Holland Bloorview
Kids Rehabilitation Hospital

Appointment Services: 150 Kilgour Rd. Toronto, ON, M4G 1R8
Tel: (416) 424-3804 Fax: (416) 422-7036

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: __47825 random st_____City:__rancity_____

Province: __random__Postal Code:___9467623_____

Tel.: __+1 2088684 256604 595992_____

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 Apple Tesla_____

Address:___47 3rd st, somecity, SO, 27475_____

Tel.:___+82 04160 23293 21693___ Fax: __+82 0310 29563 290488_

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: _____