

Referral Criteria - Music & Arts Ambulatory Care

Music and Arts programs at Holland Bloorview Kids Rehabilitation Hospital offer a wide range of year-round art and music programs for children and youth with disabilities and their siblings.

Led by accredited music therapists and professional artists, Music and Arts programs provide opportunities for self-expression and social participation through programs that focus on music education, music therapy, visual and performing arts.

Services Include:

Music Therapy and Arts Assessment for all new clients
Individual Music Therapy
Group Music Therapy
Adapted Music Education
Seasonal Visual and Performance Art Programs

In order to be eligible for this service a **referral is required**. Referrals are accepted from **parents/caregivers, clients, physicians, hospitals, health professionals, community programs** and **other agencies** who provide services for young children. The client must meet **all** the following criteria:

- Live in the Greater Toronto Area
- Is aged from birth to 21 years
- Has an interest in Music and Arts
- Individuals referred or self-referring must complete a registration form. Registration forms can be found on the **Music and Arts Program Page** under "Program information and registration."

Please note for all sibling applicants **only a completed registration form is required.**

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