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| Referal FormPaediatric chronic pain PROGRAM | | | | | | | | | | | | |
| LHSC PIN # | | | | | | | | | | | | |
| Patient Name | |  | | | | | | | Date of Referral | | |  |
| **Parent Name (s):** | |  | | | | | | | DOB | | |  |
| **Parent Name (s):** | |  | | | | | | | | | | |
| **Address:** | | | | **Phone: Home:** | | | | | | **Referring Physician / Service:** | | |
|  | | | | **Business:** | | | | | |  | | |
|  | | | | **Cell:** | | | | | | **Form Completed by:** | | |
|  | | | |  | | | | | |  | | |
| reason for referral: | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **Medical Diagnoses: (Diagnostic workups must be completed)** | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
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|  | | | | | | | | | | | | |
| Pain location and type: | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| **PAIN DURATION:** | | | | | | | | | | | | |
| 🞎 < 4mo | 🞎 4-6 mo | | | | 🞎 6-12 mo | 🞎 >12 mo | | | | | | |
| **IMPACT ON FUNCTION:** | | | | | | | | | | | | |
| 🞎 ADLs | 🞎 Academic | | | | 🞎 Social | 🞎 Emotional | | 🞎 Other | | | | |
| **Please Describe:** | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| past and current treatments (PHARMACEUTICAL, PHYSICAL, PSYCHOLOGICAL): | | | | | | | | | | | | |
| 🞎 OTC analgesics | | | 🞎 Opioids | | | | 🞎 Non-Opioids | | | | | 🞎 Nerve Blocks |
| 🞎 Other Medication | | | | | | | | | | | | |
| 🞎 PT/OT | | | 🞎 Psychology | | | | 🞎 Psychiatry | | | | | 🞎 Other |
| Previous Pain Clinic(s) attended: | | | | | | | | | | | | |
|  | | | | | | | | | | | 🞎 Records included (required if applicable) | |
| **Please forward relevant consultation notes with referral** | | | | | | | | | | | | |

**Send referral to: Paediatric Chronic Pain Program (PMDU – B1-234) or Fax to 519-685-8431.**

**For additional information or questions, contact ext. 57920**