

HIPS Referral Questionnaire

Hunter Integrated Pain Service

Updated September 2011

This questionnaire requests information helpful to a Specialist Pain Management Centre in prioritising your case and making treatment recommendations. If it is completed as part of a referral to Hunter Integrated Pain Service then please send it along with a medical referral letter to:

Fax: 4922 3900 or Mail: PO Box 664J, Newcastle 2300

Date: _____

A. PERSONAL PARTICULARS



Mr / Mrs / Miss / Ms Surname: _____

Given Names: _____ Previous Surnames: _____

Address: _____ Postcode: _____

Telephone: (H): _____ (W): _____ (Mob): _____

DOB: _____ Age: _____ Country of Birth _____ Language Spoken: _____

Marital Status: _____ How tall are you?  _____ How much do you weigh?  _____

Name & address of family doctor: _____

Referring Doctor: _____

B. CLASSIFICATION

Have you been seen by a pain clinic before (give details) _____

Are you currently visiting a pain clinic? (give details) _____

Medicare Number (include digit next to your name) _____

Do you have private health fund cover? (circle one) No / Yes Name of fund _____

Is there a current compensation case related to your pain problem? (circle one) No / Yes (If Yes, circle compensation type below)

Workers Comp. / Motor Vehicle Accident / Public Liability Insurer (name & address): _____

Claim No.: _____ Case Manager: _____

Office Use Only

Triage Date: _____ MRN: _____

Baseline Measures:

Pain Severity (BPI): _____ /10

Pain Interference (BPI): _____ /10

K10 Score: _____ /50

CSQ:(czg / coping) _____

PSEQ: _____ /60

Healthcare Utilisation: / / / / / / Total ____

Opiate medication >2 days/week Y/N

Daily oral morphine equivalent _____ mg

Number of analgesic drug groups _____ /5

Treatment benefit ____% Side effects _____ /10

Priority: Urgent (A) 1 month
High (B) 3 months
Moderate (C) 6 months

Category:

Medical assessment: Anaesthetist / Any

Multidisciplinary Assessment: Anaesthetist / Any
Physiotherapy
Psychology / Psychiatry / Any

Understanding Pain

GP Contact Signature: _____

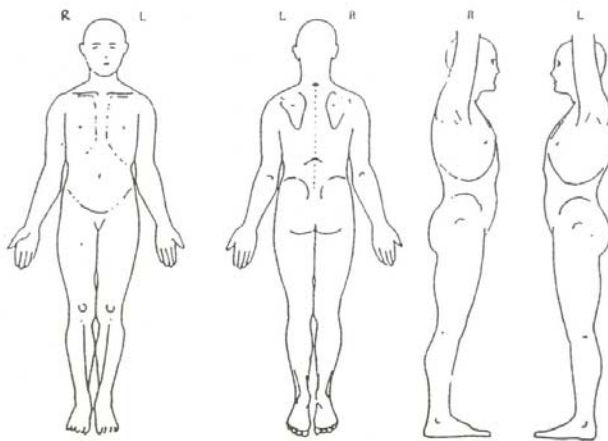
C. WORK STATUS

1. What was your main occupation before your pain/injury? _____
2. What is your current work status?

<input type="checkbox"/> full time work	<input type="checkbox"/> part time work (hours)	<input type="checkbox"/> unemployed due to pain
<input type="checkbox"/> voluntary work reasons	<input type="checkbox"/> home duties	<input type="checkbox"/> unemployed due to other reasons
<input type="checkbox"/> retired	<input type="checkbox"/> student	<input type="checkbox"/> retraining

D. BPI

1. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts most.



2. Please rate your pain by circling the one number that best describes your pain at its worst in the last week.

0	1	2	3	4	5	6	7	8	9	10
No pain									Pain as bad as you can imagine	
3. Please rate your pain by circling the one number that best describes your pain at its least in the last week.

0	1	2	3	4	5	6	7	8	9	10
No pain									Pain as bad as you can imagine	
4. Please rate your pain by circling the one number that best describes your pain on average.

