Referral to Paediatric Chronic Pain Service

Our program provides pain rehabilitation. All investigations must be complete prior to referral.

Please fax to 519-663-3162 or email to paedpainprogram@lhsc.on.ca. Please include all relevant clinical notes otherwise referral will be delayed.

Date of referral:	**LHSC Personal Identification Number (PIN):**
Patient last name:	**Patient first name:**
Date of birth:	**Referring physician/nurse practitioner:**
Home address:	**Phone number:**

Reason for referral:

Past medical history:

Pain and location type:

Please describe patient's functional disability:

Treatments tried:

- **Physical:**
- **Psychological:**

Medications:

Do they identify as Indigenous? If so, would they like to access additional support?