

# Referral Criteria – Clinical Seating Services

## Ambulatory Care

Clinical seating services support children and youth who benefit from the use of wheelchairs, adapted strollers and related seating and positioning devices. This transdisciplinary team provides consultation, prescription (both short and long term) and follow up for wheelchairs (manual and powered) and adapted strollers. The appointments are completed in collaboration with vendors selected by the client and/or family.

To enable co-ordination of care for each child, the clinical seating services team communicates and collaborates with other involved community partners such as community therapists, physicians, equipment vendors, other medical facilities, and government agencies.

When equipment is prescribed for a client, the professionals will assist the client and their family to research the various funding options available to them and assist with the completion of any necessary applications and supporting documentation.

In order to be eligible for this service a **Physician referral** is required and the client must meet **all** the following criteria:

- Live in the Toronto area or in regions that do not have a specialized seating service able to meet the client's mobility needs
- Is under the age of 19 (at the time of referral)

***\* The client/family must be aware of the referral***

Please use the referral form online at: [hollandbloorview.ca/referrals](http://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](http://www.hollandbloorview.ca)

A teaching hospital fully affiliated with the University of Toronto

**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:**

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**Other Diagnoses:**

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

If yes, what for: \_\_\_\_\_

**Medical History/Allergies:**

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**Taking Medication:**    Yes    No

**Risks** (i.e. frequent falls)

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**Reason for Referral/Concern/Goals:**

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**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***