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**

Family is aware of this referral: ☐**Yes** ☐**No (must be checked)** **Referral Date: _____(dd/mm/yy)**

CLIENT INFORMATION:

Client Name: _____
Last Name First Name Middle Initial

Chosen Name: _____Birth Sex: ☐ Female ☐ Male ☐ Unknown

Gender: ☐ Female ☐ Male ☐ Non-Binary ☐ Other ☐ Unknown/Undifferentiated

Preferred Pronouns: ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐ He/They ☐ She/They ☐ Ze/Zir

Date of Birth (Day/Month/Year):_____

Client Address:_____

Apt/Unit #: _____City:_____ Province: _____

Postal Code:_____Tel.:_____

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

Health Card Number:_____ **Version Code:** ____ **Expiry Date:** _____ **Province:**_____

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

Client lives with: ☐ Parent(s) / Legal Guardian(s) ☐ Separated / Split arrangement ☐ Under care of child protection agency /

Foster family ☐ Extended family caregiver or Kinship caregiver ☐ Independent ☐ Group home ☐ Other: _____

Do you have any past experience with services offered at Holland Bloorview? ☐**Yes** ☐**No**

Are there any decision-making or parenting time agreements (formerly referred to as custody and access) that the health care team should be aware of? ☐**Yes** ☐**No**

Primary Contact:

Name: _____Relationship to Child:_____

Address (if different from child):_____

Email:_____

Tel. (home):_____Tel. (cell):_____Tel. (work): _____

Secondary Contact:

Name: _____Relationship to Child:_____

Address (if different from child):_____

Email:_____

Tel. (home):_____Tel. (cell):_____Tel. (work): _____

PRIMARY CARE PHYSICIAN / NURSE PRACTITIONER:

Name: _____

Address : _____

Tel.:_____Fax: _____

* R E F O U T P *

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AGENCIES/PROFESSIONALS CURRENTLY INVOLVED:

Agency (e.g. Child Protection, Community)	Professional (e.g. OT, SLP, 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

Other information/Risks (i.e. frequent falls)

Reason for Referral/Concern/Goals:

Use checkbox for referral:

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* (additional form required) ☐ Employment & Volunteering ☐ Post-Secondary Transition Service ☐ Therapeutic Recreation & Life Skills ☐ Bridging to Adulthood ☐ Adaptive Recreation Equipment	**Dental Services:** ☐ Cleft Lip & Palate (general anesthesia 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/AACReferralCriteria
Writing Aids (WA) : https://hollandbloorview.ca/WAReferralCriteria

REF OUTP

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REFERRING PROFESSIONAL/CLIENT OR FAMILY:

Name: _____

Hospital: _____

Telephone: _____ Fax: _____

Email: _____

Signature: _____

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.

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