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? o Yes o No Languages spoken: ________________

If yes, would over-the-phone interpretation be possible for this client (i.e. is hearing/speaking an issue?) ☐ Yes ☐ No

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 / NURSE PRACTITIONER:

Name: ____

Address:____

Tel.:______________________________________Fax: ________________________

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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 Communication & Writing Aids Services: ❑ Augmentative & Alternative Communication (AAC) ❑ Writing Aids (WA) ❑ Clinical Seating ❑ Infant Development Services ❑ Music Therapy	❑ Nursery Schools (Holland Bloorview) ❑ Orthotics (including protective headwear) ❑ Prosthetics (including myoelectric & cosmetic) ❑ Extensive Needs* (supplementary form required) **Transitions, Recreation & Life skills:** ❑ Employment & Volunteering ❑ Life Skills Coaching ❑ Post-Secondary Transition Service ❑ Therapeutic Recreation Services ❑ Transitions to Adult Services	**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

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REFERRING PROFESSIONAL/CLIENT OR FAMILY:

Name:_______________________________ Organization:_______________________________

Telephone:_______________________________Fax:_______________________________

Email: _______________________________

Signature:_______________________________

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