Employer or school			
Specialist			

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Physiotherapist

Psychologist

Other

9. Attached documents

Please list all the documents you're attaching to this referral. For example clinical notes, radiology reports etc.

10. Additional comments

Other relevant advice and notes about this client's case.

When we collect, use and store information, we comply with the Privacy Act 1993 and the Health Information Privacy Code 1994. For further details see ACC's privacy policy, available at www.acc.co.nz. We use the information collected on this form to fulfil the requirements of the Accident Compensation Act 2001.