AQUATIC THERAPY

Before completing our Aquatic Therapy self-referral form, please review the criteria and additional information to make sure this program is an appropriate fit for your child.

Criteria
Diagnostic groups that may participate in the program but are not limited to:

- Ages 2-18 years of age
- Cerebral palsy, acquired brain injury, spinal cord injury, muscular dystrophy, amputation, epilepsy, spina bifida, arthritis, autism spectrum disorder, pain conditions, and other developmental disabilities.
- Aquatic therapy is most beneficial for those who have limited potential to participate in land-based therapeutic interventions.
- Participants must have either physical or functional goals that could be addressed with aquatic therapy.
- Participant must be comfortable in an aquatic setting.
- Participant must be able to participate in a group-based aquatic setting with or without support from parents/caregivers staff.
- Participants must be supported by parent/caregiver in the water.

Program Details (Semi Private)

When:

- Day of week: Tuesdays (October 12- December 07)
- Timeslots: 4:15-4:45 / 4:50-5:20 / 5:25-5:55 / 6:00- 6:30
  (times assigned based on appropriate grouping)

Cost: $810.00 ($90.00 per session) (9 weeks session)

Assessment Costs:

- $105.00 (new clients)
- $80.00 (for any client whose condition has changed or who has missed 2 or more consecutive sessions)

If your child meets these guidelines, please complete the application form and return it by mail, fax, or in person to:

Holland Bloorview Kids Rehabilitation Hospital
Attention: Krysta Pigden (Aquatics)
150 Kilgour Road
Toronto, ON M4G 1R8
Fax: 416-422-7036

Questions? Please contact:
Krysta Pigden, Aquatics Program Assistant
Phone: 416-425-6220, ext. 3707
kpigden@hollandbloorview.ca
Aquatic Therapy Self-Referral Form

Please complete all of the sections of this form. Incomplete forms cannot be processed.

Date: __________ (dd/mm/yy)

Please tell us how you heard about our program: __________________________

Please note that completion of this form does not guarantee a place in the Aquatic Therapy Program. All application forms will be reviewed to ensure applicants are safe to participate in the water. Due to limited spaces, applicants may be placed on a wait list until a space in the program becomes available.

CLIENT INFORMATION:

Client Name: ___________________________ Surname: ___________________________ First Name: ___________________________ Middle Initial: ___________________________

Date of Birth: __________ (dd/mm/yy)  □ Male  □ Female  Age: _______

Primary Language: ___________________________

Client Address: ___________________________ City: ___________________________

Province: ___________________________ Postal Code: ___________________________

Telephone Number: ___________________________

Health Care Number: ___________________________ Version Code: ___________________________

Client Lives With: □ Both Parents  □ Father  □ Mother  □ Guardians  □ Independent  □ Group Home  □ Other

Parent(s)/Guardian(s) Information:

Mother/Guardian’s Name: ___________________________

Address: ___________________________

Telephone Number: ___________________________ (Home) ___________________________ (Work) ___________________________ (Cell)

Email: __________________________________________

Father/Guardian’s Name: ___________________________

Address: ___________________________

Telephone Number: ___________________________ (Home) ___________________________ (Work) ___________________________ (Cell)

Email: __________________________________________
SERVICE PROVIDERS:
Family Doctor:
Name: _______________________________________________________
Telephone Number: ____________________________________________
Fax Number: __________________________________________________

Other Care Provider(s) (if applicable):
Name: _______________________________________________________
Title: _________________________________________________________
Telephone Number: ____________________________________________
Fax Number: __________________________________________________

MEDICAL INFORMATION:
Primary Diagnosis: _____________________________________________
Relevant Medical History: _________________________________________
Current Medication: _____________________________________________
Reason For Seeking Aquatic Therapy/Goals: ___________________________
Medical Conditions:
Cardiorespiratory
Cardiovascular issues: ☐ Yes ☐ No Describe:
Respiratory issues: ☐ Yes ☐ No Describe:
History of aspiration: ☐ Yes ☐ No Describe:
Tracheotomy ☐ Yes ☐ No Describe:
Requires Oxygen: ☐ Yes ☐ No Describe:
Gastrointestinal
Loss of bowel or bladder control/incontinence: ☐ Yes ☐ No Describe:
G-tube/NG tube: ☐ Yes ☐ No Describe:
Thickened Liquid Diet: ☐ Yes ☐ No Describe:
Neurological

History of seizures: □ Yes □ No Describe (please include type and typical duration):
__________________________________________________________

Trigger if known: ____________________________________________

Skin

Open wounds/skin break down: □ Yes □ No Describe:
__________________________________________________________

Skin infection: □ Yes □ No Describe:
__________________________________________________________

Abnormal/decreased sensation: □ Yes □ No Describe:
__________________________________________________________

Allergy/sensitivity to chlorine: □ Yes □ No Describe:
__________________________________________________________

Other

Other medical conditions (please describe):
__________________________________________________________

Other external lines or tubes (please describe):
__________________________________________________________

Mobility:

□ Walks independently □ Walks independently with equipment □ Requires supervision
□ Requires assistance □ Dependent on others for mobility
□ Additional information: ______________________________________
__________________________________________________________

Transfers:

□ Transfers independently with or without equipment □ Requires supervision
□ Requires assistance – one person transfer □ Requires assistance – two person transfer
□ Requires assistance – more than two persons or lift required
□ Additional information: ______________________________________
__________________________________________________________

Is your child currently enrolled in any other program at the hospital (Eg. therapeutic program or research study) that would prevent them from participating in the Aquatic Therapy Program at this time?

□ Yes □ No
Additional Information:
Is there any additional information you would like to provide us regarding your client’s participation in the Aquatic Therapy Program at Holland Bloorview?

____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Consent to Contact:
I hereby give Holland Bloorview Kids Rehabilitation Hospital consent to contact the above listed Care Providers to discuss my child’s health information if necessary.

☐ Yes  ☐ No

_____________________________________________  ________________________________
Signature                                          Date

Thank You for your Application!

How to return this form:

BY MAIL or IN PERSON:
Holland Bloorview Kids Rehabilitation Hospital
150 Kilgour Rd.
Toronto, ON
M4G 1R8
Attention: Krysta Pigden

BY FAX:  416-422-7036

To protect your privacy, please do not email this form

If you have any questions please feel free to contact the
Krysta Pigden at 416-425-6220 ext. 3707