Holland Bloorview
Kids Rehabilitation Hospital

Referral Criteria – Infant Development Services

Ambulatory Care

The Infant Development Services use an interprofessional approach to provide opportunities for optimal development for a child and their family but supporting families in their efforts to be active participants in their child's care.

Early Childhood Educators and Occupational Therapist provide early interventions to reduce risk using both in- home and centre based models.

In order to be eligible for this service a **referral is required** Referrals are accepted from **parents, doctors, hospitals, neonatal follow-up programs, therapists, community programs** and **other agencies** who provide services for young children. The client must meet **all** the following criteria:

- Live in the Toronto (postal code begins with M)
- Is between birth and 5 years of age (at the time of referral)
- Has been identified as having developmental delays and disabilities including physical markers or prematurity
- Is not receiving Infant Developmental Services in Toronto from any of the following agencies; Centennial Nursery School Infant Development Centre, Surrey Place Centre, Mothercraft or Centre Francophone de Toronto
- Is not enrolled in the following services; Holland Bloorview Nursery Schools (Scarborough site or Play & Learn site), a childcare or day care centre

***If the referral is being made on behalf of a client, the client/family must be aware of the referral**

Please use the referral form online at: hollandbloorview.ca/referrals

Holland Bloorview Kids Rehabilitation Hospital
150 Kilgour Road, Toronto ON Canada M4G 1R8
T 416 425 6220 **T** 800 363 2440 **F** 416 425 6591
www.hollandbloorview.ca

A teaching hospital fully affiliated with the University of Toronto

Holland Bloorview
Kids Rehabilitation Hospital

Appointment Services: 150 Kilgour Rd. Toronto, ON, M4G 1R8
Tel: (416) 424-3804 Fax: (416) 422-7036

PHYSICIAN REFERRAL FORM – OUTPATIENT SERVICES

Please complete all sections of this form as incomplete forms will result in processing delays.

NOTE: This information will be shared with Holland Bloorview staff as required.

Family is aware of this referral: Yes ☐ (must be checked) Referral Date: ________________(dd/mm/yy)

CLIENT INFORMATION:

Client Name: ____
Last Name First Name Middle Initial

Date of Birth: ______________________ ☐ Male ☐ Female
Day / Month / Year

Is an interpreter required? ☐ Yes ☐ No Language spoken:______________

Client Address: ______________________City:______________

Province: ____________ Postal Code: ____________ Tel.:______________

Health Card Number: ______________ Version Code: ______________

☐ Interim Federal Health Program (IFHP) ☐ Health Card In Process

Client lives with: ☐ Both parents ☐ Father ☐ Mother ☐ Guardian ☐ Independent ☐ Group Home ☐ Other:

PARENT(S) OR GUARDIAN(S): (if different from client address)

Parent/Guardian: ____

Address:____

Email:____

Tel. (home): ______________Tel. (work):______________Tel. (cell): ______________

Parent/Guardian: ____

Address:____

Email:____

Tel. (home): ______________Tel. (work):______________Tel. (cell): ______________

AGENCIES/PROFESSIONALS CURRENTLY INVOLVED:

Agency (eg. Child Protection, Community)	Professional (eg. OT, SLT, Psychologist)
1.______________	______________
2.______________	______________
3.______________	______________

MEDICAL INFORMATION:

Primary Diagnosis:

____

Other Diagnoses:

____

Does this client require any special infectious disease precautions? **Yes** **No**

If yes, what for: ____

Medical History/Allergies:

____

____

Taking Medication: ☐ Yes ☐No

Risks (i.e. frequent falls)

____

Reason for Referral/Concern/Goals:

____

____

Use check box for referral:

- ❑ Query Autism
- ❑ Acquired Brain Injury Rehabilitation
- ❑ Concussion Clinic
- ❑ Cleft Lip & Palate Speech Language Pathology
- ❑ Infant Development Services
- ❑ Neuromotor (e.g. cerebral palsy, global developmental delay, Retts)
- ❑ Psychopharmacology* (additional forms required)
- ❑ Neuromuscular (e.g. muscular dystrophy)
- ❑ Feeding* (additional forms required)
- ❑ Spina Bifida
- ❑ Spinal Cord Injury
- ❑ Augmentative & Alternative Communication (AAC)
  - ❑ Writing Aids
- ❑ Orthotics (including protective headwear)
- ❑ Prosthetics (including myoelectric & cosmetic)
- ❑ Clinical Seating

Dental Services:

- ❑ Cleft Lip & Palate (general anesthesia available for qualifying clients)
- ❑ Special Needs Dentistry (general anesthesia available for qualifying clients)

***Pre-assessment forms are required with the referral. Click here:**

Feeding: http://hollandbloorview.ca/programsandservices/programsservicesaz/feedingservices
Psychopharmacology: http://hollandbloorview.ca/programsandservices/ProgramsServicesAZ/Psychopharmacologyclinic

REFERRING M.D./D.D.S. Name: ____

OHIP Billing Number: ________________________

Hospital: ____

Telephone: ____ Fax: ____

Email: ____

Signature: ____

Please fax your completed Referral Form to Appointment Services: (416) 422-7036

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