150 Kilgour Road
Toronto, ON M4G 1R8
Tel: (416) 753-6022
Fax: (416) 422-7036

Holland Bloorview
Kids Rehabilitation Hospital

MEDICAL REFERRAL FORM

☐ **Brain Injury Rehab Team**	☐ **Specialized Orthopaedic Developmental Rehab**	☐ **Complex Continuing Care**
☐ Inpatient	☐ Inpatient	☐ Inpatient
☐ Day patient	☐ Day Patient	☐ Day Patient

Referring Agency:

☐ SickKids ☐ McMaster Children's ☐ London Children's ☐ CHEO

Other: _____

Key Team Contact: _____

Team Contact/Key Worker Contact#: _____ Email: _____

Referring Provider Contact#: _____ OHIP Billing Number: _____

MRP: _____ Contact#: _____

Information

Client Name: _____

Chosen Name: _____ Pronoun: ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs

Child's Primary Address: _____

City: _____ Postal Code: _____

Date of Birth: _____ ☐ Female ☐ Male ☐

OHIP: ☐ No ☐ Yes, OHIP#: _____ Version Code: _____

If No, Please Explain: _____

Caregiver Name: _____ Relationship to Child: _____

Caregiver Contact#: _____

Interpreter Required: _____ ☐ No ☐ Yes If yes, for whom: _____

☐ Language Spoken: _____

Name of Legal Guardian(s): _____

Relationship to Child: _____

Child Protection Agency: ☐ No ☐ Yes If yes, specify: _____

Information

Primary Diagnosis: _____

Secondary Diagnosis(es): _____

Isolation d/t Infection Control: ☐ No ☐ Yes If yes, isolation type & organism: _____

_____

☐ **Current Medical History:** Please attach a brief medical history or recent medical summary

☐ **Current List of all Medications:** Please attach a complete medication list **or** complete the Client Medication Profile (page 4)

Allergies ☐ No ☐ Yes If yes, please describe: _____

_____

REF INPT

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Reason(s) for Referral (please indicate all that apply)

☐ Rehabilitation/Habilitation Goal(s):_____

_____

_____

☐ Teaching and Training ☐ Transition to Community

Post Acquired Brain Injury, Post Trauma, & Post Operative Information

Trauma:_____ ☐ No ☐ Yes

If yes, date & mechanism of injury:_____

_____

Surgical Intervention: ☐ No ☐ Yes If yes, date & type of surgery:_____

_____

CPM (Continous Passive Motion Machine): ☐ Yes ☐ No

Seating Assessment Initiated: ☐ Yes ☐ No ☐ N/A

Activity Restrictions: ☐ No ☐ Yes If yes, please describe:_____

_____

Rancho Level (Circle): ❍**1** ❍ **2** ❍ **3** ❍ **4** ❍ **5** ❍ **6** ❍ **7** ❍ **8** ❍ **N/A**

Disposition

Medically Ready for Transition: ☐ Yes ☐ No, If no, estimated date of medical readiness:_____

Safe for Discharge Home While Waiting for Admission to Holland Bloorview: ☐ Yes ☐ No

Discharge Destination or Disposition from HBKR Identified: ☐ No ☐ Yes

If yes, please specify:_____

_____

If residence other than child's primary, please provide caregiver address:_____

_____

Seizure Activity

☐ No ☐ Yes, if yes, ☐ Pre-existing ☐ New onset

Describe Seizures:_____

_____

_____

Describe Seizure Management:_____

_____

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MEDICAL REFERRAL FORM

Nutrition/Diet

Oral Feeding: ☐ No – NPO

☐ Yes – Expressed Breast Milk (EBM)/ formula

☐ Yes - Regular Diet ☐ Yes - Special Diet

Please describe type of diet and feeding schedule:

_____

_____

_____

Enteral and Parenteral Nutrition Support:

☐ NG-tube ☐ OG-tube ☐ G-tube ☐ G/J tube

☐ Other, Please Describe:_____

_____

Date of insertion:_____

Delivery: ☐ Pump ☐ Gravity

Feeding schedule and type (EBM, formula and name concentration, rate, flushes):_____

_____

Total Parenteral Nutrition (TPN) ☐ Yes ☐ No

Please specify TPN type/formulation, or include in medication summary:_____

Anticipated Interventions Required

	Type	Frequency
☐ **Imaging:**		
☐ **Blood Work:**		
☐ **Other:**		

Access for Blood Work:

☐ Phlebotomy ☐ Central Line

Skin Condition:

☐ Normal ☐ Wound/Incision ☐ Burn

☐ Stoma Care Specialized Dressings

☐ Specialized Surface

Type:_____

☐ Other, Please Describe:_____

_____

Other Needs:

Specialized Rehabilitation Equipment: ☐ Yes ☐ No

Complementary Therapies: ☐ Yes ☐ No

Please describe:_____

_____

_____

_____

Medical Assistive Technology Anticipated at Time of Admission

☐ Oxygen ☐ Suction ☐ Tracheostomy: Type:_____ Size:_____Date of Insertion:_____

☐ Invasive via tracheostomy (IPPV) ☐ Non-invasive (NIPPV e.g. BIPAP) ☐ CPAP ☐ Nocturnal only ☐ 24hrs

☐ Airvo ☐ In/exsufflator

☐ CVC/PICC line/Port Date of Insertion:_____Size:_____Length:_____

☐ VP Shunt ☐ Vagal Nerve Stimulator ☐ Dialysis ☐ Insulin Pump

☐ Other:_____

School ☐ Yes ☐ No School Name:_____ Grade:_____

Psychosocial/Behaviour Issues

Safety Risks (e.g. falls/wandering/aggression/ substance misuse) ☐ Yes ☐ No If Yes, details:_____

_____

Safety Strategies (e.g. behavioural plan):_____

_____

1:1 Supervision: ☐ No ☐Yes If yes, type: ☐ PSW ☐ CYW ☐ Observers/Sitters ☐ Security

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MEDICAL REFERRAL FORM

***If assistance is required in completing this form, please contact the Transition Coordinator:**

BIRT Ref. 416-425-6220 x6030, CCC Ref. 416-425-6220 x3265, SODR Ref. 416-425-6220 x6395*

Client Medication Profile

Client Medication Profile

Allergies	
Reaction to allergies?	
Epi-pen required?	

Medication name, strength & dosage form	Dose	Route	Frequency	Comments
Complementary and alternative medicines				
Substance use/medicinal marijuana				
Hazardous/cytotoxic medications that requires special handling				

Key Contact for Medication-Related Issues / Contact #:_____

_____

REF INPT