

# Referral Criteria – Cleft Lip and Palate/Craniofacial Team

## Ambulatory Care

The Cleft Lip and Palate (CLP)/Craniofacial Team serves children and youth with communication difficulties and psychosocial/emotional challenges related to cleft lip and palate/craniofacial anomalies. Speech-Language Pathologists and Social Workers provide consultation, assessment, intervention and follow-up services.

In addition to onsite outpatient care, annual clinics are held in northern Ontario locations. The Holland Bloorview Kids Rehabilitation Hospital Team acts as a resource to community professionals and works closely with the cleft lip/palate and craniofacial programs at SickKids regarding clinical care and educational programs for clients and families.

In order to be eligible for this service a **Physician/Specialist** preferred **referral is required** and the client must meet **all** the following criteria:

- Live in Ontario without access to services through a local CLP team.
- Is under the age of 19 (at the time of referral)
- Has a diagnosis of cleft lip and palate, craniofacial anomaly or velopharyngeal dysfunction

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

**PHYSICIAN 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: \_\_\_\_\_  Male  Female  
Day / Month / Year

Is an interpreter required?  Yes  No Language spoken: \_\_\_\_\_

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. \_\_\_\_\_

**MEDICAL INFORMATION:**

**Primary Diagnosis:**

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**Other Diagnoses:**

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**Does this client require any special infectious disease precautions?**    **Yes**       **No**

If yes, what for: \_\_\_\_\_

**Medical History/Allergies:**

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**Taking Medication:**    Yes    No

**Risks** (i.e. frequent falls)

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**Reason for Referral/Concern/Goals:**

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**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

**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>

**REFERRING M.D./D.D.S. Name:** \_\_\_\_\_

**OHIP Billing Number:** \_\_\_\_\_

**Hospital:** \_\_\_\_\_

**Telephone:** \_\_\_\_\_       **Fax:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

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