NL Health Services

Child/Women's Health Program

Pediatric Complex Pain Referral (Part I)

Email: pediatric.pain@easternhealth.ca
Telephone: (709) 777-4890
Digital Fax: (709) 777-1487

Incomplete referrals will be returned. See referral criteria.

ADI 860 2378 05 2023

Name:

HCN:

Date of Birth:

Date of Referral: DD/MONTH/YYYY

Referring Zone: ☐ Eastern Urban ☐ Eastern Rural ☐ Central Western ☐ Labrador

Patient Information:

Allergies: _____ ☐ **No Known**

Telephone: _____ Email: _____

Mailing Address: _____

Weight: _____ Kg Immunizations up to date: ☐ Yes ☐ No

Does patient require an Interpreter? ☐ Yes ☐ No If Yes, Language: _____

Parent/Guardian information:

Name: _____ Telephone: _____

Address: _____ Email: _____

Preferred method of contact: _____

Primary physician/health care professional:

Name: _____ Telephone: _____

Address: _____

Primary reason for referral –Check all that apply

☐ Chronic abdominal pain
☐ Chronic headaches
☐ Chronic musculoskeletal pain
☐ Widespread joint pain
☐ Other: _____

Complete PRIOR to sending referrals

Chronic headache consults:
- Neurology consult and head CT

Chronic abdominal pain consults:
- Gastrointestinal specialist consult and medical imaging

Chronic musculoskeletal pain consults:
- Orthopedics consult and medical imaging

Widespread joint pain consults:
- Rheumatology consult

Pain assessment:

Average pain score (0= no pain, 10= worst pain possible): _____

Pain duration: ☐ Less than 3 months ☐ 3-6 months ☐ 6-12 months ☐ Greater than 12 months

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

Referring Pracitioner's:

Name: _____ Telephone: _____

Signature: _____

NL Health Services

Child/Women's Health Program

Pediatric Complex Pain Referral (Part II)

Email: pediatric.pain@easternhealth.ca
Telephone: (709) 777-4890
Digital Fax: (709) 777-1487

Incomplete referrals will be returned. See referral criteria.

ADI 860 2378 05 2023

Name:

HCN:

Date of Birth:

Functional ability:

School attendance: ☐ not currently attending ☐ frequently absent ☐ regularly attends

Other areas of function affected:

Other current medical history:

Past medical history:

Has the patient been diagnosed or treated for any of the following psychiatric disorders or mental health conditions? Select hose that apply:

- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar
- ☐ Borderline Personality
- ☐ Suicidal Ideation
- ☐ Substance Abuse
- ☐ Attention Deficit Disorder (Hyperactivity/Inattentive)
- ☐ Eating Disorder
- ☐ PTSD (Post-Traumatic Stress Disorder)

If yes, confirm whether the patient is receiving ongoing treatment, include the name of the provider and their telephone number(s): _____

Learning difficulties: ☐ Yes ☐ No If Yes, select those that apply: ☐ Developmental delay

☐ Learning disability (specify):

Select primary affected area(s):

- ☐ Head
- ☐ Neck
- ☐ Abdomen
- ☐ Back ☐ Upper ☐ Lower
- ☐ Lower Extremity ☐ Left ☐ Right
- ☐ Upper Extremity ☐ Left ☐ Right
- ☐ Joint - Specify:
- ☐ Other:

Select all pain descriptors that apply:

- ☐ Continuous
- ☐ Tingling
- ☐ Sharp
- ☐ Stabbing
- ☐ Aching
- ☐ Burning
- ☐ Intermittent
- ☐ Heavy
- ☐ Cramping
- ☐ Shooting
- ☐ Throbbing
- ☐ Cramping
- ☐ Numb
- ☐ Other:_____

Referring Pracitioner's:

Name:_____ Telephone:_____

Signature:_____

NL Health Services

Child/Women's Health Program

Pediatric Complex Pain Referral (Part III)

Email: pediatric.pain@easternhealth.ca
Telephone: (709) 777-4890
Digital Fax: (709) 777-1487

Incomplete referrals will be returned. See referral criteria.

ADI 860 2378 05 2023

Name:

HCN:

Date of Birth:

Pharmacological Interventions (name/dose/frequency):

Physical Interventions:

- ☐ Physiotherapy
- ☐ Massage Therapy
- ☐ Chriopractor
- ☐ Accupuncture
- ☐ Occupational Therapy
- ☐ Other: _____

Psychological Interventions:

- ☐ Mindfulness
- ☐ Cognitive Behavioural Therapy (CBT)
- ☐ Meditation
- ☐ Relaxation Techniques
- ☐ Psychologist
- ☐ Counsellor
- ☐ Social Worker
- ☐ Other: _____

Name and telephone numbers of any providers:

Other Strategies: ☐ Naturopathic ☐ Osteopath

Other care providers/investigations/imaging; Indicate other relevant consultations and attach a copy of the respective reports (physiotherapy, psychology, psychiatry, medical images):

Referring Pracitioner's:

Name:_____ Telephone:_____

Signature:_____