

Referral Criteria – Communication, Learning & Behaviour Team

Ambulatory Care

The Child Development Program provides diagnostic assessments for children who are suspected of having a developmental disorder such as autism and may display complex and challenging behaviour.

After a child is diagnosed the Holland Bloorview team refers the child to the most appropriate community-based organizations to receive services.

In order to be eligible for this service a **Physician/Pediatrician** preferred **referral is required** and the client must meet **all** the following criteria:

- Live in Toronto or in areas that cannot access a local Ontario treatment centre
- Is under the age of 18 years six months (at the time of referral)

**** 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

A teaching hospital fully affiliated with the University of Toronto

PHYSICIAN REFERRAL FORM – OUTPATIENT SERVICES

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: _____
Last Name
First Name
Middle Initial

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

Is an interpreter required? Yes No Language spoken: _____

Client Address: _____ City: _____

Province: _____ Postal Code: _____ Tel.: _____

Health Card Number: _____ Version Code: _____

Interim Federal Health Program (IFHP) Health Card In Process

Client lives with: Both parents Father Mother Guardian Independent Group Home Other:

PARENT(S) OR GUARDIAN(S): (if different from client address)

Parent/Guardian: _____

Address: _____

Email: _____

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

Parent/Guardian: _____

Address: _____

Email: _____

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

AGENCIES/PROFESSIONALS CURRENTLY INVOLVED:

Agency (eg. Child Protection, Community)	Professional (eg. OT, SLT, 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:

Use check box for referral:

- Query Autism
- Acquired Brain Injury Rehabilitation
- Concussion Clinic
- Cleft Lip & Palate Speech Language Pathology
- Infant Development Services
- Neuromotor (e.g. cerebral palsy, global developmental delay, Retts)
- Psychopharmacology* (additional forms required)
- Neuromuscular (e.g. muscular dystrophy)
- Feeding* (additional forms required)
- Spina Bifida

- Spinal Cord Injury
- Augmentative & Alternative Communication (AAC)
 - Writing Aids
- Orthotics (including protective headwear)
- Prosthetics (including myoelectric & cosmetic)
- Clinical Seating

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:**

Feeding: <http://hollandbloorview.ca/programsandservices/programsservicesaz/feedingservices>

Psychopharmacology: <http://hollandbloorview.ca/programsandservices/ProgramsServicesAZ/Psychopharmacologyclinic>

REFERRING M.D./D.D.S. Name: _____

OHIP Billing Number: _____

Hospital: _____

Telephone: _____ **Fax:** _____

Email: _____

Signature: _____

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