Children's Inpatient Pain Service Referral Form

Date of Referral:
Patient Name:
D.O.B:
LHSC PIN:
Referring MD/NP:
Address:
Reason for Referral:
Upcoming Surgery/Date:
Description of pain problem and what you have done to manage pain:

History of chronic pain (pain lasting >3 months)? YES NO
History of opioid use? YES NO
Parental catastrophizing? YES NO
Psychosocial reasons for referral (if any – circle as appropriate): Maladjustment Anxiety Depression Behavioural concerns History of medical trauma Fear Other:____________________ ____________________ ____________________ ____________________

Please fax to: Paediatric Pain Program @ 519 685 8431
Or if more urgent email or page 15131

paedpainprogram@lhsc.on.ca