

REFERRAL – HOLLAND BLOORVIEW KIDS REHABILITATION HOSPITAL EXTENSIVE NEEDS SERVICE

About this service

The Extensive Needs Service is a publicly funded program delivered on an ambulatory basis at Holland Bloorview. The aim is to provide wrap around services (clinical and therapy) for children and youth whose needs are currently not being met by the current healthcare system. The program takes an equity-focused, trauma-informed lens aimed at participation, inclusion, and quality of life for children, youth, and their families. The focus is to work with families and current care teams to enhance capacity, reduce challenging behaviours, and treat the underlying medical and mental health concerns.

Eligibility criteria

The Extensive Needs Service provides vital wrap around services for children and youth (up to 18 years of age) with urgent and extensive needs in Ontario who have co-occurring:

- a. Neurodevelopmental conditions or an acquired brain injury, and
- b. Mental health conditions(s), and
- c. Chronic physical health conditions(s)

Additionally, there are existing needs that are not currently met with respect to:

- a. Challenging/interfering behaviours (for longer than 12 months or escalating over the past 6 months)
- b. They have already accessed 3 or more healthcare or service providers
- c. Safety concerns (impaired functioning that is a barrier to engagement in home, school, community)
- d. Caregiver family complexity (financial, language, cultural, capacity, living arrangements, etc)

Referral details

This is a referral to the Extensive Needs Service at Holland Bloorview. Upon receipt of referral, the family will be contacted for an intake assessment.

Name of child being referred: _____

Date of birth: _____

Client safety concerns:



Please select the relevant diagnoses for this client:

<input type="checkbox"/>	Acquired brain injury
<input type="checkbox"/>	ADHD
<input type="checkbox"/>	Autism
<input type="checkbox"/>	Communication disorder
<input type="checkbox"/>	Global developmental delay
<input type="checkbox"/>	Intellectual developmental disorder
<input type="checkbox"/>	Learning disorder
<input type="checkbox"/>	Cerebral Palsy
<input type="checkbox"/>	Other

Please select any relevant mental health conditions:

<input type="checkbox"/>	Anxiety (GAD, social, panic)
<input type="checkbox"/>	OCD
<input type="checkbox"/>	Mood disturbance (depression, DMDD)
<input type="checkbox"/>	ADHD
<input type="checkbox"/>	Externalizing disorder (ODD, conduct)
<input type="checkbox"/>	Psychosis
<input type="checkbox"/>	Substance use
<input type="checkbox"/>	Attachment/trauma
<input type="checkbox"/>	Somatic symptoms
<input type="checkbox"/>	Chronic irritability
<input type="checkbox"/>	Other

Please select any medical conditions for this client:

<input type="checkbox"/>	Seizures/Epilepsy
<input type="checkbox"/>	Sleep disturbance
<input type="checkbox"/>	Feeding issues/restrictive eating
<input type="checkbox"/>	Reflux/GERD
<input type="checkbox"/>	Constipation
<input type="checkbox"/>	Known genetic condition (please specify)
<input type="checkbox"/>	Other

Does the client have any medication/polypharmacy concerns that need to be addressed, such as:

<input type="checkbox"/>	Multiple psychotropic meds (on several medications with no clear benefit)
<input type="checkbox"/>	Psychotropic medication side effects
<input type="checkbox"/>	Diagnostic complexity impacting medication choices
<input type="checkbox"/>	Failed behavior medications for longer than a year
<input type="checkbox"/>	Other



Please identify the behaviours of concern:

<input type="checkbox"/>	Aggression
<input type="checkbox"/>	Hyperactivity
<input type="checkbox"/>	Impulsivity
<input type="checkbox"/>	Compulsions
<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	Sadness
<input type="checkbox"/>	Anhedonia
<input type="checkbox"/>	Self-injury
<input type="checkbox"/>	Irritability
<input type="checkbox"/>	School avoidance

Have there been challenging behaviours present for over 12 months, or significantly escalating for over 6 months?

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No

Please list any agency involvement and therapy provided over the past 12 months

Are the needs of the client/family unmet with present services?

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No

Are there family/caregiver complexities present?

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No



What services are most needed for this client? For each service indicated, please provide as much detail as possible with respect to reason for involvement or goals of therapy. This will help the intake team make the best decision for team member involvement.

- **Behaviour therapy**
Please indicate details around service needs _____
- **Occupational therapy**
Please indicate details around service needs _____
- **Speech & language pathology**
Please indicate details around service needs _____
- **Child life**
Please indicate details around service needs _____
- **Psychology**
Please indicate details around service needs _____
- **Family counselling**
Please indicate details around service needs _____
- **Clinical pharmacy**
Please indicate details around service needs _____
- **Psychiatry**
Please indicate details around service needs _____
- **Developmental pediatrics**
Please indicate details around service needs _____
- **Coordinated service planning**
Please indicate details around service needs _____
- **Registered dietitian**
Please indicate details around service needs _____

Does the client or the family require any accommodations for on-site or virtual visits'?

Is there anything else you would like the team to know?

