Multidisciplinary Review

This treatment form relates to the patients MDT assessment

Patient First Name: _____ **Patient Last Name:** _____

Date of prescription: _____ dd / mm / yyyy

Clinical Diagnosis

- [ ] Arthritis
- [ ] Back and/or Neck Pain
- [ ] Cancer Related Pain
- [ ] Chemotherapy Induced Nausea and Vomiting
- [ ] Chronic Pain
- [ ] Cluster Headaches
- [ ] Colitis
- [ ] Complex Regional Pain Syndrome
- [ ] Crohn's Disease
- [ ] Crohn's Disease and/or Ulcerative Colitis
- [ ] Ehlers-Danlos Syndromes
- [ ] Endometriosis
- [ ] Fibromyalgia
- [ ] Headaches
- [ ] IBS / IBD
- [ ] Irritable Bowl Syndrome
- [ ] Migraines
- [ ] Movement Disorder
- [ ] Muscle Spasms
- [ ] Muscle Spasms/Spasticity
- [ ] Musculoskeletal Pain
- [ ] Neuropathic Pain
- [ ] Other condition that causes Chronic Pain
- [ ] Palliative Care Pain
- [ ] Scoliosis
- [ ] Spinal Cord Injury/Disease

Trialled simple analgesia

- ◯ Yes ◯ No

Trialled neuropathic pain medication

- ◯ Yes ◯ No

Medication

- [ ] Oil
- [ ] Irradiated Flower
- [ ] Non-Irradiated Flower
- [ ] Capsules
- [ ] None

Medication Description

Patient not immunocompromised

- ◯ Yes ◯ No ◯ Not applicable

Patient has no chronic respiratory disorder

- ◯ Yes ◯ No ◯ Not Applicable

Co-morbidities

Contraindications

Follow up required

- [ ] 3 week Pain questionnaire
- [ ] 6-8 week
- [ ] 12 week
- [ ] 26 week

No Follow up Required

Can Patient be included in Shared Care Agreement?

- ◯ No
- ◯ Yes

Date for Review of Shared Care Agreement: dd / mm / yyyy

Comments