Holland Bloorview
Kids Rehabilitation Hospital

# AQUATIC THERAPY

Before completing our Aquatic Therapy self-referral form, please review the criteria and additional information to make sure this program is an appropriate fit for your child.

## Criteria

***Diagnostic groups that may participate in the program but are not limited to:***

- Ages 0-21 years of age
- Cerebral palsy, acquired brain injury, spinal cord injury, muscular dystrophy, amputation, epilepsy, spina bifida, arthritis, autism spectrum disorder, pain conditions, and other developmental disabilities.
- Aquatic therapy is most beneficial for those who have limited potential to participate in land-based therapeutic interventions.

---

- Participants must have either physical or functional goals that could be addressed with aquatic therapy.
- Participant must be comfortable in an aquatic setting.
- Participant must be able to participate in a group-based aquatic setting with or without support from volunteer staff.
- **Participants under 3 years old must be supported by parent/caregiver in the water. For children 3 years and older, parents/caregivers must be prepared to go into the water in the case where volunteer support is not available.**

## Program Details (Semi Private)

When:
Mondays
4:15pm – 4:45pm
4:50pm – 5:20pm
5:25pm – 5:55pm
6:00pm – 6:30 pm
(times assigned based on appropriate grouping)

Cost:
$90.00 per session
(Sessions run typically 8-10 weeks)

Assessment Costs:
$105.00 (new clients)
$80.00 (for any client whose condition has changed or who has missed 2 or more consecutive sessions)

**If your child meets these guidelines, please complete the application form and return it by mail, fax, or in person to:**

Holland Bloorview Kids Rehabilitation Hospital
Attention: Krysta Pigden (Aquatics)
150 Kilgour Road
Toronto, ON M4G 1R8
Fax: 416-422-7036

***Questions? Please contact:***
Krysta Pigden, Aquatics Program Assistant
Phone: 416-425-6220, ext. 3707
kpigden@hollandbloorview.ca

# Aquatic Therapy Self-Referral Form

Please complete all of the sections of this form. Incomplete forms cannot be processed.

**Date**: __________ (dd/mm/yy)

**Please tell us how you heard about our program**: __________________________

Please note that completion of this form does not guarantee a place in the Aquatic Therapy Program. All application forms will be reviewed to ensure applicants are safe to participate in the water. Due to limited spaces, applicants may be placed on a wait list until a space in the program becomes available.

**CLIENT INFORMATION:**

Client Name: ________________________________________________________
Surname First Name Middle Initial

Date of Birth: ______________________________ ☐ Male ☐ Female Age: _______
(dd/mm/yy)

Primary Language: __________________________

Client Address: ___________________________ City: ____________________

Province: _______________________ Postal Code: _______________________

Telephone Number: ______________________________________________

Health Care Number: _____________________ Version Code: ________________

Client Lives With: ☐ Both Parents ☐ Father ☐ Mother ☐ Guardians ☐ Independent
☐ Group Home ☐ Other

**Parent(s)/Guardian(s) Information:**

Mother/Guardian's Name: _______________________________________________
Address: ____________________________________________________________
Telephone Number: __________________ __________________ __________________
(Home) (Work) (Cell)
Email: ______________________________________________________________

Father/Guardian's Name: _______________________________________________
Address: ____________________________________________________________
Telephone Number: __________________ __________________ __________________
(Home) (Work) (Cell)
Email: ________________________________________________________

**SERVICE PROVIDERS:**
**Family Doctor**:
Name: ____________________
Telephone Number: ____________________
Fax Number: ____________________

**Other Care Provider(s) (if applicable):**
Name: ____________________
Title: ____________________
Telephone Number: ____________________
Fax Number: ____________________

**MEDICAL INFORMATION:**

Primary Diagnosis: ____________________

Relevant Medical History: ____________________
____________________
____________________

Current Medication: ____________________
____________________

Reason For Seeking Aquatic Therapy/Goals: ____________________
____________________

**Medical Conditions:**

*Cardiorespiratory*

Cardiovascular issues: ☐ Yes ☐ No Describe:
____________________

Respiratory issues: ☐ Yes ☐ No Describe:
____________________

History of aspiration: ☐ Yes ☐ No Describe:
____________________

Tracheotomy: ☐ Yes ☐ No Describe:
____________________

Requires Oxygen: ☐ Yes ☐ No Describe:
____________________

*Gastrointestinal*

Loss of bowel or bladder control/incontinence: ☐ Yes ☐ No Describe:
____________________

G-tube/NG tube: ☐ Yes ☐ No Describe:
____________________

Thickened Liquid Diet: ☐ Yes ☐ No Describe:
____________________

*Neurological*

History of seizures: ☐ Yes ☐ No Describe (please include type and typical duration):

______________________________________________

Trigger if known: ______________________________________________

*Skin*

Open wounds/skin break down: ☐ Yes ☐ No Describe:

______________________________________________

Skin infection: ☐ Yes ☐ No Describe:

______________________________________________

Abnormal/decreased sensation: ☐ Yes ☐ No Describe:

______________________________________________

Allergy/sensitivity to chlorine: ☐ Yes ☐ No Describe:

______________________________________________

*Other*

Other medical conditions (please describe):______________________________________________

______________________________________________

Other external lines or tubes (please describe): ______________________________________________

______________________________________________

**Mobility:**

☐ Walks independently ☐ Walks independently with equipment ☐ Requires supervision
☐ Requires assistance ☐ Dependent on others for mobility
☐ Additional information: ______________________________________________

______________________________________________

**Transfers:**

☐ Transfers independently with or without equipment ☐ Requires supervision
☐ Requires assistance – one person transfer ☐ Requires assistance – two person transfer
☐ Requires assistance – more than two persons or lift required
☐ Additional information: ______________________________________________

______________________________________________

Is your child **currently** enrolled in any other program at the hospital (Eg. therapeutic program or research study) that would prevent them from participating in the Aquatic Therapy Program at this time?

☐ Yes ☐ No

**Additional Information:**
Is there any additional information you would like to provide us regarding your client's participation in the Aquatic Therapy Program at Holland Bloorview?

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

**Consent to Contact:**

I hereby give Holland Bloorview Kids Rehabilitation Hospital consent to contact the above listed Care Providers to discuss my child's health information if necessary.

☐ Yes ☐ No

____________________________ ____________________________
Signature Date

**Please choose one:**

I would like to participate in the pool with my child ☐

I would prefer to have a volunteer participate in the pool with my child* ☐

* Please note that if we are short of volunteers on any given week, you will need to accompany your child in the pool.

**Thank You for your Application!**

How to return this form:

**BY MAIL or IN PERSON:** Holland Bloorview Kids Rehabilitation Hospital
150 Kilgour Rd.
Toronto, ON
M4G 1R8
Attention: Krysta Pigden

**BY FAX:** 416-422-7036

**To protect your privacy, please do not email this form**

**If you have any questions please feel free to contact the Krysta Pigden at 416-425-6220 ext. 3707**