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

Chosen Name:_____Pronoun: ☐He/Him/His ☐She/Her/Hers ☐They/Them/Theirs
Date of Birth:_____Birth Sex: ☐ Male ☐ Female ☐ Unknown
Day / Month / Year

Is an interpreter required? ☐ Yes ☐ 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:** _____**Expiry Date:** _____**Province:** _____

Interim Federal Health Program (IFHP) ☐Yes ☐No Health Card In Process ☐

Client lives with: ☐ Both parents ☐ Father ☐ Mother ☐ Guardian ☐ 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: _____

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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 * (additional forms required):
  - ❑ Augmentative & Alternative Communication (AAC) *
  - ❑ Writing Aids (WA)
- ❑ Clinical Seating
- ❑ Infant Development Service (Family Centred Intervention Services for Children (0-5))
- ❑ Music Therapy
- ❑ Nursery Schools (Holland Bloorview)
- ❑ Orthotics (including protective headwear)
- ❑ Prosthetics (including myoelectric & cosmetic)
- ❑ Extensive Needs* (supplementary form required)
- ❑ Employment & Volunteering
- ❑ Post-Secondary Transition Service
- ❑ Therapeutic Recreation & Life Skills
- ❑ Bridging to Adulthood
- ❑ Adaptive Recreation Equipment

Dental Services:

- ❑ Cleft Lip & Palate (generalanesthesia available for qualifying clients)
- ❑ Special Needs Dentistry* (general anesthesia available for qualifying clients)

***Pre-assessment forms are required with the referral. Click here:**
Extensive Needs: https://hollandbloorview.ca/services/programs-services/extensive-needs-service
Special Needs Dentistry: https://hollandbloorview.ca/services/programs-services/dental-services
Augmentative & Alternative Communication (AAC) : https://hollandbloorview.ca/sites/default/files/2021-06/AAC-ReferralCriteria.pdf

* R E F O U T P *

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REFERRING PROFESSIONAL/CLIENT OR FAMILY:

Name:_____ Organization:_____

Telephone:_____Fax:_____

Email: _____

Signature:_____

Please fax your completed Referral Form to Appointment Services: (416) 422-7036