Holland Bloorview
Kids Rehabilitation Hospital

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.

What are Life Skills?

Life skills prepare clients to manage daily life tasks in different areas, such as:

- Self-management
- Friendships and social skills
- Community participation
- Recreation or leisure activities
- Employment readiness and volunteering

Who do we serve?

Clients who:

- Are 7-18 (21 if still in high school)
- Have a disability
- Are able to set goals
- Want to work on life skills
- Want to work on recreation goals

Who is on our team?

- Therapeutic Recreation Specialists
- Therapeutic Recreation Assistants
- Occupational Therapists
- Occupational Therapist Assistants
- Life Skills Coaches
- Youth Facilitators
- Clinical Care Assistants

What services do we offer?

- Individual goal setting
- Working 1:1 with staff to learn and practice new skills
- Skill building groups and workshops
- Linking to community resources and programs

What types of goals do clients work on?

- Learning about meal preparation and cooking
- Learning how to use money
- Getting involved in community recreation activities
- Learning about friendship skills
- Learning how to use public transportation (e.g. subway/buses, Wheel trans)
- Preparing for getting a volunteer position or job
- Preparing for living on your own
- Accessing adapted recreation equipment

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.

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.

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