

## Referral Criteria – Transitions, Recreation and Life Skills Community Services

Transitions, Recreation and Life Skills use recreational, skill building activities and real world experiences to improve the health and quality of life for children and youth with disabilities. Our services help youth work towards goals so they can learn how to do tasks themselves and get involved in home and community activities.

<p><b>What are Life Skills?</b></p> <p>Life skills prepare clients to manage daily life tasks in different areas, such as:</p> <ul style="list-style-type: none"> <li>• Self-management</li> <li>• Friendships and social skills</li> <li>• Community participation</li> <li>• Recreation or leisure activities</li> <li>• Employment readiness and volunteering</li> </ul>	<p><b>Who do we serve?</b></p> <p>Clients who:</p> <ul style="list-style-type: none"> <li>• Are 7-18 (21 if still in high school)</li> <li>• Have a disability</li> <li>• Are able to set goals</li> <li>• Want to work on life skills</li> <li>• Want to work on recreation goals</li> </ul>
<p><b>Who is on our team?</b></p> <ul style="list-style-type: none"> <li>• Therapeutic Recreation Specialists</li> <li>• Therapeutic Recreation Assistants</li> <li>• Occupational Therapists</li> <li>• Occupational Therapist Assistants</li> <li>• Life Skills Coaches</li> <li>• Youth Facilitators</li> <li>• Clinical Care Assistants</li> </ul>	<p><b>What services do we offer?</b></p> <ul style="list-style-type: none"> <li>• Individual goal setting</li> <li>• Working 1:1 with staff to learn and practice new skills</li> <li>• Skill building groups and workshops</li> <li>• Linking to community resources and programs</li> </ul>
<p><b>What types of goals do clients work on?</b></p> <ul style="list-style-type: none"> <li>• Learning about meal preparation and cooking</li> <li>• Learning how to use money</li> <li>• Getting involved in community recreation activities</li> <li>• Learning about friendship skills</li> <li>• Learning how to use public transportation (e.g. subway/buses, Wheel trans)</li> <li>• Preparing for getting a volunteer position or job</li> <li>• Preparing for living on your own</li> <li>• Accessing adapted recreation equipment</li> </ul> <p><b>Please note that this service does not provide 1:1 support for medical or behavioural needs. If 1:1 support is required while receiving service, it is the client/caregivers responsibility to make the necessary arrangements.</b></p>	

For more information, and to ensure this service is a good fit for you, please contact: 416-425-6220 ext 6208 or call ext. 6044 to self-refer and book a Transitions, Recreation & Life Skills appointment.

### HEALTH PROFESSIONAL REFERRAL FORM – OUTPATIENT SERVICES

Referral Source:       Health Care Professional               Client and Family               Other

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: \_\_\_\_\_  
                            Surname                              First Name                              Middle Initial

Date of Birth: \_\_\_\_\_  Male  Female  
  Day / Month / Year

Is an interpreter required?  Yes  No Languages spoken: \_\_\_\_\_

Client Address: \_\_\_\_\_ City: \_\_\_\_\_

Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Tel.: \_\_\_\_\_

Health Card Number: \_\_\_\_\_ Version Code: \_\_\_\_\_

Interim Federal Health Program (IFHP)  Yes  No      Health Card In Process

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

#### Primary Contact(s) – Parent/Legal Guardian:

\_\_\_\_\_  
Address: \_\_\_\_\_  
Email: \_\_\_\_\_  
Tel. (home): \_\_\_\_\_ Tel. (work): \_\_\_\_\_ Tel. (cell): \_\_\_\_\_

#### Secondary Contact(s) – Parent/Legal Guardian:

\_\_\_\_\_  
Address: \_\_\_\_\_  
Email: \_\_\_\_\_  
Tel. (home): \_\_\_\_\_ Tel. (work): \_\_\_\_\_ Tel. (cell): \_\_\_\_\_

#### PRIMARY CARE PHYSICIAN:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Tel.: \_\_\_\_\_ Fax: \_\_\_\_\_

**COMMUNITY AGENCIES/PROFESSIONALS CURRENTLY INVOLVED:**

Agency(s) (e.g. Child Protection, Community)

Professional (e.g. OT, 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:**

\_\_\_\_\_

\_\_\_\_\_

**Specialized Services:**

- Aquatic Therapy
- Augmentative & Alternative Communication (AAC)
  - Writing Aids
- Clinical Seating
- Infant Development Services
- Life Skills Services
- Music Therapy
- Nursery Schools (Holland Bloorview)
- Orthotics (including protective headwear)

- Post-Secondary Transition Service
- Prosthetics (including myoelectric & cosmetic)
- Therapeutic Recreation Services

**Dental Services:**

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

**REFERRING PROFESSIONAL/CLIENT OR FAMILY:**

Name: \_\_\_\_\_

Organization: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Signature: \_\_\_\_\_

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