

HEALTH PROFESSIONAL REFERRAL FORM – OUTPATIENT SERVICES

Referral Source: ☐ **Health Care Professional** ☐ **Client**
and Family ☐ **Other**

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

Referral Date: 21/11/22 (dd/mm/yy)

CLIENT INFORMATION:

Client Name: Pai Sanghoon h
Surname First Name Middle Initial

Birth:

21/Feb/85 ☐ Male Day / Month / Year ☐ Female

Is an interpreter required? ☐ Yes ☐ No Languages spoken: Korean

Client Address: 4782 random st City: rancity

Province: random Postal Code: 94762

Tel.: +1 204 204 5959

Health Card Number: _____ **Version Code:** _____

Interim Federal Health Program (IFHP) ☐ Yes ☐ No Health Card In Process ☐

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

Primary Contact(s) – Parent/Legal Guardian:

Address: _____
Email: _____
Tel. (home): _____ Tel. (work): _____ Tel. (cell): _____

Secondary Contact(s) – Parent/Legal Guardian:

Address: _____
Email: _____
Tel. (home): _____ Tel. (work): _____ Tel. (cell): _____

PRIMARY CARE PHYSICIAN:

Name: Dr Sanjay Pant
Address: 47 3rd st, somecity, SO, 27475
Tel.: +82 010 2393 2193 Fax: +82 010 2953 2948

April 2015

COMMUNITY AGENCIES/PROFESSIONALS CURRENTLY INVOLVED:

Agency(s) (e.g. Child Protection, Community)

Professional (e.g. OT, Psychologist)

1. _____

2. _____

3. _____

MEDICAL INFORMATION:**Primary Diagnosis:**

Other Diagnoses:

Medical History:

Taking Medication: ☐ Yes ☐ No**Reason for Referral/Concern:**

Specialized Services:☐

Aquatic Therapy

☐

Augmentative & Alternative Communication

☐

Clinical Seating

☐

Infant Development Services

☐

Life Skills Services

☐

Music Therapy

☐

Nursery Schools (Holland Bloorview)

☐

Orthotics (including protective headwear)

☐

Post-Secondary Transition Service

☐

Prosthetics (including myoelectric & cosmetic)

☐

Therapeutic Recreation Services

☐

Writing Aids

Dental Services:☐Cleft Lip & Palate (general anesthesia
available for qualifying clients)☐Special Needs Dentistry (general anesthesia
available for qualifying clients)**REFERRING PROFESSIONAL/CLIENT OR FAMILY:**

Name:

Organization:

Telephone:

Fax:

Email:

Signature:
