Holland Bloorview
Kids Rehabilitation Hospital

150 Kilgour Rd. Toronto, ON M4G 1R8
Tel: (416) 753-6022
Fax: (416) 422-7036

MEDICAL REFERRAL FORM

☐ **Brain Injury Rehab Team**
☐ Inpatient
☐ Day patient

☐ **Specialized Orthopaedic Developmental Rehab**
☐ Inpatient
☐ Day Patient

☐ **Complex Continuing Care**
☐ Inpatient
☐ Day Patient

Referring Hospital/ Clinic:

☐ SickKids ☐ McMaster Children's ☐ London Children's ☐ CHEO

☐ Other:_____

Key Team Contact:_____

Team Contact/Key Worker Contact#:_____ Email: _____

Referring Provider Contact#:_____ OHIP Billing Number:_____

MRP:_____ Contact#:_____

Information

Client Name: _____

Chosen Name: _____ Birth Sex: ☐ Female ☐ Male ☐ Unknown

Gender: ☐ Female ☐ Male ☐ Non-Binary ☐ Other ☐ Unknown/Undifferentiated

Preferred Pronouns: ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐ He/They ☐ She/They ☐ Ze/Zir

Child's Primary Address: _____

City: _____ Postal Code:_____

Date of Birth (Day/Month/Year): _____

OHIP: ☐ No ☐ Yes, OHIP#:_____ Version Code: _____

If No, Please Explain:_____

Caregiver Name: _____ Relationship to Child: _____

Caregiver Contact#: _____

Interpreter Required:_____ ☐ No ☐ Yes If yes, for whom: _____

☐ Language Spoken:_____

Name of Legal Guardian(s): _____ Relationship to Child: _____

Information

Primary Diagnosis:_____

Secondary Diagnosis(es):_____

Isolation d/t Infection Control: ☐ No ☐ Yes If yes, isolation type & organism:_____

_____

☐ **Current Medical History:** Please attach a brief medical history or recent medical summary

☐ **Current List of all Medications:** Please attach a complete medication list **or** complete the Client Medication Profile (page 4)

Allergies ☐ No ☐ Yes If yes, please describe:_____

_____

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Reason(s) for Referral (please indicate all that apply)

☐ Rehabilitation/Habilitation Goal(s):_____

_____

_____

☐ Teaching and Training ☐ Transition to Community

Post Acquired Brain Injury, Post Trauma, & Post Operative Information

Trauma:_____ ☐ No ☐ Yes

If yes, date & mechanism of injury:_____

_____

Surgical Intervention: ☐ No ☐ Yes If yes, date & type of surgery:_____

_____

CPM (Continous Passive Motion Machine): ☐ Yes ☐ No

Seating Assessment Initiated: ☐ Yes ☐ No ☐ N/A

Activity Restrictions: ☐ No ☐ Yes If yes, please describe:_____

_____

Rancho Level (Circle): ❍**1** ❍ **2** ❍ **3** ❍ **4** ❍ **5** ❍ **6** ❍ **7** ❍ **8** ❍ **N/A**

Disposition

Medically Ready for Transition: ☐ Yes ☐ No, If no, estimated date of medical readiness:_____

Safe for Discharge Home While Waiting for Admission to Holland Bloorview: ☐ Yes ☐ No

Discharge Destination or Disposition from HBKR Identified: ☐ No ☐ Yes

If yes, please specify:_____

_____

If residence other than child's primary, please provide caregiver address:_____

_____

Seizure Activity

☐ No ☐ Yes, if yes, ☐ Pre-existing ☐ New onset

Describe Seizures:_____

_____

_____

Describe Seizure Management:_____

_____



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MEDICAL REFERRAL FORM

Nutrition/Diet

Oral Feeding: ☐ No – NPO

☐ Yes – Expressed Human Milk (EHM)/ formula

☐ Yes - Regular Diet ☐ Yes - Special Diet Please describe type of diet and feeding schedule:

_____

_____

_____

Enteral and Parenteral Nutrition Support:

☐ NG-tube ☐ OG-tube ☐ G-tube ☐ G/J tube

☐ Other, Please Describe:_____

_____

Date of insertion:_____

Delivery: ☐ Pump ☐ Gravity

Feeding schedule and type (EBM, formula and name concentration, rate, flushes):_____

_____

Total Parenteral Nutrition (TPN): ☐ No ☐ Yes

Please specify TPN type/formulation, or include in medication summary: _____

Anticipated Interventions Required

	Type	Frequency
☐ **Imaging:**		
☐ **Blood Work:**		
☐ **Other:**		

Access for Blood Work:

☐ Phlebotomy ☐ Central Line

Skin Condition:

☐ Normal ☐ Wound/Incision ☐ Burn

☐ Stoma Care Specialized Dressings

☐ Specialized Surface

Type: _____

☐ Other, Please Describe: _____

_____

Other Needs:

Specialized Rehabilitation Equipment: ☐ No ☐ Yes

Complementary Therapies: ☐ No ☐ Yes

Please Describe: _____

_____

_____

_____

Medical Assistive Technology Anticipated at Time of Admission

☐ Oxygen ☐ Suction ☐ Tracheostomy: Type:_____ Size:_____Date of Insertion:_____

☐ Invasive via tracheostomy (IPPV) ☐ Non-invasive (NIPPV e.g. BIPAP) ☐ CPAP ☐ Nocturnal only ☐ 24hrs

☐ Airvo ☐ In/exsufflator

☐ CVC/PICC line/Port Date of Insertion:_____Size:_____Length:_____

☐ VP Shunt ☐ Vagal Nerve Stimulator ☐ Dialysis ☐ Insulin Pump

☐ Other:_____

School ☐ No ☐ Yes, School Name:_____ Grade:_____

Psychosocial/Behaviour Issues

Safety Risks (e.g. falls/wandering/aggression/substance misuse) ☐ No ☐ Yes If yes, please describe: _____

_____

Safety Strategies (e.g. behavioural plan):_____

1:1 Supervision: ☐ No ☐ Yes If yes, type: ☐ PSW ☐ CYW ☐ Observers/Sitters ☐ Security

* R E F I N P T *

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MEDICAL REFERRAL FORM

***If assistance is required in completing this form, please contact the Transition Coordinator:**
BIRT Ref. 416-425-6220 x6030, CCC Ref. 416-425-6220 x3265, SODR Ref. 416-425-6220 x6395*

Client Medication Profile

Client Medication Profile

Allergies	
Reaction to allergies?	
Epi-pen required?	

Medication name, strength & dosage form	Dose	Route	Frequency	Comments
Complementary and alternative medicines				
Substance use/medicinal marijuana				
Hazardous/cytotoxic medications that requires special handling				

Key Contact for Medication-Related Issues / Contact #:_____

_____

REF INPT