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 *

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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
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)

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***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