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

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._____	_____

* R E F O U T P *

Holland Bloorview
Kids Rehabilitation Hospital

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

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)

_____

_____

- ❑ 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
- ❑ 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

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)

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

***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

Holland Bloorview
Kids Rehabilitation Hospital

HOLLAND BLOORVIEW KIDS REHABILITATION HOSPITAL
150 Kilgour Road, Toronto ON, M4G 1R8
T: 416-425-6220 1-800-363-2440

Client Name: _____

Date of Birth: _____

Dental Services: Pre-Assessment Information Form

Client's Height (in centimeters): _____ Client's Weight (in kilograms): _____

Does the child have: ☐ Behavioural issues ☐ Anxiety ☐ Other: _____

Please tell us about the child's previous experiences in health care settings		
Has the child received dental services? If yes: When: _____ Where: _____ Were there behavioural issues? _____ _____ Is therapeutic stabilization required at dental or medical appointments?	☐ Yes ☐ Yes	☐ No ☐ No
Has the child received sedation prior to dental services? If yes: When: _____ Where: _____ Were there any issues? Explain: _____ _____	☐ Yes ☐ Yes	☐ No ☐ No
Please tell us about your child's behaviour		
How does the child react to new environments? _____ _____ Does the child demonstrate physical aggression? If yes, are they physically aggressive towards: ☐ Self? ☐ Others? If yes, how do they act when aggressive? _____ _____		

Please tell us about the child's communication skills

What is the best way to communicate with the child?

- ☐ Verbal
- ☐ Communication device, please specify: _____
- ☐ Sign language
- ☐ Other: _____

How does the child communicate that they are in pain?

Your referral will be processed when this completed form has been received. Thank you for your prompt reply.

Please fax or return this form to the address below. For privacy reasons, we do not recommend that you send this by email.

Client Appointment Services
Holland Bloorview Kids Rehabilitation Hospital
150 Kilgour Road, Toronto, ON.
M4G 1R8
Fax: 416- 422-7036