COMMUNITY 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.

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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, 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.**

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Program Details (Semi Private)

When:

Day of week: **TBD**   Cost: **TBD**

Timeslots: **TBD**

(times assigned based on appropriate grouping)

Assessment Costs **TBD**

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

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Holland Bloorview Kids Rehabilitation Hospital
Attention: Jenna Lazarou
150 Kilgour Road
Toronto, ON M4G 1R8
Fax: 416-422-7036

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Questions? Please contact:
Jenna Lazarou, Aquatics Program Assistant
Phone: 416-425-6220, ext. 3569
jlazarou@hollandbloorview.ca

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Office Use Only

Date Received: ________________
Session: ______________________
Treatment Time: _______________

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: _____________________________ ☐ Male ☐ Female Age: _______
(dd/mm/yy)

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 Jenna Lazarou at 416-425-6220 ext. 3569