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: _____ Birth Sex: ☐ Male ☐ Female ☐ Unknown
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
Special Needs Dentistry: https://hollandbloorview.ca/services/programs-services/dental-services

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 *