PAEDIATRIC CHRONIC PAIN PROGRAM

Children's Hospital
London Health Sciences Centre

Paediatric Chronic Pain Referral Form

OUR PROGRAM PROVIDES PAIN REHABILITATION. ALL INVESTIGATIONS MUST BE COMPLETE PRIOR TO REFERRAL.

Date of Referral:
Patient Name:
DOB:
LHSC PIN:
Referring MD/NP:
Address:

Reason for Referral:

Past Medical History:

Pain and Location Type:

Please describe patient's functional disability:

Treatments Tried:
Physical:

Psychological:

Medication trialed:

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

Please fax to 519 685 8431, questions to ext. 57920
Please include all relevant clinical notes otherwise referral will be delayed