London Health Sciences Centre

Children's Hospital
London Health Sciences Centre

# Referral to Children's Inpatient Pain Service (ChIPS)

Please fax to 519-937-0615, or email paedpainprogram@lhsc.on.ca. For more urgent referrals please page 15131

**Date of Referral:**

**Referring Physician:**

**Patient First Name:**

**Patient Last Name:**

**Date of Birth:**

**Patient Phone Number:**

**Patient Address:**

**LHSC Personal ID Number (PIN) or HC:**

**Reason for referral:**

**Upcoming surgery/date:**

**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, check all that apply):**

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

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