Holland Bloorview
Kids Rehabilitation Hospital

Appointment Services: 150 Kilgour Rd. Toronto, ON, M4G 1R8
Tel: (416) 424-3804 Fax: (416) 422-7036

PHYSICIAN / NURSE PRACTITIONER 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: _____

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) ☐ 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. _____ _____

* R E F O U T P *

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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
- ❑ Extensive Needs* (additional forms required)

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
Extensive Needs: https://hollandbloorview.ca/services/programs-services/extensive-needs-service

REFERRING MD/NP/DDS Name: _____

OHIP Billing Number: _____

Hospital: _____

Telephone: _____ Fax: _____

Email: _____

Signature: _____

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

* R E F O U T P *

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Kids Rehabilitation Hospital

REFERRAL – HOLLAND BLOORVIEW KIDS REHABILITATION HOSPITAL
EXTENSIVE NEEDS SERVICE

About this service
The Extensive Needs Service is a publicly funded program delivered on an ambulatory basis at Holland Bloorview. The aim is to provide wrap around services (clinical and therapy) for children and youth whose needs are currently not being met by the current healthcare system. The program takes an equity-focused, trauma-informed lens aimed at participation, inclusion, and quality of life for children, youth, and their families. The focus is to work with families and current care teams to enhance capacity, reduce challenging behaviours, and treat the underlying medical and mental health concerns.

Eligibility criteria
The Extensive Needs Service provides vital wrap around services for children and youth (up to 18 years of age) with urgent and extensive needs in Ontario who have co-occurring:

a. Neurodevelopmental conditions or an acquired brain injury, and
b. Mental health conditions(s), and
c. Chronic physical health conditions(s)

Additionally, there are existing needs that are not currently met with respect to:

a. Challenging/interfering behaviours (for longer than 12 months or escalating over the past 6 months)
b. They have already accessed 3 or more healthcare or service providers
c. Safety concerns (impaired functioning that is a barrier to engagement in home, school, community)
d. Caregiver family complexity (financial, language, cultural, capacity, living arrangements, etc)

Referral details
This is a referral to the Extensive Needs Service at Holland Bloorview. Upon receipt of referral, the family will be contacted for an intake assessment.

Name of child being referred: _____
Date of birth: _____

Client safety concerns:
_____
_____
_____
_____
_____

Please select the relevant diagnoses for this client:

	Acquired brain injury
	ADHD
	Autism
	Communication disorder
	Global developmental delay
	Intellectual developmental disorder
	Learning disorder
	Cerebral Palsy
	Other

Please select any relevant mental health conditions:

	Anxiety (GAD, social, panic)
	OCD
	Mood disturbance (depression, DMDD)
	ADHD
	Externalizing disorder (ODD, conduct)
	Psychosis
	Substance use
	Attachment/trauma
	Somatic symptoms
	Chronic irritability
	Other

Please select any medical conditions for this client:

	Seizures/Epilepsy
	Sleep disturbance
	Feeding issues/restrictive eating
	Reflux/GERD
	Constipation
	Known genetic condition (please specify)
	Other

Does the client have any medication/polypharmacy concerns that need to be addressed, such as:

	Multiple psychotropic meds (on several medications with no clear benefit)
	Psychotropic medication side effects
	Diagnostic complexity impacting medication choices
	Failed behavior medications for longer than a year
	Other

Please identify the behaviours of concern:

	Aggression
	Hyperactivity
	Impulsivity
	Compulsions
	Anxiety
	Sadness
	Anhedonia
	Self-injury
	Irritability
	School avoidance

Have there been challenging behaviours present for over 12 months, or significantly escalating for over 6 months?

	Yes
	No

Please list any agency involvement and therapy provided over the past 12 months

_____
_____
_____
_____

Are the needs of the client/family unmet with present services?

	Yes
	No

Are there family/caregiver complexities present?

	Yes
	No

What services are most needed for this client? For each service indicated, please provide as much detail as possible with respect to reason for involvement or goals of therapy. This will help the intake team make the best decision for team member involvement.

- **Behaviour therapy**
  Please indicate details around service needs_____
- **Occupational therapy**
  Please indicate details around service needs_____
- **Speech & language pathology**
  Please indicate details around service needs_____
- **Child life**
  Please indicate details around service needs_____
- **Psychology**
  Please indicate details around service needs_____
- **Family counselling**
  Please indicate details around service needs_____
- **Clinical pharmacy**
  Please indicate details around service needs_____
- **Psychiatry**
  Please indicate details around service needs_____
- **Developmental pediatrics**
  Please indicate details around service needs_____
- **Coordinated service planning**
  Please indicate details around service needs_____
- **Registered dietitian**
  Please indicate details around service needs_____

Does the client or the family require any accommodations for on-site or virtual visits'?

_____
_____
_____

Is there anything else you would like the team to know?

_____
_____
_____
_____