

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.

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.
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- 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: **TBD**

Cost: TBD

Timeslots: **TBD**

(times assigned based on appropriate grouping)

Assessment Costs TBD

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
150 Kilgour Road
Toronto, ON M4G 1R8
Fax: 416-422-7036

Questions? Please contact:

Krysta Pigden, Aquatic Programmer
Phone: 416-425-6220, ext. 3707
kpigden@hollandbloorview.ca

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
Krysta Pigden at 416-425-6220 ext. 3707**