Holland Bloorview
Kids Rehabilitation Hospital

# AQUATIC THERAPY

Before completing our Aquatic Therapy self-referral form, please review the criteria and additional information to make sure this program is an appropriate fit for your child.

## Criteria

***Diagnostic groups that may participate in the program but are not limited to:***

- Ages 2-18 years of age
- Cerebral palsy, acquired brain injury, spinal cord injury, muscular dystrophy, amputation, epilepsy, spina bifida, arthritis, autism spectrum disorder, pain conditions, and other developmental disabilities.
- Aquatic therapy is most beneficial for those who have limited potential to participate in land-based therapeutic interventions.

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- Participants must have either physical or functional goals that could be addressed with aquatic therapy.
- Participant must be comfortable in an aquatic setting.
- Participant must be able to participate in a group-based aquatic setting with or without support from parents/caregivers staff.
- **Participants must be supported by parent/caregiver in the water.**

## Program Details (Semi Private)

When:

Day of week: **Tuesdays**
**(October 12- December 07)**

Timeslots:4:15-4:45 / 4:50-5:20 /
5:25-5:55 / 6:00- 6:30
*(times assigned based on appropriate grouping)*

Cost:

$810.00 *($90.00 per session)*
(9 weeks session)

Assessment Costs:

$105.00 (new clients)
$80.00 (for any client whose condition has changed or who has missed 2 or more consecutive sessions)

**If your child meets these guidelines, please complete the application form and return it by mail, fax, or in person to:**

Holland Bloorview Kids Rehabilitation Hospital
Attention: Krysta Pigden (Aquatics)
150 Kilgour Road
Toronto, ON M4G 1R8
Fax: 416-422-7036

***Questions? Please contact:***
Krysta Pigden, Aquatics Program Assistant
Phone: 416-425-6220, ext. 3707
kpigden@hollandbloorview.ca

**Office Use Only**

Date Received: _____
Session: _____
Treatment Time: _____

## Aquatic Therapy Self-Referral Form

Please complete all of the sections of this form. Incomplete forms cannot be processed.

**Date**: _____ (dd/mm/yy)

**Please tell us how you heard about our program**: _____

Please note that completion of this form does not guarantee a place in the Aquatic Therapy Program. All application forms will be reviewed to ensure applicants are safe to participate in the water. Due to limited spaces, applicants may be placed on a wait list until a space in the program becomes available.

**CLIENT INFORMATION:**

Client Name: _____
Surname First Name Middle Initial

Date of Birth: _____ □ Male □ Female Age: _____
(dd/mm/yy)

Primary Language: _____

Client Address: _____ City: _____

Province: _____ Postal Code: _____

Telephone Number: _____

Health Care Number: _____ Version Code: _____

Client Lives With: □ Both Parents □ Father □ Mother □ Guardians □ Independent
□ Group Home □ Other

**Parent(s)/Guardian(s) Information:**

Mother/Guardian's Name: _____
Address: _____
Telephone Number: _____ _____ _____
(Home) (Work) (Cell)
Email: _____

Father/Guardian's Name: _____
Address: _____
Telephone Number: _____ _____ _____
(Home) (Work) (Cell)
Email: _____

**SERVICE PROVIDERS:**
**Family Doctor**:
Name: _____
Telephone Number: _____
Fax Number: _____

**Other Care Provider(s) (if applicable):**
Name: _____
Title: _____
Telephone Number: _____
Fax Number: _____

**MEDICAL INFORMATION:**

Primary Diagnosis: _____

Relevant Medical History: _____
_____
_____

Current Medication: _____
_____

Reason For Seeking Aquatic Therapy/Goals: _____
_____

**Medical Conditions:**

*Cardiorespiratory*

Cardiovascular issues: □ Yes □ No Describe:
_____
Respiratory issues: □ Yes □ No Describe:
_____
History of aspiration: □ Yes □ No Describe:

Tracheotomy □ Yes □ No Describe:
_____
Requires Oxygen: □ Yes □ No Describe:
_____

*Gastrointestinal*

Loss of bowel or bladder control/incontinence: □ Yes □ No Describe:
_____
G-tube/NG tube: □ Yes □ No Describe:
Thickened Liquid Diet: □ Yes □ No Describe:

*Neurological*

History of seizures: □ Yes □ No Describe (please include type and typical duration):
_____
Trigger if known: _____

*Skin*

Open wounds/skin break down: □ Yes □ No Describe:
_____
Skin infection: □ Yes □ No Describe:
_____
Abnormal/decreased sensation: □ Yes □ No Describe:
_____
Allergy/sensitivity to chlorine: □ Yes □ No Describe:
_____

*Other*

Other medical conditions (please describe):_____
_____
Other external lines or tubes (please describe): _____
_____

**Mobility:**

□ Walks independently □ Walks independently with equipment □ Requires supervision
□ Requires assistance □ Dependent on others for mobility
□ Additional information: _____
_____

**Transfers:**

□ Transfers independently with or without equipment □ Requires supervision
□ Requires assistance – one person transfer □ Requires assistance – two person transfer
□ Requires assistance – more than two persons or lift required
□ Additional information: _____
_____

Is your child **currently** enrolled in any other program at the hospital (Eg. therapeutic program or research study) that would prevent them from participating in the Aquatic Therapy Program at this time?

□ Yes □ No

**Additional Information:**
Is there any additional information you would like to provide us regarding your client's participation in the Aquatic Therapy Program at Holland Bloorview?

_____
_____
_____
_____

**Consent to Contact:**

I hereby give Holland Bloorview Kids Rehabilitation Hospital consent to contact the above listed Care Providers to discuss my child's health information if necessary.

☐ Yes ☐ No

_____ _____
Signature Date

**Thank You for your Application!**

How to return this form:

**BY MAIL or IN PERSON:** Holland Bloorview Kids Rehabilitation Hospital
150 Kilgour Rd.
Toronto, ON
M4G 1R8
Attention: Krysta Pigden

**BY FAX:** 416-422-7036

**To protect your privacy, please do not email this form**

**If you have any questions please feel free to contact the Krysta Pigden at 416-425-6220 ext. 3707**