

QST & MPT REFERRAL

Referral date: ___ / ___ / ___

Triage: Routine / Soon / Follow up

Clinical notes: _____

PATIENT DETAILS

Name: _____
 Date of Birth: ___ / ___ / ___
 Phone Number: _____
 Email: _____

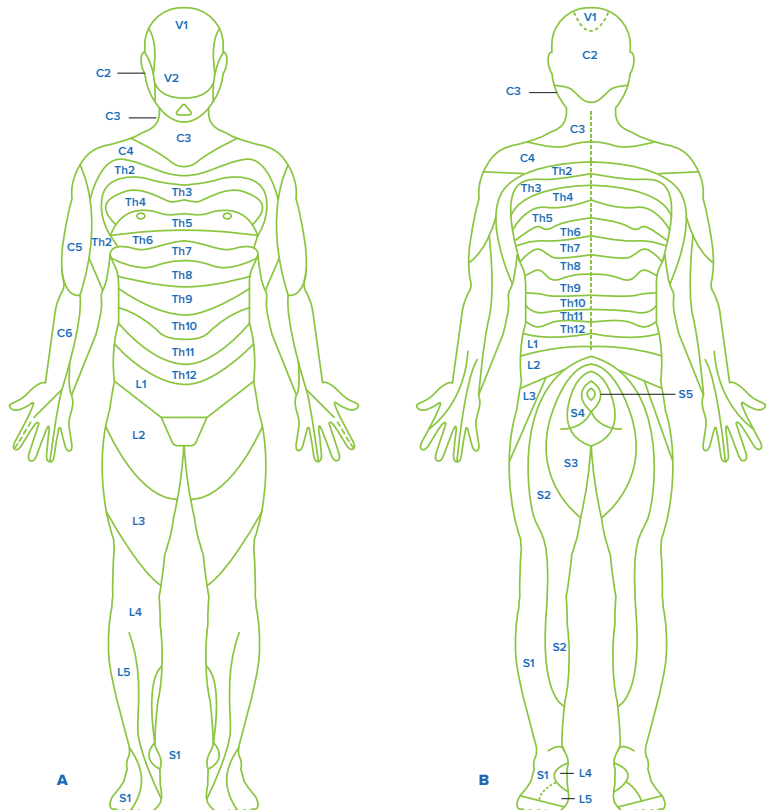
QST	MPT
Indication	Indication
<input type="checkbox"/> Peripheral Neuropathy <input type="checkbox"/> Pre / Post Neuromodulation <input type="checkbox"/> Post Discectomy (Lumbar / Cervical) <input type="checkbox"/> Polyneuropathy (Diabetic / Chemo) <input type="checkbox"/> Other	<input type="checkbox"/> Myofascial Pain (<2 sites) <input type="checkbox"/> Widespread (>4 sites) <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Long Covid <input type="checkbox"/> Other
Present Medication	

- | | | |
|---|--|--|
| <input type="checkbox"/> Pregabalin / Gabapentin | <input type="checkbox"/> NSAIDs / Tramadol | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Duloxetine/Amitriptyline | <input type="checkbox"/> Paracetamol / Opioids | <input type="checkbox"/> Transdermal Patches |

KEY FOCUS

- Upper Limbs
- Hand/Hands
- Lower Limb
- Foot/Feet
- Comparisons Required

Notes:



NRS	Present	Activity	Night-time	QoL Score
Pain Intensity Score (0-10)				

DN4 Neuropathic Score		
Does your pain feel like?	In the painful area do you have:	Does... effect the pain?
<input type="checkbox"/> Burning <input type="checkbox"/> Cold <input type="checkbox"/> Electric Shocks	<input type="checkbox"/> Tingling <input type="checkbox"/> Pins & Needles <input type="checkbox"/> Numbness <input type="checkbox"/> Itch	<input type="checkbox"/> Touching the area <input type="checkbox"/> Sharp items <input type="checkbox"/> Brushing against the skin
Score:	Score:	Total:

Widespread Pain Index (WPI)				
No. Sites	<2	4	6	>9
Severity Score (0-3)	Nil	Mild	Moderate	Severe
Fatigue	0	1	2	3
Sleep	0	1	2	3
Cognitive	0	1	2	3
Headache	No (0)	Yes (1)		
Abdominal Pain	No (0)	Yes (1)		
				Total (20)

COMMENTS/PLAN

- Repeat Post Procedure
 Clinic Review