

Comfort Kids Referral - procedural related distress, pain and anxiety

Child/ Adolescent Name _____
UR # _____

Referral date ___/___/___

Contact person / details _____

Priority: Next available Semi urgent Urgent

Referred by _____
Contact details x _____
p _____

Responsible physician _____

Reason for referral

Diagnosis 1 _____

Diagnosis 2 _____

Diagnosis 3 _____

Procedures required for this child's treatment

Next scheduled procedure and location

Please fax to 9345 5606

Thank you,

Lisa Takacs
Procedural Pain Management –Nurse
Pager 4877
Ext 7933