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

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? o Yes o No Languages spoken: _____

If yes, would over-the-phone interpretation be possible for this client (i.e. is hearing/speaking an issue?) ☐ Yes ☐ No

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 / NURSE PRACTITIONER:

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 Communication & Writing Aids Services: ❑ Augmentative & Alternative Communication (AAC) ❑ Writing Aids (WA) ❑ Clinical Seating ❑ Infant Development Services ❑ Music Therapy	❑ Nursery Schools (Holland Bloorview) ❑ Orthotics (including protective headwear) ❑ Prosthetics (including myoelectric & cosmetic) **Transitions, Recreation & Life skills:** ❑ Employment & Volunteering ❑ Life Skills Coaching ❑ Post-Secondary Transition Service ❑ Therapeutic Recreation Services ❑ Transitions to Adult 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

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