150 Kilgour Road
Toronto, ON M4G 1R8
Tel: (416) 753--6030
Fax: (416) 422-7036

Holland Bloorview
Kids Rehabilitation Hospital

Referral Form: Get up and go - Persistent Pediatric Pain Service

Referral Date: _____

To be completed in pen by a health care professional. Please print.

Please complete this form and attach accompanying information where appropriate. Incomplete forms may delay the referral process.

Client and family Information

Name: _____
Sex M F
Date of Birth Y/M/D _____
Home Address: _____
Parent/guardian Name(s): Mother: _____ Father: _____
Who is legal custodian: Mother Father Other:
Name of Legal Guardian: _____
Phone (H) _____ Phone (W) _____
Phone (M) _____
Health Card No. _____

Interpreter required? Y ☐ N☐ Language:_____

Has the client and family consented to the referral? Y ☐ N☐

Referring Physician/Provider

Name: _____
Title: _____
Organization: _____
Address: _____
Phone _____ FAX _____
Email _____

Primary Care Physician:

Name: _____
Title: _____
Organization: _____
Address: _____
Phone_____ FAX _____
Email _____

REF INPT

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Reason for Referral: Please tick the relevant box(es)

All reasonable investigations have been completed ☐

Reasonable and accessible management in the primary care sector has been tried with insufficient success ☐

Pain has significant impact on life (sleep, self -care, or pain necessitating assistance of others) ☐

Pain impacting on: mobility ☐

school attendance ☐

recreation ☐

relationships and/or emotions ☐

Pain exacerbations have resulted in Emergency Department presentation or hospital admission in the last 3 months ☐

There seem to be complex psychosocial influences on pain behaviour which require specialized assessment and care ☐

Current or past history of prescribed medication use which seem to be complicating current management ☐

Patient History

Please describe pain problem/reason for referral	
Relevant Clinical History (please attach relevant correspondence e.g. clinic letters, consultation notes, etc.)	Attachments Y ☐ N ☐ # pages ____
Relevant Surgical or imaging history (please attach relevant reports)	Attachments Y ☐ N ☐ # pages ____

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History of assessment by another pain service or rehabilitation service for pain management in the last 2 years Name of Service: Please attach relevant correspondence	Y ☐ N☐ Attachments Y ☐ N ☐ # pages ____
Current Medications (including prescription and non-prescription) **Scheduled:** Name Dosage Route Frequency Indication **PRN:** Name Dosage Route Frequency Indication	
Allergies/adverse reactions If yes, please list:	Y ☐ N☐
Psychiatric history? Please describe: History of addiction?	Y ☐ N☐ Y ☐ N☐
Have any addiction services been involved? Please describe:	Y ☐ N☐
Medical Co-morbidities Please describe:	Y ☐ N☐

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Does the patient have difficult accessing information/services? Impaired cognitive function? Visual impairment? Hearing impairment? Difficulty reading?	Y ☐ N☐ Y ☐ N☐ Y ☐ N☐ Y ☐ N☐ Y ☐ N☐
Thank you for completing this referral! Name of person completing the form: Date:	

PLEASE FAX COMPLETED REFERRAL TO:

Admissions Facilitator 416-422-7036