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

Get Up and Go: Persistent Pediatric Pain Service

REFERRAL FORM

Holland Bloorview
Kids Rehabilitation Hospital

Please fax completed referral to: Admissions Facilitator 416-422-7036

Referral Source

☐ CHEO ☐London Children's ☐McMaster Children's ☐SickKids

☐Other (specify): ______________________________

Person completing referral: ______________________ Contact#: ______________

Referring Physician: ______________________ Contact#: ______________

The client and family have consented to the referral: ☐ Yes ☐ No

Client Information

Name: ______________________________

Date of Birth (dd/mm/yy): ______________________________

Sex: ☐ Female ☐ Male

Gender: ☐ Female ☐ Male ☐ Other: ______________

Primary Address: ______________________________

City: ______________________ Postal Code: ______________

Client Email: ______________________ Client Contact #: ______________

OHIP#: ______________________ Version Code: ______________

Caregiver (Name/Role): ______________________ Contact #: ______________

Caregiver (Name/Role): ______________________ Contact #: ______________

Caregiver email(s): ______________________________

Custody arrangement or legal guardian: ______________________________

Interpreter Required ☐ No ☐ Yes (specify for whom & language spoken): ______________

Health Information

Primary Pain Diagnosis: ______________________________

____

Other Medical Condition(s): ______________________________

____

☐ Current Medical History: Please attach relevant clinical history or recent medical summary

☐ Current List of Treating Providers: Please attach (e.g., PT, OT, Psychologist, Alternative Therapist)

☐ Current List of Medications: Please attach a complete medication list **or** complete the Client Medication Profile (last page of this document)

Allergies: ☐ NKDA ☐ Yes (If yes, please describe): ______________________________

Special Diet ☐ No ☐ Yes (If yes, please describe): ______________________________

10/18/2018

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Goals

Client's Goal(s) (e.g., social, physical, school/work, psychological, family, ADLs):

(1)____

(2)____

(3)____

(4)____

(5)____

Psychosocial/Behavioural Factors

DSM-V Diagnoses:__________________________________

Additional Psychosocial or Behavioural Concerns:____________________

Recent Significant Family Stressors:__________________________

Factors that may impact client/family readiness:____________________

Safety Risks (e.g. falls; suicidal behaviour; substance misuse) ☐ No ☐ Yes

If yes, provide details and behavioural safety plan:__________________

Physical Functioning/Mobility

Is the client able to walk independently in the following environments?:

Home ☐ Yes ☐ No

School ☐ Yes ☐ No

Community ☐ Yes ☐ No

Does the client use a mobility aid? ☐ No ☐ Yes If yes, please describe:____________

Frequency of use: ☐ Full-Time ☐ Part-Time or ☐ Occasional

Client's ability to walk before requiring a rest (minutes and/or distance):____________

School:

School Name:____________________________Grade:____________

Frequency of Attendance:________________________________

School Accommodations: ☐ No ☐ Yes, please explain:____________________

Trusted adult at school:________________________________

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Current List of Treating Providers (Please include Chronic Pain Clinic and Community providers):

Provider's Name	Role/Discipline	Frequency of Appointments

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Client Medication Profile:

Name (please include complementary/OTC medications & supplements)	Dose	Indication

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