Tel: (416) 424-3804 Fax: (416) 422-7036

## **HEALTH PROFESSIONAL REFERRAL FORM – OUTPATIENT SERVICES**

Referral Source:	□ Health C	are Professional	⊔ Clien	it and Family	□ Other
Please complete <u>all</u> secti	ons of this form	as incomplete forms will re	esult in proces	ssing delays.	
NOTE: This information	will be shared v	vith Holland Bloorview sta	ff as required		
Family is aware of the	nis referral:	Yes [] (must be checked	ed) Ref	erral Date:	(dd/mm/yy)
CLIENT INFORMATION:					
Client Name:Surr	name	First Na	ıme	Middle	e Initial
Chosen Name: Date of Birth: Day /				ne/Her/Hers □They/Th ] Unknown	em/Theirs
Is an interpreter require	ed? □ Yes □ No	Languages spoken:			
If yes, would over-	the-phone inte	rpretation be possible for	this client (i.e	. is hearing/speaking	an issue?) $\square$ Yes $\square$ No
Client Address:				_City:	
Province:		Postal Code:			
Tel.:					
Health Card Number:		V	ersion Code:	Expiry Date:	Province:
Interim Federal Health F	Program (IFHP)	□Yes □No	Health Card In	Process 🗆	
		er 🗆 Mother 🗆 Guardian 🗆	Independent	$\square$ Group Home $\square$ Ot	her:
Primary Contact(s) – Pa	rent/Legal Gua	rdian:			
Address:					
		Tel. (work):		Tel. (cell):	
Secondary Contact(s) –	Parent/Legal G	uardian:			
Address:					
Email:					
Tel. (home):		Tel. (work):		Tel. (cell):	
PRIMARY CARE PHYSICI	IAN / NURSE PR	ACTITIONER:			
Name:					
Address:					
Tel.:			Fax:		



## Holland Blcorview

Kids Rehabilitation Hospital

Appointment Services: 150 Kilgour Rd. Toronto, ON, M4G 1R8

Tel: (416) 424-3804 Fax: (416) 422-7036

## COMMUNITY AGENCIES/PROFESSIONALS CURRENTLY INVOLVED:

Agency(s) (e.g. Child Protection, Community)  1  2  3  MEDICAL INFORMATION:  Primary Diagnosis:		
Other Diagnoses:		
Does this client require any special infection of the second of the seco	•	
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	<ul> <li>□ Nursery Schools (Holland Bloorview)</li> <li>□ Orthotics (including protective headwear)</li> <li>□ Prosthetics (including myoelectric &amp; cosmetic)</li> <li>□ Extensive Needs Service*         <ul> <li>(additional forms required)</li> <li>□ Employment &amp; Volunteering</li> <li>□ Post-Secondary Transition Service</li> <li>□ Therapeutic Recreation &amp; Life Skills</li> <li>□ Bridging to Adulthood</li> <li>□ Adaptive Recreation Equipment</li> </ul> </li> </ul>	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 Service: <a href="http://hollandbloorview.ca/ENSPreAssessmentForm">http://hollandbloorview.ca/ENSPreAssessmentForm</a>
Special Needs Dentistry: <a href="https://hollandbloorview.ca/DentalPreassessmentForm">https://hollandbloorview.ca/DentalPreassessmentForm</a>

Augmentative & Alternative Communication (AAC): https://hollandbloorview.ca/AACReferralCriteria



Page **2** of **3** (09/2025)





REFERRING PROFESSIONAL/CLIENT OR FAMILY:

Tel: (416) 424-3804 Fax: (416) 422-7036

Name:	_ Organization:
Telephone:	Fax:
Email:	
Signature:	

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

