

Referral Criteria – Communication, Learning & Behaviour Team

Ambulatory Care

The Child Development Program provides diagnostic assessments for children who are suspected of having a developmental disorder such as autism and may display complex and challenging behaviour.

After a child is diagnosed the Holland Bloorview team refers the child to the most appropriate community-based organizations to receive services.

In order to be eligible for this service a **Physician/Pediatrician or Nurse Practitioner (NP) referral is required** and the client must meet **all** the following criteria:

- Live in Toronto or in areas that cannot access a local Ontario treatment center
- Is under the age of 18 years six months (at the time of referral)
- Does not have an existing diagnosis of Autism Spectrum Disorder
- Recent relevant consult note must be included with referral

**** The client/family must be aware of the referral***

Please use the referral form online at: hollandbloorview.ca/referrals

Holland Bloorview Kids Rehabilitation Hospital
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www.hollandbloorview.ca

A teaching hospital fully affiliated with the University of Toronto

PHYSICIAN / NURSE PRACTITIONER REFERRAL FORM – OUTPATIENT SERVICES

Family is aware of this referral: Yes No (must be checked) Referral Date: _____ (dd/mm/yy)

CLIENT INFORMATION:

Client Name: _____
 Last Name First Name Middle Initial

Chosen Name: _____ Preferred Pronoun: _____

Date of Birth: _____ Gender: Male Female _____
 Day / Month / Year

Client Address: _____

Apt/Unit #: _____ City: _____ Province: _____

Postal Code: _____ Tel.: _____

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

Health Card Number: _____ Version Code: _____

Interim Federal Health Program (IFHP) Yes No Health Card In Process Self-Pay 3rd Party

Client lives with: Both Parents Father Mother Guardian Independent Group Home Other _____

Does the child have a sibling that receives/received services at Holland Bloorview? Yes No

Are there custody or access arrangements that the health care team should be aware of? Yes No

Are child welfare services involved with the child? E.g. CAS, JF&CS, CFS, etc.? Yes No

Preferred Contact

Name: _____ Relationship to Child: _____

Address (if different from child): _____

Email: _____

Tel. (home): _____ Tel. (cell): _____ Tel. (work): _____

Secondary Contact

Name: _____ Relationship to Child: _____

Address (if different from child): _____

Email: _____

Tel. (home): _____ Tel. (cell): _____ Tel. (work): _____

AGENCIES/PROFESSIONALS CURRENTLY INVOLVED:

Agency (e.g., Child Protection, Community)	Professional (e.g., OT, SLP, 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

Please include PRN medications and provide details related to frequency, dose, effectiveness/response, side effects, etc.)

Other information/Risks (i.e. frequent falls)

Reason for Referral/Concern/Goals:

Use check box for referral:

- Query Autism
 - Client does not already have a diagnosis of autism spectrum disorder (must be checked to be accepted)
 - Client has not been assessed for ASD in the past 12 months (must be checked to be accepted)
 - Description of child's current presentation and/or issues that led to this question (most recent relevant consult note must be attached to be accepted)
 - Spinal Cord Injury
 - Orthotics (including protective headwear)
 - Prosthetics (including myoelectric & cosmetic)
 - Clinical Seating
 - Communication & Writing Aids Services
 - Augmentative & Alternative Communication (AAC)
 - Writing Aids
 - Extensive Needs* (additional forms required)
 - Motion Analysis Centre
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- Acquired Brain Injury Rehabilitation
- Baby CIMT
- Concussion Clinic* (additional forms required)
- Cleft Lip & Palate Speech Language Pathology
- Family Centred Intervention Services for Children (0-5)
- Neuromotor (e.g. cerebral palsy, global developmental delay, Retts)
- Psychopharmacology* (additional forms required)
- Neuromuscular (e.g. muscular dystrophy)
- Feeding* (additional forms required)
- Spina Bifida

Transitions, Recreation & Life skills:

- Employment & Volunteering
- Life Skills Coaching
- Post-Secondary Transition Service
- Therapeutic Recreation 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:

Feeding: <http://hollandbloorview.ca/programsandservices/programsservicesaz/feedingservices>

Psychopharmacology: <http://hollandbloorview.ca/programsandservices/ProgramsServicesAZ/Psychopharmacologyclinic>

Augmentative & Alternative Communication (AAC): <https://hollandbloorview.ca/services/programs-services/augmentative-and-alternative-communication>

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

Special Needs Dentistry: <https://hollandbloorview.ca/services/programs-services/dental-services>

Concussion Service: <https://hollandbloorview.ca/services/programs-services/concussion-centre/concussion-services/clinical-services>

REFERRING MD/NP/DDS Name: _____

OHIP Billing Number: _____

Referring provider is not the client's Primary Care Provider

Hospital: _____

Telephone: _____ Fax: _____

Email: _____

Signature: _____

*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.**

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