0	1	2	3	4	5	6	7	8	9	10
No pain									Pain as bad as you can imagine	
5. Please rate your pain by circling the one number that tells how much pain you have right now.

0	1	2	3	4	5	6	7	8	9	10
No pain									Pain as bad as you can imagine	
6. What treatments or medications are you receiving for your pain? _____

3. Which statement describes the typical pattern of your main pain? Please circle the best option.
- 0 *Single episode*
 - 1 *Always or almost always present, constant intensity*
 - 2 *Always or almost always present, variable intensity*
 - 3 *Recurring irregularly (eg: like headache)*
 - 4 *Recurring regularly (eg: premenstrual pain)*
4. How long has your main pain been present? Please circle the best option.
Please also give the month and year this pain started if possible _____
- 0 *1 month or less*
 - 1 *1 month to 6 months*
 - 2 *6 months to 12 months*
 - 3 *12 months to 3 years*
 - 4 *3-5 years*
 - 5 *5-10 years*
 - 6 *>10 years*
5. How did your main pain begin? Please circle the best option.
- 0 *Accident at work*
 - 1 *Accident at home*
 - 2 *Motor vehicle crash*
 - 3 *After surgery*
 - 4 *Related to cancer*
 - 5 *Related to another illness* _____
 - 6 *Pain just began, no clear reason*
 - 7 *Other* _____

F. K-10

<i>Please circle the number that best describes how you felt</i>	None of the time	A little of the time	Some of the time	Most of the time	All of the time
1. In the last 4 weeks, how often did you feel tired out for no good reason?	1	2	3	4	5
2. In the last 4 weeks, how often did you feel nervous?	1	2	3	4	5
3. In the last 4 weeks, how often did you feel so nervous that nothing could calm you down?	1	2	3	4	5
4. In the last 4 weeks, how often did you feel hopeless?	1	2	3	4	5
5. In the last 4 weeks, how often did you feel restless or fidgety?	1	2	3	4	5
6. In the last 4 weeks, how often did you feel so restless that you could not sit still?	1	2	3	4	5
7. In the last 4 weeks, how often did you feel depressed?	1	2	3	4	5
8. In the last 4 weeks, how often did you feel that everything was an effort?	1	2	3	4	5
9. In the last 4 weeks, how often did you feel so sad that nothing could cheer you up?	1	2	3	4	5
10. In the last 4 weeks, how often did you feel worthless?	1	2	3	4	5

G. CSQ-R

Individuals who experience pain have developed a number of ways to cope with, or deal with, their pain. These include saying things to themselves when they experience pain, or engaging in different activities. Below are a list of things that patients have reported doing when they feel pain. For each activity, I want you to indicate, using the scale below, how much you engage in that activity when you feel pain, where a 0 indicates you never do that when you experience pain, a 3 indicates you sometimes do that when you experience pain, and a 6 indicates you always do it when you are experiencing pain. Remember, you can use any point along the scale.

0 1 2 3 4 5 6
Never do that sometimes do that always do
that

When I feel pain . . .

- _____ 1. I try to feel distant from the pain, almost as if the pain was in somebody else's body
- _____ 2. I try to think of something pleasant
- _____ 3. It's terrible and I feel it's never going to get any better
- _____ 4. I tell myself to be brave and carry on despite the pain
- _____ 5. I tell myself that I can overcome the pain
- _____ 6. It's awful and I feel that it overwhelms me
- _____ 7. I feel my life isn't worth living
- _____ 8. I pray to God it won't last long
- _____ 9. I try not to think of it as my body, but rather as something separate from me
- _____ 10. I don't think about the pain
- _____ 11. I tell myself I can't let the pain stand in the way of what I have to do
- _____ 12. I don't pay attention to it
- _____ 13. I pretend it's not there
- _____ 14. I worry all the time about whether it will end
- _____ 15. I replay in my mind pleasant experiences in the past
- _____ 16. I think of people I enjoy doing things with
- _____ 17. I pray for the pain to stop
- _____ 18. I imagine that the pain is outside of my body
- _____ 19. I just go on as if nothing happened
- _____ 20. Although it hurts, I just keep on going
- _____ 21. I feel I can't stand it any more
- _____ 22. I ignore it
- _____ 23. I rely on my faith in God
- _____ 24. I feel like I can't go on
- _____ 25. I think of things I enjoy doing
- _____ 26. I do something I enjoy, such as watching TV or listening to music
- _____ 27. I pretend it's not a part of me

H. PSEQ

Please rate how confident you are that you can do the following things at present despite the pain. To indicate your answer, circle one of the numbers on the scale under each item, where 0 = not at all confident and 6 = completely confident. Remember, this questionnaire is not asking whether or not you have been doing these things, but rather how confident you are that you can do them at present, despite the pain.

