McMaster Children's Hospital

Pediatric Chronic Pain Program
Referral Form

Physician/Nurse Practitioner Referral Only

Referral Date:

INCLUSION CRITERIA

- Under 17 ½ at time of referral
- Chronic pain lasting >3 months
- Chronic pain as a **primary** complaint
- Chronic pain interfering with functioning

PHYSICIAN INFORMATION

Referring MD: ______________________ Specialty: ______________________

Phone: ______________________ Fax: ______________________

Primary Care Practitioner: ______________________

Phone: ______________________ Fax: ______________________

PATIENT INFORMATION

Last Name: ______________________ First Name: ______________________

DOB: ______________________ Gender: ______________________

Address: ______________________ City: ______________ Postal Code: __________

Health Card Number: ______________________ Version Code: __________

CAREGIVER INFORMATION

Parent/Caregiver Name: ______________________

Relationship to Child: ______________________

Home Phone: ______________________ Other Phone: ______________________

Email: ______________________

Is the patient/family aware of this referral? ❑Yes ❑No

REASON FOR REFERRAL

Primary Pain Concern

Is there a concern regarding possible Complex Regional Pain Syndrome (CRPS)? ❑Yes ❑No

Investigations/Tests Completed or Pending:

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Other Specialists Involved:

For patients referred for chronic headache, we request that the patient has been assessed by a neurologist.

Mental Health Providers Involved:

Comorbid Conditions

Select all that apply and add details as applicable:

- ❑ Mood disorder ______________________
- ❑ Anxiety disorder ______________________
- ❑ Somatic symptom disorder ______________________
- ❑ Trauma history ______________________
- ❑ Substance abuse ______________________
- ❑ Suicidal ideation or self-harm ______________________
- ❑ Learning and developmental disabilities ______________________
- ❑ Other: ______________________

Impact of Pain on Functioning

School attendance:

- ❑ Attends regularly
- ❑ Frequently absent
- ❑ Not currently attending

Other areas of functioning affected by pain:

- ❑ Sleep
- ❑ Activities of daily living or self-care
- ❑ Social interactions or extracurricular activities
- ❑ Physical activity or mobility
- ❑ Family functioning

Please include any additional information below:

Referring Provider Signature: ____

Please fax the completed referral form to 905-521-2330.

Note: This form must be complete for the referral to be considered.

A digital version of this referral form is available on the McMaster Children's Hospital Website.