

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): _____

***If assistance is required in completing this form, please contact Carrie Moss, Intake & Clinical Coordinator at 416-425-6220 ext. 6277**

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):

<u>Provider's Name</u>	<u>Role/Discipline</u>	<u>Frequency of Appointments</u>	<u>Consultation or most recent clinical note attached?</u>
	Primary Care		Yes
	Physiotherapy Please specify: <input type="checkbox"/> Multidisciplinary Assessment <input type="checkbox"/> Individual Assessment <input type="checkbox"/> Treatment		Yes
	Occupational Therapy Please specify: <input type="checkbox"/> Multidisciplinary Assessment <input type="checkbox"/> Individual Assessment <input type="checkbox"/> Treatment		Yes
	Psychology Please specify: <input type="checkbox"/> Multidisciplinary Assessment <input type="checkbox"/> Individual Assessment <input type="checkbox"/> Treatment		Yes
	Social Work Please specify: <input type="checkbox"/> Multidisciplinary Assessment <input type="checkbox"/> Individual Assessment <input type="checkbox"/> 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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