1. I can enjoy things, despite the pain.

0 1 2 3 4 5 6

Not at all Confident

Completely Confident

2. I can do most of the household chores (eg. tidying-up, washing dishes etc.) despite the pain.

0 1 2 3 4 5 6

Not at all Confident

Completely Confident

3. I can socialise with my friends or family members as often as I used to do, despite the pain.

0 1 2 3 4 5 6

Not at all Confident

Completely Confident

4. I can cope with my pain in most situations.

0 1 2 3 4 5 6

Not at all Confident

Completely Confident

5. I can do some form of work, despite the pain ("work" includes housework, paid and unpaid work).

0 1 2 3 4 5 6

Not at all Confident

Completely Confident

6. I can still do many of the things I enjoy doing, such as hobbies or leisure activities, despite the pain.

0 1 2 3 4 5 6

Not at all Confident

Completely Confident

7. I can cope with my pain without medication.

0 1 2 3 4 5 6

Not at all Confident

Completely Confident

8. I can still accomplish most of my goals in life, despite the pain.

0 1 2 3 4 5 6

Not at all Confident

Completely Confident

9. I can live a normal lifestyle, despite the pain.

0 1 2 3 4 5 6

Not at all Confident

Completely Confident

10. I can gradually become more active, despite the pain.

0 1 2 3 4 5 6

Not at all Confident

Completely Confident

I. HEALTHCARE UTILISATION

1. How many times in the past 3 months have you seen a general practitioner in regard to pain? _____times
2. How many times in the past 3 months have you seen medical specialists (eg. orthopaedic surgeon or neurologist) in regard to pain? _____times
3. How many times in the past 3 months have you seen health professionals other than doctors (eg. physiotherapist, chiropractor or psychologist) in regard to pain? _____times
4. How many times in the past 3 months have you visited a hospital emergency department in regard to pain?_____times
5. For how many days in total over the past 3 months have you been in hospital as an inpatient because of pain?_____days

J. MANAGEMENT

1. Please indicate any of the following treatments that you have tried, and whether or not they were helpful:

Treatment	Never Tried	Helpful	No help	Pain worse	Ongoing
Surgery					
Nerve blocks					
TENS					
Bed rest in hospital					
Bed rest with traction					
Psychology					
Hypnosis					
Relaxation					
Acupuncture					
Chiropractic					
Osteopathic					
Physiotherapy (hands on)					
Hydrotherapy					

2. Please list any operations you have had relating to your pain problem(s):

Type of Operation	Date	Surgeon

8. Please circle if you are a: smoker / non-smoker / ex-smoker
9. If you currently smoke, please circle how many cigarettes you smoke in a normal day? <5 5-14 15+
10. Please circle how many days of the week you drink alcohol <1 1 2 3 4 5 6 7
11. If you currently drink alcohol, please circle how many *standard* drinks you usually have on these days
- 1-2 3-4 5-6 7-8 8-15 15+
12. Do you ever drink alcohol to relieve your pain? NO / YES
13. How many cups or glasses of caffeinated drinks (ie. tea/coffee/caffeinated or energy drinks) do you have per day?
- 0 1-3 4-5 6-7 8+
14. Are there any questions you would like answered if you attend for an assessment at Hunter Integrated Pain Service?

15. What are you hoping to achieve if you attend the Hunter Integrated Pain Service?

16. Your Story

If you wish to, this section is reserved for you to tell *your* story. This may be the story of your pain and how it affects you and your lifestyle, or what you do now to limit your pain's effect on your life.
