Referral to Children's Inpatient Pain Service (ChIPS)

Please fax to 519-663-3162 or email to paedpainprogram@lhsc.on.ca. For more urgent referrals, please page 15131.

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:

Upcoming Surgery/Date:

	Yes	No
History of chronic pain (pain lasting >3 months)?		
History of opioid use?		
Parental catastrophizing?		

Psychosocial reasons for referral (if any, check all that apply):

	Maladjustment		Anxiety
	Depression		Behavioural concerns
	History of medical trauma		Fear
Other:			

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