Holland Bloorview
Kids Rehabilitation Hospital

Client Name: _____

Date of Birth: _____

Dental Services: Pre-Assessment Information Form

Client's Height (in centimeters): _____ Client's Weight (in kilograms): _____

Does the child have: ☐ Behavioural issues ☐ Anxiety ☐ Other: _____

Please tell us about the child's previous experiences in health care settings.		
Has the child received dental services? If yes: When: _____ Where: _____ Were there behavioural issues? _____ _____	☐ Yes	☐ No
Is therapeutic stabilization required at dental or medical appointments? _____	☐ Yes	☐ No
Has the child received sedation prior to dental services? If yes: When: _____ Where: _____ Were there any issues? Explain: _____ _____	☐ Yes	☐ No
Please tell us about your child's behaviour.		
How does the child react to new environments? _____ _____		
Does the child demonstrate physical aggression? If yes, are they physically aggressive towards: ☐ Self? ☐ Others? If yes, how do they act when aggressive? _____ _____	☐ Yes	☐ No

Please tell us about the child's communication skills.

What is the best way to communicate with the child?

- ☐ Verbal
- ☐ Communication device, please specify: _____
- ☐ Sign language
- ☐ Other: _____

How does the child communicate that they are in pain?

Your referral will be processed when this completed form has been received. Thank you for your prompt reply.

Please fax or return this form to the address below. For privacy reasons, we do not recommend that you send this by email.

Client Appointment Services
Holland Bloorview Kids Rehabilitation Hospital
150 Kilgour Road, Toronto, ON.
M4G 1R8
Fax: 416- 422-7036