Holland Bloorview
Kids Rehabilitation Hospital

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

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

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:

_____

Medical History:

_____

_____

_____

Taking Medication: ☐ Yes ☐No

Reason for Referral/Concern:

_____

_____

Specialized Services:

- ❑ Aquatic Therapy
- ❑ Augmentative & Alternative Communication
- ❑ 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
- ❑ Writing Aids

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: _____