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

Date of Birth:_____ Birth Sex: ☐ Male ☐ Female ☐ Unknown
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: ☐ Both Parents ☐ Father ☐ Mother ☐ Guardian ☐ Independent ☐ Group Home ☐ Other_____

Does the child have a sibling that receives/received services at Holland Bloorview? ☐**Yes** ☐**No**

Are there custody or access arrangements that the health care team should be aware of? ☐**Yes** ☐**No**

Are child welfare services involved with the child? E.g. CAS, JF&CS, CFS, etc.? ☐**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.	

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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:

- ☐ Query Autism
  - ☐ **Client has not been diagnosed with autism spectrum disorder** (must be checked to be accepted)
  - ☐ **Client's recent consult note or the client's current presentation documented above under "Reason for Referral/Concern/Goals" (must be checked to be accepted)**
- ☐ Brain Injury Rehabilitation - Ambulatory
- ☐ Baby CIMT
- ☐ 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)

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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
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 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 *