Children's Hospital
London Health Sciences Centre

REFERAL FORM
PAEDIATRIC CHRONIC PAIN PROGRAM

LHSC PIN #			
Patient Name		**Date of Referral**	
Parent Name (s):		**DOB**	
Parent Name (s):			
Address:	**Phone: Home:**	**Referring Physician / Service:**	
	Business:		
	Cell:	**Form Completed by:**	
REASON FOR REFERRAL:			
Medical Diagnoses: (Diagnostic workups must be completed)			

PAIN LOCATION AND TYPE:				
PAIN DURATION:				
☐ < 4mo	☐ 4-6 mo	☐ 6-12 mo	☐ >12 mo	
IMPACT ON FUNCTION:				
☐ ADLs	☐ Academic	☐ Social	☐ Emotional	☐ Other
Please Describe:				
PAST AND CURRENT TREATMENTS (PHARMACEUTICAL, PHYSICAL, PSYCHOLOGICAL):				
☐ OTC analgesics	☐ Opioids	☐ Non-Opioids	☐ Nerve Blocks	
☐ Other Medication				
☐ PT/OT	☐ Psychology	☐ Psychiatry	☐ Other	
PREVIOUS PAIN CLINIC(S) ATTENDED:				
			☐ Records included (required if applicable)	

Please forward relevant consultation notes with referral

Send referral to: Paediatric Chronic Pain Program (PMDU – B1-234) or Fax to 519-685-8431.

For additional information or questions, contact ext. 57920