



COMPLEX PAIN SERVICE

CPS Office: Tel: 604.875.2345 ext 5108 / Fax: 604.875.2767

TOLL-FREE within BC: 1.888.300.3088 ext 5108 / Fax ext 2767

Website: www.bcchildrens.ca/our-services/clinics/pain-service

Physicians

Gill Lauder, MB BCh, FRCA, FRCPC
Tim Oberlander, MD, FRCPC

Psychologist

Sue Bennett, PhD, R. Psych

Physiotherapist

Lawren De Marchi, MPT

Nurse Clinician

Sarb Randhawa, RN, BScN

**CPS Referral Form – To be completed by Referring Physician
Referral will NOT be processed if incomplete**

COMPLEX PAIN SERVICE (CPS)

- The CPS is an innovative outpatient service provided by an interdisciplinary team that includes a pediatrician, anesthesiologist, pain nurse clinician, psychologist and physiotherapist.
- The CPS team is dedicated to the prevention and management of complex pain in children and youth.
- Some of the common types of pain we treat are headaches, abdominal and musculoskeletal pain.
- A psychiatrist and pharmacist are available to assist the CPS team as needed.

CPS USE ONLY
CPS Dr
<input type="checkbox"/> ND
<input type="checkbox"/> ND/PT
<input type="checkbox"/> ND/Psych
<input type="checkbox"/> Team

DATE OF REFERRAL

DD _____ /MONTH _____ /20 ____

PATIENT INFORMATION (must be under 17 at time of referral)

Last Name:	_____	First:	_____	DOB:	_____
PHN:	_____	BCCH#:	_____	Sex:	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other
Address:	_____	City:	_____	Postal:	_____
PARENT/GUARDIAN	Mother:	_____	Father:	_____	
Home Phone #:	_____	Cell #:	_____	Work #:	_____
Email Address:	_____				

REFERRING PHYSICIAN INFORMATION

Name:	_____	Specialty:	_____	<input type="checkbox"/> GP	<input type="checkbox"/> Emergency Room
Address:	_____	City:	_____	Postal:	_____
Phone #:	_____	Fax #:	_____		

PRIMARY PEDIATRICIAN INFORMATION

Name:	_____	Phone #:	_____	Fax #:	_____
Address:	_____	City:	_____	Postal:	_____

FAMILY PHYSICIAN INFORMATION

Name:	_____	Phone #:	_____	Fax #:	_____
Address:	_____	City:	_____	Postal:	_____

REASON FOR REFERRAL

Interdisciplinary Team Care

Medication Consult

PAIN SITE AND DURATION

Localized (PLEASE DOCUMENT SITE) SITE: _____

Multiple Site

DURATION OF PAIN:

3-12 months

1-3 years

> 3 years

Diffuse/ Whole Body

PAIN DESCRIPTION (please check all that apply)

TYPE OF PAIN:

IMPACT OF PAIN ON: (PLEASE SPECIFY)

Inflammatory _____

Physical ability _____

Neuropathic _____

Mood _____

Mechanical _____

Sleep _____

Complex Regional
Pain Syndrome (CRPS) _____

School _____

Oncological _____

Family _____

Other (not known) :

INCLUSION CRITERIA --- ALL MUST APPLY	EXCLUSION CRITERIA
<input type="checkbox"/> Patient has a primary care provider	<input type="checkbox"/> Untreated addiction to prescription or recreational drugs
<input type="checkbox"/> All appropriate investigations have been done	<input type="checkbox"/> Ongoing infection source without treatment
<input type="checkbox"/> Unresponsive to conventional treatment	<input type="checkbox"/> Medically unstable or suffers from a condition requiring inpatient care and monitoring
<input type="checkbox"/> Primary care provider(s) agree to participate with suggested regime	<input type="checkbox"/> Scheduled for surgery specifically for pain issues
<input type="checkbox"/> Patient and/or caregivers are cognitively capable and willing to participate with suggested regime of therapy	<input type="checkbox"/> Poorly controlled Psychopathology
<input type="checkbox"/> Patient aware and agreeable to the Pain Program including self-management strategies and interdisciplinary team members as an option	** There are NO addiction services in our clinic **

Patients will be triaged according to our predetermined criteria and seen by the appropriate provider(s).

All patients referred from the emergency department must have a primary physician, GP or pediatrician or these referrals should go through Complex Care Clinic, the pediatrician or the GP to ensure the involvement of an MRP. The patient's primary physician (GP or pediatrician) is responsible for ongoing care, during and after participation in the program, including reordering prescribed medications.

GI referrals for abdominal pain must have a referral to and have been linked with Medical Psychology or Youth Health prior to a CPS appointment.

Patients with anxiety and depression must also have a Youth Health or Psychiatry referral as appropriate.

All referrals from Orthopedics must have a physiotherapist involved.

The consultative service provided by the Complex Pain Service is **not for long term follow-up**.

Patients must be followed by their family physicians during and after their participation in the program.

Medical workup to be completed prior to referral to CPS, i.e. MRI, CT scan, seen by specialties, etc.

PAIN DESCRIPTION continued (please check all that apply)

Medical History: No issues History Attached

Allergies/Sensitivities No issues List: _____

Mental Health: No issues Attached

Followed by Mental Health Team: No Yes Name: _____

Current Medication List: _____

Substance Use Concerns: Not Applicable Active History Past History See Attached

Previous Pain Care: Occupation Therapy Physiotherapy Chiropractic's Naturopath
 Massage Therapy Acupuncture Other: _____

Previous Medications Tried: _____

Activities of Daily Living: No issues Coping adequately Struggling to cope

Self-care: No issues Coping adequately Struggling to cope

Home Activity: No Issues Coping adequately Struggling to cope Homemaker

School Activity: No issues Occasionally absent due to pain Absent due to pain >50% school term
 Not attending school due to other reasons Please specify: _____

Mobility Aid: None Cane Crutches Wheelchair

OTHER SPECIALISTS/SERVICES CONSULTED (check all that apply)

SERVICE	NAME OF PRACTITIONER	SERVICE	NAME OF PRACTITIONER
<input type="checkbox"/> Endocrinology	_____	<input type="checkbox"/> Physiotherapy	_____
<input type="checkbox"/> Gastroenterology	_____	<input type="checkbox"/> Psychiatry	_____
<input type="checkbox"/> Neurology	_____	<input type="checkbox"/> Psychology	_____
<input type="checkbox"/> Orthopedics	_____	<input type="checkbox"/> Rheumatology	_____
<input type="checkbox"/> General Surgery	_____	<input type="checkbox"/> Other:	_____

INVESTIGATIONS PERFORMED (check all that apply)

NAMED INVESTIGATION	DATE OF EXAM	OTHER INVESTIGATIONS
<input type="checkbox"/> X-RAY	_____	<input type="checkbox"/> _____
<input type="checkbox"/> MRI	_____	<input type="checkbox"/> _____
<input type="checkbox"/> Bone Scan	_____	<input type="checkbox"/> _____
<input type="checkbox"/> Bloodwork	_____	<input type="checkbox"/> _____

Please attach ALL RELEVANT REPORTS as well as a REFERRAL LETTER outlining reason for referral, current medications and other therapies tried.

FAX ALL DOCUMENTS to the CPS: 604.875.2767 [BC toll-free: 1.888.300.3088 ext 2767]
For additional information, please contact our CPS Nurse Clinician, 604.875.3627