

HEALTH PROFESSIONAL REFERRAL FORM – OUTPATIENT SERVICES

Referral Source: ☐ Health Care Professional ☐ Client and Family ☐ Other

Family is aware of this referral: ☐ Yes ☐ No (must be checked) Referral Date: _____ (dd/mm/yy)

CLIENT INFORMATION:

Client Name: _____

Surname

First Name

Middle Initial

Chosen Name: _____ Pronoun: ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs

Date of Birth: _____ Birth Sex: ☐ Male ☐ Female ☐ Unknown

Day / Month / Year

Client Address: _____ City: _____

Province: _____ Postal Code: _____

Tel.: _____

Is an interpreter required? ☐ Yes ☐ No Languages 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: _____ Expiry Date: _____ Province: _____

Interim Federal Health Program (IFHP) ☐ Yes ☐ No Health Card In Process ☐

Client lives with: ☐ Parent(s) / Legal Guardian(s) ☐ Separated / Split arrangement ☐ Under care of child protection agency / Foster family ☐ Extended family caregiver or Kinship caregiver ☐ Independent ☐ Group home ☐ Other: _____

Do you have any past experience with services offered at Holland Bloorview? ☐ Yes ☐ No

Are there any decision-making or parenting time agreements (formerly referred to as custody and access) that the health care team should be aware of? ☐ Yes ☐ No

Primary 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): _____

PRIMARY CARE PHYSICIAN / NURSE PRACTITIONER:

Name: _____

Address: _____

Tel.: _____ Fax: _____



COMMUNITY AGENCIES/PROFESSIONALS CURRENTLY INVOLVED:

Agency(s) (e.g. Child Protection, Community)

Professional (e.g. OT, Psychologist)

1. _____

2. _____

3. _____

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

Risks (i.e. frequent falls)

Reason for Referral/Concern/Goals:

Specialized Services:

- ☐ Aquatic Therapy
- ☐ Communication & Writing Aids Services * (additional forms required):
 - ☐ Augmentative & Alternative Communication (AAC) *
 - ☐ Writing Aids (WA)*
- ☐ Clinical Seating
- ☐ Infant Development Service (Family Centred Intervention Services for Children (0-5))
- ☐ Music Therapy

- ☐ Nursery Schools (Holland Bloorview)
- ☐ Orthotics (including protective headwear)
- ☐ Prosthetics (including myoelectric & cosmetic)
- ☐ Extensive Needs* (supplementary form required)
- ☐ Employment & Volunteering
- ☐ Post-Secondary Transition Service
- ☐ Therapeutic Recreation & Life Skills
- ☐ Bridging to Adulthood
- ☐ Adaptive Recreation Equipment

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:

Extensive Needs: <https://hollandbloorview.ca/services/programs-services/extensive-needs-service>

Special Needs Dentistry: <https://hollandbloorview.ca/services/programs-services/dental-services>

Augmentative & Alternative Communication (AAC): <https://hollandbloorview.ca/AACReferralCriteria>

Writing Aids: <https://hollandbloorview.ca/WAReferralCriteria>



REFERRING PROFESSIONAL/CLIENT OR FAMILY:

Name: _____ Organization: _____

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

