Holland Bloorview
Kids Rehabilitation Hospital

Referral Criteria – Neuromuscular Team

Ambulatory Care

The Neuromuscular Team provides tertiary and quaternacy care for clients with neuromuscular conditions.

Our multidisciplinary family-centred approach includes a paediatrician, a respirologist, ambulatory care nurses, physiotherapists, occupational therapists, a speech language pathologist, a social worker, a psychologist, a respiratory therapist, a life skills coach and youth facilitator.

Clients are seen within multidisciplinary clinics and required intervention is available for clients who reside in the Toronto area between clinic visits. Consultation services are available for all clients who reside outside Toronto.

To enable co-ordination of care for each child, the Neuromuscular Team communicates with other involved community partners such as schools, Community Care Access Centre, other medical facilities, local children's treatment centres and government agencies.

In order to be eligible for this service a **Physician referral** is required and the client must meet **all** the following criteria:

- Live in Ontario except where multidisciplinary services are available for this client population
- Is under the age of 19 (at the time of referral)
- Has a confirmed Neuromuscular diagnosis
- **Genetic Testing Results** must be provided before referral will be processed

****The client/family must be aware of the referral***

Please use the referral form online at: hollandbloorview.ca/referrals

Holland Bloorview Kids Rehabilitation Hospital
150 Kilgour Road, Toronto ON Canada M4G 1R8
T 416 425 6220 **T** 800 363 2440 **F** 416 425 6591
www.hollandbloorview.ca

Holland Bloorview
Kids Rehabilitation Hospital

Appointment Services: 150 Kilgour Rd. Toronto, ON, M4G 1R8
Tel: (416) 424-3804 Fax: (416) 422-7036

PHYSICIAN REFERRAL FORM – OUTPATIENT SERVICES

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.

Family is aware of this referral: Yes ☐ (must be checked) **Referral Date:** _____(dd/mm/yy)

CLIENT INFORMATION:

Client Name: _____
Last Name First Name Middle Initial

Date of Birth: _____ ☐Male ☐Female
Day / Month / Year

Is an interpreter required? ☐Yes ☐No Language spoken:_____

Client Address: _____City:_____

Province: _____ Postal Code: _____ Tel.:_____

Health Card Number: _____ Version Code: _____

☐ Interim Federal Health Program (IFHP) ☐ Health Card In Process

Client lives with: ☐Both parents ☐Father ☐Mother ☐Guardian ☐Independent ☐Group Home ☐Other:

PARENT(S) OR GUARDIAN(S): (if different from client address)

Parent/Guardian: _____

Address:_____

Email:_____

Tel. (home): _____Tel. (work):_____Tel. (cell): _____

Parent/Guardian: _____

Address:_____

Email:_____

Tel. (home): _____Tel. (work):_____Tel. (cell): _____

AGENCIES/PROFESSIONALS CURRENTLY INVOLVED:

Agency (eg. Child Protection, Community)	Professional (eg. OT, SLT, 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:

_____

_____

Use check box for referral:

- ❑ Query Autism
- ❑ Acquired Brain Injury Rehabilitation
- ❑ Concussion Clinic
- ❑ Cleft Lip & Palate Speech Language Pathology
- ❑ Infant Development Services
- ❑ Neuromotor (e.g. cerebral palsy, global developmental delay, Retts)
- ❑ Psychopharmacology* (additional forms required)
- ❑ Neuromuscular (e.g. muscular dystrophy)
- ❑ Feeding* (additional forms required)
- ❑ Spina Bifida
- ❑ Spinal Cord Injury
- ❑ Augmentative & Alternative Communication (AAC)
  - ❑ Writing Aids
- ❑ Orthotics (including protective headwear)
- ❑ Prosthetics (including myoelectric & cosmetic)
- ❑ Clinical Seating

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:**

Feeding: http://hollandbloorview.ca/programsandservices/programsservicesaz/feedingservices
Psychopharmacology: http://hollandbloorview.ca/programsandservices/ProgramsServicesAZ/Psychopharmacologyclinic

REFERRING M.D./D.D.S. Name: _____

OHIP Billing Number: _____

Hospital: _____

Telephone: _____ Fax: _____

Email: _____

Signature: _____

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