

## Referral Form

E: [admin@northernpaincentre.com.au](mailto:admin@northernpaincentre.com.au)

T: 02 9439 6456

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**EMPOWER**  
PAIN MANAGEMENT PROGRAM

Dear Empower Pain Management Program,

### Patient Details

Name: .....

Date of Birth: .....

Telephone Number: .....

Email Address: .....

### Funding

*Please circle*

Workers Compensation	CTP	Third Party	DVA	Department of Defence
Self-funded				

### Presenting Complaints

*Please circle*

Back Pain	Arm Pain	Knee Pain	Neuropathic Pain
Leg Pain	Shoulder Pain	Headache	Complex Regional Pain Syndrome
Neck Pain	Hip Pain	Pain after Surgery	Other – please specify below

### Clinical Information

.....  
.....  
.....  
.....  
.....

### Referrer Details

Name: .....

Address: .....

Provider Number: .....

Signature: ..... Date: .....

### Practice Locations

**St Leonards**  
Suite 6, Level 4  
North Shore Private Hospital  
Westbourne Street  
St Leonards 2065

**Norwest**  
Q Central Building  
Suite 107A, Level 1  
10 Norbrik Drive  
Bella Vista 2153

**Brookvale**  
Dale Street Medical Specialists  
Unit 119/20 Dale Street  
Brookvale 2100

**Erina**  
Central Coast Neurosciences  
Element Building  
Suite 2, Level 1  
200 Central Coast Highway  
Erina 2250