Holland Bloorview
Kids Rehabilitation Hospital

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

# 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.**

**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:**

_____

**Other Diagnoses:**

_____

**Medical History:**

_____

_____

_____

**Current Medication(s):**

_____

_____

**Reason for Referral/Concern:**

_____

_____

## Use check box for referral:

- ❑ Query Autism
- ❑ Acquired Brain Injury Rehabilitation
- ❑ Concussion Clinic
- ❑ Cleft Lip & Palate Speech Language Pathology
- ❑ Neuromotor (e.g. cerebral palsy, global developmental delay, Retts)
- ❑ Psychopharmacology
- ❑ Neuromuscular (e.g. muscular dystrophy)
- ❑ Feeding* (additional forms required)
- ❑ Spina Bifida
- ❑ Spinal Cord Injury
- ❑ Augmentative & Alternative Communication
- ❑ Orthotics (including protective headwear)
- ❑ Prosthetics (including myoelectric & cosmetic)
- ❑ Writing Aids
- ❑ 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:**
**http://hollandbloorview.ca/programsandservices/programsservicesaz/feedingservices**

**REFERRING M.D./D.D.S.:**

Name: _____

OHIP Billing Number: _____

Hospital: _____

Telephone: _____

Fax: _____

Email: _____

Signature: _____