Children's Hospital of Eastern Ontario
Centre hospitalier pour enfants de l'est de l'Ontario

Partners Against Pain - Integrated Pain Services
REQUEST FOR CONSULTATION
CHRONIC PAIN CLINIC
TRANSITIONAL PAIN CLINIC
Pages 1 - 4

Thank you for your referral. Please fax completed form to (613) 738-4893
Attention: Megan Greenough, Nurse Practitioner, Chronic Pain

The goal of the chronic pain service is to treat and manage children and teens up to 17.5 years of age who are experiencing pain that is difficult to explain and / or manage with conventional treatment(s). Investigations into the diagnosis and cause of pain *must be completed prior to the referral*. Completing this form in full will allow us to best triage your patient to the following: emergent, urgent, semi-urgent or routine/regular.

For patients > 17.5 years at the time of the referral, please refer to an adult pain specialist as we will be unable to accommodate this request.

NOTE: PATIENTS WILL NOT BE BOOKED FOR A CLINIC APPOINTMENT UNTIL THIS REQUEST IS COMPLETE

Check the most appropriate referral:

□ **Consult for Transitional Pain Clinic**
- **Includes *patients with pain < 3 months*, complex severe acute pain, suspected neuropathic pain, Complex Regional Pain Syndrome (CRPS) or unusual persistent post-operative pain.**

OR

□ **Consult for Chronic Clinic Inclusion Criteria: *pain has persisted for >than 3 months***
- ***Chronic pain is the primary complaint*, pain impacts school attendance, sleep, mood, quality of life and activities of daily living.**
  Exclusion Criteria: *any major psychiatric disorder which has not been properly assessed or treated.*

□ **Is this referral a result of an accident or Workman's Compensation? □yes □no**

A. CLIENT DEMOGRAPHICS:

Name (last): ________________________________ First: ___________________________
Address: __________________________City:_____________________________________
Postal Code: ____________________Home Phone Number: ____________________
Alternate Number: ________________
Date of Birth (day/month/year): ___________
Name of Parent or Guardian(s):____

B. REFERRING PHYSICIAN:
Name: _______________________ Phone: ________________ Fax: _________________
Address: ____

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PRIMARY PHYSICIAN:
Name: ______________________ **Phone:** _______________ **Fax:** ________________
Address: ____

C. PATIENT HISTORY: Review of the pharmacotherapies, physical strategies and psychological strategies trialed to date.
Weight _________ **Allergies**____________________
Immunizations Updated □yes □no

CURRENT MEDICATIONS:

Drug	Dosage/Frequency	Evaluation/Adjustments

Previous Regional Blocks □yes □no If so, type of block _______________ **Date:** _____________

PHYSICAL STRATEGIES: □physiotherapy □TENS □massage therapy □chiropractor □acupuncture □other ________________________
Occupational Therapy □yes □no

PSYCHOLOGICAL STRATEGIES: □mindfulness □Cognitive Behavioural Therapy (CBT) □relaxation techniques □meditation □other ________________________
Other: □naturopathic

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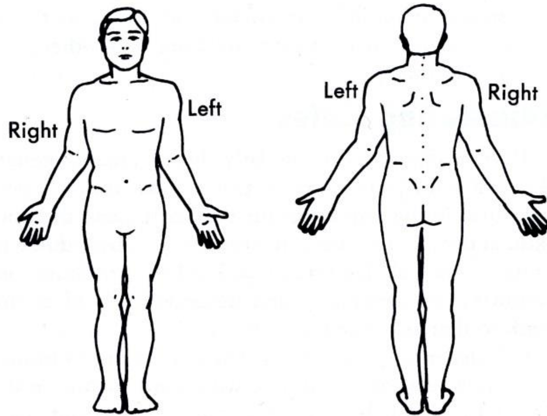
2. PHYSICAL EXAMINATION: Please mark with an "X" the primary source(s) of pain:

Pain Scores: _______ Numerical Rating Scale 0 = no pain 10 = worst pain possible

Pain Duration: □ < 3 months □ 3 - 6 months □ 6 - 12 months □ > 12 months

BODY PAIN DIAGRAM



Circle Pain Descriptors

tingling	cramping	exhausting
sharp	stabbing	shooting
burning	aching	heavy
nagging	deep	burning
throbbing	excruciating	continuous
numb	unbearable	

Concurrent Medical History: ____

____

____

PAST MEDICAL HISTORY:

Has the patient been assessed or treated for any of the following psychiatric disorders or mental health conditions? □ Yes □ No If yes, please check those that apply.

□depression □anxiety □bipolar □conversion □borderline personality □suicidal ideation
□substance abuse □Attention Deficit Disorder (Hyperactivity/Inattentive)
□Autism Spectrum Disorder □Eating Disorder

If yes, please confirm whether the patient is receiving ongoing treatment and include the name of the provider: ________________________

Learning Difficulties: □Yes □No Please check those that apply
□ Developmental Delay □ Learning Disability (specify)______________
□ Formalized IEP

D. OTHER CARE PROVIDERS: Please indicate other relevant consultants and attach a copy of the respective reports (physiotherapy, psychology, psychiatry).

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Is patient followed by a social worker? □ Yes □ No
If so please provide name of provider: ____________________

E. **INVESTIGATIONS/IMAGING**: (please attach reports, IF investigations not performed at CHEO):
____
____
____
Labs (attach reports, IF investigations not performed at CHEO: ______________________

F. **FUNCTIONAL ASSESSMENT**: Briefly describe the impact of chronic pain on the patient and/or their family, including impact upon activities of daily living and school attendance by checking the appropriate boxes that apply:

□ Not currently attending school

Number of days of school missed due to pain in the past three months______
□ Pain impacts sleep □Difficulty Falling Asleep □Difficulty Sustaining Sleep
□ Pain Impacts Mood □Anxiety □Sadness
□ Pain Impacts activities of daily living or self-care
□ Pain impacts social interactions
□ Pain impacts mobility
□ Pain affects family function □parent on parental leave
Comments:
____
____

LANGUAGE:
□ Primary Language □English □French □Other (specify): _______________
□Interpreter required □yes □no

G. **HOW CAN WE ASSIST**? In what ways can we assist with the pain management of your patient?
____

H. **CO-JOINT MANAGEMENT**: Will you be willing to co-jointly follow this patient? □ Yes □ No
This may include medication prescriptions, ongoing follow-up and securing community providers such as physical therapy and psychology.
Best Method to Contact Primary Physician: ______________________________________
e-mail contact information: ____
Date: ________________________ Signature ______________________________

CHRONIC PAIN USE ONLY	Triage Date: __________	
□Multidisciplinary Clinic	Date ____________	□ Transition Clinic Date ____________
□Medication Management	Date ____________	