150 Kilgour Road
Toronto, ON M4G 1R8
Tel: (416) 753-6030
Fax: (416) 422-7036

MEDICAL REFERRAL FORM

Holland Bloorview
Kids Rehabilitation Hospital

Referral Date: _____

To be completed in pen by a health care professional. Please print.

☐ ***Brain Injury Rehab Team***	☐ ***Specialized Orthopaedic Developmental Rehab***	☐ ***Complex Continuing Care***
☐ **Inpatient**	☐ **Inpatient**	☐ **Inpatient**
☐ **Day patient**	☐ **Day patient**	

Information:

Client Name: _____

Address: _____

City: _____ Postal Code: _____

Date of Birth: _____ ☐ Female ☐ Male

Health Card Number: _____ VC: _____

Mother/Guardian _____ Father/Guardian _____

(H)_____(Cell)_____ (H)_____(Cell)_____

(Work)_____ (Work)_____

Interpreter required: ☐ Yes ☐ No Language spoken: _____

Child Protection Agency: ☐ Specify: _____

Emergency Contact:

Name: _____ Tel.: _____

Family Physician: _____ Tel.: _____

Health Information:

Primary Diagnosis: _____

Secondary Diagnosis: _____

Imaging/Diagnostic Reports: ☐ Faxed ☐ eCHN

If MVC – No fault insurance initiated: ☐ Yes ☐ No ☐ NA

Need for Isolation: ☐ Yes ☐ No **If yes, Type:** _____

Brief Current Medical History: _____

_____

_____

Reason for Referral: _____

_____

REF INPATIENT

Medically Ready for transfer: ☐ Yes ☐ No Estimated date of medical readiness: _____

Service requested: ☐ OT ☐ SLP ☐ PT

Date of Injury/Illness/Surgery:_____Surgical Intervention(s):_____

Post-Op Guidelines:_____

Glasgow Coma Scale: ___/15 Rancho Level --**Circle-- 1 2 3 4 5 6 7 8 N/A**

Level of Consciousness: ☐ Alert ☐ Semi –Alert ☐ Lethargic ☐ Comatose

Safe for discharge home: ☐ Yes ☐ No Discharge Destination: _____

Seizure Activity:

Yes ☐ No ☐ Existing ☐ New onset ☐

Prophylactic Medications: Yes ☐ No ☐

Describe:_____

Medical Assistive Technology:

☐ Suction ☐ Oxygen
☐ Ventilator: ☐ Nocturnal only or ☐ 24 hrs
☐ Tracheostomy ☐ Peripheral IV
☐ Central Venous Line ☐ Monitor
☐ Dialysis ☐ EVD
☐ PICC Line

Date of Insertion:_____
Size:_____ Length:_____

Skin Condition:

☐ Normal ☐ Wound/Incision(s) ☐ Burn

☐ Stoma Care ☐ Specialized Dressings ☐ Other

Explain:_____

Mode of Nutrition: ☐ Oral ☐ NG/J ☐ TPN

☐ GJ/G-Tube Date of G-tube insertion:_____

Nutrition Plan:

_____

Other Supplies/Equipment required:

_____

_____

Medications: Please send most updated medication list including medication name (s) & length of treatment.

School Y/N Grade:_____

Psychosocial/Behaviour Issues:_____

_____

Psychology/Psychiatry Involved: ☐ Yes ☐ No **If yes, please send report.**

Safety Risks (eg. falls/wandering/aggression): ☐ Yes ☐ No Details:_____

1:1 supervision ☐ Yes ☐ No **If yes, Type:** ☐ **PSW** ☐ **CYW** ☐ **Observers/Sitters** ☐ **Security**

Social worker involved: _____Phone: _____

Parents informed of diagnosis? ☐ Yes ☐ No Parents informed of prognosis? ☐ Yes ☐ No

Referring Physician's Name: _____Speciality:_____

Referring Physician Signature:_____

Referral Contact:_____Contact Number: _____

If assistance is required in completing this form, please contact the Intake/Discharge Coordinator at (416) 753-6030.

REF INPATIENT