Holland Bloorview
Kids Rehabilitation Hospital

Referral Criteria – Infant Development Services

Ambulatory Care

The Infant Development Services use an interprofessional approach to provide opportunities for optimal development for a child and their family but supporting families in their efforts to be active participants in their child's care.

Early Childhood Educators and Physiotherapists provide early interventions to reduce risk using both in-home and centre based models.

In order to be eligible for this service a **referral is required** Referrals are accepted from **parents, doctors, hospitals, neonatal follow-up programs, therapists, community programs** and **other agencies** who provide services for young children. The client must meet **all** the following criteria:

- Live in the Toronto (postal code begins with M)
- Is between birth and 5 years of age (at the time of referral)
- Has been identified as having developmental delays and disabilities including physical markers or prematurity
- Is not receiving Infant Developmental Services in Toronto from any of the following agencies; Centennial Nursery School Infant Development Centre, Surrey Place Centre, Mothercraft or Centre Francophone de Toronto
- Is not enrolled in the following services; Holland Bloorview Nursery Schools (Scarborough site or Play & Learn site), a childcare or day care centre

**** If the referral is being made on behalf of a client, the client/family must be aware of the referral***

Please use the referral form online at: hollandbloorview.ca/referrals

Holland Bloorview Kids Rehabilitation Hospital
150 Kilgour Road, Toronto ON Canada M4G 1R8
T 416 425 6220 **T** 800 363 2440 **F** 416 425 6591
www.hollandbloorview.ca

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

Date of Birth: _____ ☐ Male ☐ Female
Day / Month / Year

Is an interpreter required? ☐ Yes ☐ No Languages spoken: _____

Client Address: _____City:_____

Province: _____Postal Code:_____

Tel.: _____

Health Card Number: _____ Version Code: _____

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

Client lives with: ☐ Both parents ☐ Father ☐ Mother ☐ Guardians ☐ 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:

Name: _____

Address:_____

Tel.:_____ Fax: _____

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
- ❑ Augmentative & Alternative Communication (AAC)
  - ❑ Writing Aids
- ❑ Clinical Seating
- ❑ Infant Development Services
- ❑ Life Skills Services
- ❑ Music Therapy
- ❑ Nursery Schools (Holland Bloorview)
- ❑ Orthotics (including protective headwear)
- ❑ Post-Secondary Transition Service
- ❑ Prosthetics (including myoelectric & cosmetic)
- ❑ Therapeutic Recreation Services

Dental Services:

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

REFERRING PROFESSIONAL/CLIENT OR FAMILY:

Name: _____

Organization: _____

Telephone: _____ Fax: _____

Email: _____

Signature: _____

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