

Holland Bloorview

Kids Rehabilitation Hospital

Attn: Health Information Management
Holland Bloorview Kids Rehabilitation Hospital
150 Kilgour Road
Toronto, ON. M4G 1R8

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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

A teaching hospital fully affiliated
with the University of Toronto

Date: _____

Client Name: _____

Date of Birth: _____

To Whom It May Concern,

This letter is to confirm the contact details for the above named client:

Person to Notify (Primary Parent/Caregiver for decision-making, arrangement of appointments, etc.)

Name: _____

Address: _____

Phone Number: _____

Email: _____

Relationship to Patient: _____

Next of Kin (Other Parent/Caregiver who may receive information related to the care plan or be notified of appointments, etc.)

Name: _____

Address: _____

Phone Number: _____

Email: _____

Relationship to Patient: _____

Guarantor (Individual who is financially responsible for payment of any medical bills)

Name: _____

Address: _____

Phone Number: _____

Email: _____

Patient's Relationship to Guarantor: _____

Are there any formal court orders or supporting documentation related to custody, access to the client, visitor restrictions, and/or access to personal health information?

Yes No In progress

If available, please provide a copy of the relevant sections of the document to the HIM dept. to update our file.

If formal documentation is currently unavailable, please complete the applicable sections below:

Custody Arrangements: _____

Are there any external agencies involved (e.g., CAS, community case workers, etc.)?

Yes No

Client is residing with: _____

Medical care decisions are made by: _____

Visitation access to the client: _____

Restrictions to visitation access: _____

Access to Personal Health Information: _____

Restrictions to Personal Health Information: _____

Additional comments:

Sincerely,

Signature of Parent/SDM

Signature of Witness

Print Name of Parent/SDM & Relationship

Print Name of Witness

Date