

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:			□He/Him/His □She/He	er/Hers □They/Them/Theirs
Date of Birth:				**
	Month / Year			
Client Address:				
Apt/Unit #:	City:		Province:	
Postal Code:		Tel.:		
s an interpreter required?				
f yes, would over-the-phone interpretation	be possible for this client (i	.e. is hearing/	speaking an issue?) 🏻 Yo	es 🗆 No
Health Card Number:		Version Code	:Expiry Date:	Province:
nterim Federal Health Program (IFHP)□Yes [	□No Health Card In Process	□ Self-Pay	☐ 3 <sup>rd</sup> Party ☐	
lient lives with: ☐ Both Parents ☐ Father ☐	☐ Mother ☐ Guardian ☐ Inc	dependent 🗆	Group Home □ Other_	
oes the child have a sibling that receives/ro	eceived services at Holland L	Bloorview?	□Yes □No	
are there custody or access arrangements	that the health care team sl	hould be awa	re of? □Yes □No	
Are child welfare services involved with the child?	E.g. CAS, JF&CS, CFS, etc.?		□Yes □No	
Primary Contact				
Name:		Relatio	nship to Child:	
Address (if different from child):				
Email:				
Tel. (home):	Tel. (cell):		Tel. (work):	
Secondary Contact		Doloti	anchin to Child.	
Name:Address (if different from child):				
Email:	Tel (cell):		Tel (work):	
rei. (nome)				
NCIES/PROFESSIONALS CURRENTLY INVOL	LVED:			
Agency (e.g., Child Protection, Community)	Professio	nal (e.g., OT,	SLP, Psychologist)	
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MEDI	CAL I	NFORMATION:		
Primar	y Diag	nosis:		
Other I	Diagno	ses:		
		nt require any special infectious disease precautions?   Year:	es	□ No
Medica	al Histo	pry/Allergies:		
_		ation: ☐ Yes ☐ No e PRN medications and provide details related to frequency, (	dose, effect	iveness/response, side effects, etc.)
Other i	nform	ation/Risks (i.e. frequent falls)		
Reason	for R	eferral/Concern/Goals:		
Use cl	heck	box for referral:		
		y Autism		
		Client has not been diagnosed with autism		Orthotics (including protective headwear)
		spectrum disorder (must be checked to be accepted)		Prosthetics (including myoelectric & cosmetic)
		Client's recent consult note or the client's current		Clinical Seating
		presentation documented above under "Reason for		Communication & Writing Aids Services * (additional forms
		Referral/Concern/Goals" (must be checked to be		required)
_		accepted)		☐ Augmentative & Alternative Communication (AAC) *
		n Injury Rehabilitation - Ambulatory		☐ Writing Aids (WA)
		CIMT		Employment & Volunteering Post-Secondary Transition Service
		cussion Clinic* (additional forms required) Lip & Palate Speech Language Pathology		Therapeutic Recreation & Life Skills
		it Development Service (Family Centred Intervention	ä	Bridging to Adulthood
		ices for Children (0-5))		Adaptive Recreation Equipment
		omotor (e.g. cerebral palsy, global developmental	_	
	delay, Retts)  Dental Services:		l Services:	
	☐ Selective Dorsal Rhizotomy* (additional forms required)			Cleft Lip & Palate (general anesthesia available for
			qualifying clients)	
	Exte	nsive Needs Service* (additional forms required)		Special Needs Dentistry* (general anesthesia
	Neur	omuscular (e.g. muscular dystrophy)		available for qualifying clients)
		ing* (additional forms required)		
	Snin	a Rifida / Sninal Cord Injury		



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

Selective Dorsal Rhizotomy: <a href="https://hollandbloorview.ca/SDRScreeningForm">https://hollandbloorview.ca/FeedingServicesPreassessment</a>
Psychopharmacology: <a href="https://hollandbloorview.ca/PPCAssessmentForm">https://hollandbloorview.ca/PPCAssessmentForm</a>
Extensive Needs Service: <a href="http://hollandbloorview.ca/ENSPreAssessmentForm">http://hollandbloorview.ca/ENSPreAssessmentForm</a>

Augmentative & Alternative Communication: https://hollandbloorview.ca/AACReferralCriteria

Special Needs Dentistry: https://hollandbloorview.ca/DentalPreassessmentForm
Concussion Service: https://hollandbloorview.ca/ConcussionServicePreassessmentForm

REFERRING MD/NP/DDS Name:	
OHIP Billing Number:	
Referring provider is not the client's Primary Care Provider □	
Hospital:	
Telephone:	Fax:
Email:	
Signature:	

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



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<sup>\*</sup>Please complete all sections of this form as incomplete forms will result in processing delays.

<sup>\*\*</sup>NOTE: This information will be shared with Holland Bloorview staff as required.