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 ☐TAPMI

☐Other (specify):_____

Person completing referral:_____Contact#:_____

Referring Physician:_____Contact#:_____

Primary Care Provider (PCP):_____Contact#:_____

Client has consented to the referral: ☐ Yes ☐ No

Parent/guardian has 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):_____

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Goals

Functional goals (e.g., social, physical, school/work, psychological, family, ADLs) from referring team:

(1)_____

(2)_____

(3)_____

(4)_____

(5)_____

Behavioural:

DSM-V Diagnoses:_____

_____

_____

Patient and family are **aware** of and understand all listed diagnoses included above: ☐ Yes ☐ No

If no, please provide details:

Additional Psychosocial or Behavioural Concerns:_____

Health Information

Pain Diagnoses:_____

Other Medical Condition(s):_____

Patient and family are aware of and understand all listed diagnoses included above: ☐ Yes ☐ No

If no, please provide details:_____

☐ Current Medical History: Please attach relevant clinical history or recent medical summary **and** any relevant consultative notes from subspecialty providers

☐ Current List of Treating Providers: Please attach (e.g., PT, OT, Psychologist, Alternative Therapist, Psychiatry, Neurology, GI, Cardiology, Rheumatology, etc.)

☐ 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: ☐ Yes ☐ No (If yes, please describe):_____

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Factors that may impact client readiness:

Safety Risks (e.g. falls; suicidal behaviour; substance use, self harm) ☐ Yes ☐ No

If yes, provide details and behavioural safety plan:

Psychosocial:

Family member(s) at home(s):

Marital status: ☐ Single ☐ Married ☐ Common Law ☐ Divorced ☐ Separated ☐ Estranged ☐ Widowed ☐ Other:

Custodial arrangement:

Current CAS involvement: ☐ Yes ☐ No

Pending litigation: ☐ Yes ☐ No

If yes, please provide details:

Significant parental distress/ family dysfunction: ☐ Yes ☐ No

If yes, please provide details:

Financial barriers to program participation or recent significant family stressors: ☐ Yes ☐ No

If yes, please provide details:

Geographic/ logistical barriers to program participation: ☐ Yes ☐ No

If yes, please provide details:

Other Factors that may impact family participation: ☐ Yes ☐ No

If yes, please provide details:

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Physical Functioning/Mobility

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

Home ☐ Yes ☐ No
School ☐ Yes ☐ No
Community ☐ Yes ☐ No
Stairs ☐ Yes ☐ No

Does the client use a mobility aid? ☐ Yes ☐ No
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):_____

Does the client use any splints or braces? ☐ Yes ☐ No
If yes, please describe:

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

Does the client require any assistance for activities of daily living (e.g. parental help or equipment)?

☐ Yes ☐ No
If yes, please describe:_____
_____

Has the client had any falls causing injury in the last 6 months?
☐ Yes ☐ No
If yes, please describe:_____
_____

Is the patient able to swim independently (e.g. without lifejacket)? ☐ Yes ☐ No

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School:

School status: ☐In school full time ☐ In school part time ☐Not in school ☐ Graduated

School Name:_____Grade:

How does patient attend school: ☐ In-person ☐ Virtual ☐ Mix- in person and online Additional details:

Percentage of school curriculum attended (on average week):

☐ Full attendance ☐ 80% ☐ 40 – 60% ☐ up to 20%

Additional details:

_____

School Accommodations (check all that apply): ☐ None ☐ Yes – informal ☐ Yes – IEP ☐EA

If yes, please specify:_____

Trusted adult at school:

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Current List of Treating Providers (Please include all **subspecialty** and **community** providers):

Provider's Name	*Role/Discipline*	*Frequency of Appointments*	*Consultation or most recent clinical note attached?*
	Primary Care		Yes ☐
	Physiotherapy *Please specify:* ☐ Multidisciplinary Assessment ☐ Individual Assessment ☐ Treatment		Yes ☐
	Occupational Therapy *Please specify:* ☐ Multidisciplinary Assessment ☐ Individual Assessment ☐ Treatment		Yes ☐
	Psychology *Please specify:* ☐ Multidisciplinary Assessment ☐ Individual Assessment ☐ Treatment		Yes ☐
	Social Work *Please specify:* ☐ Multidisciplinary Assessment ☐ Individual Assessment ☐ Treatment		Yes ☐
	Case Manager		☐
	Other:		☐
	Other:		☐
	Other:		☐
	Other:		☐
	Other:		☐

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Client Medication Profile: Please include all current medications

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

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