Holland Bloorview
Kids Rehabilitation Hospital

Referral Criteria – Feeding Services Clinic

Ambulatory Care

The Feeding Clinic serves children and youth with feeding and swallowing issues. Our multidisciplinary team provides consultation, assessment, intervention and follow up by a physician, a speech-language pathologist, an occupational therapist and a dietician to improve feeding safety and feeding skill development.

Recommendations may also be made to seek help from community therapists and we will work to facilitate the process.

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

- Live in the Toronto area or in regions that do not have a specialized feeding service able to meet the client's needs
- Is under the age of 19 (at the time of referral)
- Has a physical or neurological origin to their feeding difficulties; for example, children with conditions such as cerebral palsy, acquired brain injury, neuromuscular conditions, genetic syndromes, and cleft lip and palate. ***We do not accept referrals for children with feeding difficulties solely related to behavior and nutrition***.
- **Feeing Clinic Pre-Assessment Information Form** must be completed before referral will be accepted

****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
A teaching hospital fully affiliated with the University of Toronto

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 the link below:**

- **Feeding services**
- **Psychopharmacology clinic**

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