Canterbury
District Health Board
Te Poari Hauora ō Waitaha

PATIENT'S NAME_____ NHI_____

ADDRESS_____

DOB_____ EMAIL ADDRESS_____

PHONE- HOME_____ MOBILE_____

MIPP Assessment Committee - Referral Form

☐ To be discussed at monthly meeting ☐ To be circulated and discussed by the committee via email

Referral Date:_____ SMO:_____ Phone: _____

Other Specialists involved (including Specialist Palliative Care):_____

Cancer Diagnosis and background:_____

_____

_____

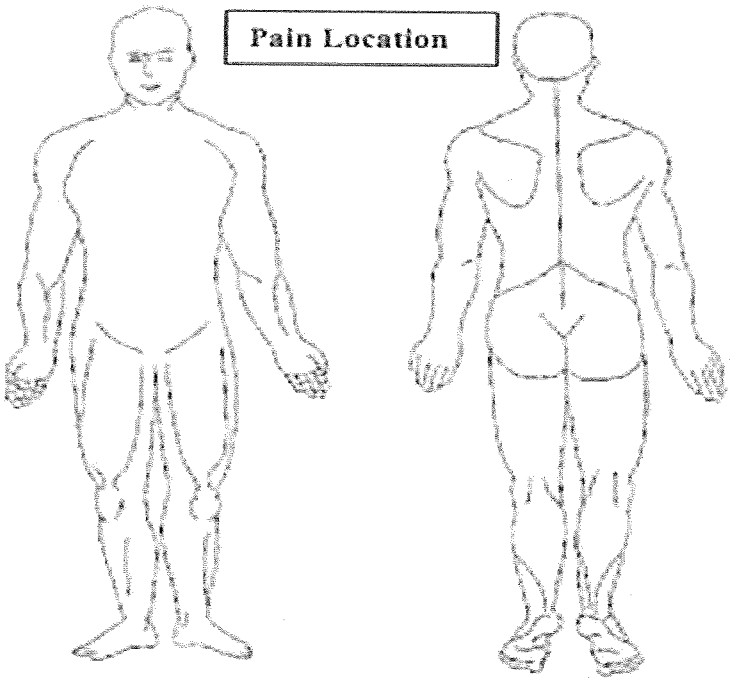
INR_____ Date_____ Platelets _____ Date_____

Imaging to be reviewed: X-Rays Date_____ Location: (CRG, PACS) _____

CT Scan Date_____ Location: (CRG, PACS) _____

MRI Date_____ Location: (CRG, PACS) _____

Reason for referral. Please describe pain(s). Write/draw clearly.



Pain Assessment (PQRST)

Provoking factors _____

Quality_____

Relieving/exacerbating factors_____

_____

_____

_____

Severity (min, max, ave) _____

Timing_____

_____

Current analgesics_____

_____

_____

_____

Previous Radiation Treatment_____

_____

_____

Patient aware of referral Yes ☐ No ☐

DNACPR Yes ☐ No ☐

Inpatient Yes ☐ No ☐ Name of admitting SMO, if required _____

Canterbury Regional Cancer and Haematology Service
Fax referral for to: 378 6233 or email: mipp@cdhb.health.nz (phone: 364 0365)