

|  |
| --- |
| Referal FormPaediatric 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**