**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:_____ 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

Date of Birth (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: _____Expiry Date: _____Province:_____**

Interim Federal Health Program (IFHP) ☐Yes ☐No Health Card In Process ☐ Self-Pay ☐ 3rd Party ☐

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): _____

**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:

- ☐ Brain Injury Rehabilitation – Ambulatory
- ☐ Early Hand Asymmetry Program
- ☐ Concussion Clinic* (additional forms required)
- ☐ Cleft Lip & Palate Speech Language Pathology
- ☐ Infant Development Service (Family Centred Intervention Services for Children (0-5))
- ☐ Neuromotor (e.g. cerebral palsy, global developmental delay, Rett Syndrome)*(medical consult note required)
- ☐ Selective Dorsal Rhizotomy* (additional forms required)
- ☐ Psychopharmacology* (additional forms required)
- ☐ Extensive Needs Service* (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 * (additional forms required)
  - ☐ Augmentative & Alternative Communication (AAC) *
  - ☐ Writing Aids (WA)*
- ☐ 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)

*REF OUTP*

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***Pre-assessment forms are required with the referral. Click here:**

**Selective Dorsal Rhizotomy: https://hollandbloorview.ca/SDRScreeningForm**
**Feeding: https://hollandbloorview.ca/FeedingServicesPreassessment**
**Psychopharmacology: https://hollandbloorview.ca/PPCAssessmentForm**

**Extensive Needs Service: http://hollandbloorview.ca/ENSPreAssessmentForm**
**Augmentative & Alternative Communication : https://hollandbloorview.ca/AACReferralCriteria**
**Writing Aids : https://hollandbloorview.ca/WAReferralCriteria**
**Special Needs Dentistry: https://hollandbloorview.ca/DentalPreassessmentForm**
**Concussion Service: https://hollandbloorview.ca/ConcussionServicePreassessmentForm**

**Please use the link to complete the Autism Diagnostic Services Referral Form: https://hollandbloorview.ca/ASDReferralForm**

**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***

* R E F O U T P *