

AQUATIC THERAPY

Before completing our Aquatic Therapy self-referral form, please review the criteria and additional information to make sure this program is an appropriate fit for your child.

Criteria

Diagnostic groups that may participate in the program but are not limited to:

- Ages 0-21 years of age
 - Cerebral palsy, acquired brain injury, spinal cord injury, muscular dystrophy, amputation, epilepsy, spina bifida, arthritis, autism spectrum disorder, pain conditions, and other developmental disabilities.
 - Aquatic therapy is most beneficial for those who have limited potential to participate in land-based therapeutic interventions.
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- Participants must have either physical or functional goals that could be addressed with aquatic therapy.
 - Participant must be comfortable in an aquatic setting.
 - Participant must be able to participate in a group-based aquatic setting with or without support from volunteer staff.
 - Participants under 3 years old must be supported by parent/caregiver in the water. For children 3 years and older, parents/caregivers must be prepared to go into the water in the case where volunteer support is not available.

Program Details

When:

Mondays
4:30pm – 5:15pm or, 5:30pm – 6:15pm
(times assigned based on appropriate grouping)

Cost:

\$70.00 per session
(Sessions run typically 8-10 weeks)

Assessment Costs:

\$105.00 (new clients)
\$80.00 (for any client whose condition has changed or who has missed 2 or more consecutive sessions)

If your child meets these guidelines, please complete the application form and return it by mail, fax, or in person to:

Holland Bloorview Kids Rehabilitation Hospital

Attention: Krysta Pigden (Aquatics)

150 Kilgour Road

Toronto, ON M4G 1R8

Fax: 416-422-7036

Questions? Please contact:

Krysta Pigden, Aquatics Program Assistant

Phone: 416-425-6220, ext. 3707

kpigden@hollandbloorview.ca

SERVICE PROVIDERS:

Family Doctor:

Name: _____

Telephone Number: _____

Fax Number: _____

Other Care Provider(s) (if applicable):

Name: _____

Title: _____

Telephone Number: _____

Fax Number: _____

MEDICAL INFORMATION:

Primary Diagnosis: _____

Relevant Medical History: _____

Current Medication: _____

Reason For Seeking Aquatic Therapy/Goals: _____

Medical Conditions:

Cardiorespiratory

Cardiovascular issues: Yes No Describe: _____

Respiratory issues: Yes No Describe: _____

History of aspiration: Yes No Describe: _____

Tracheotomy: Yes No Describe: _____

Requires Oxygen: Yes No Describe: _____

Gastrointestinal

Loss of bowel or bladder control/incontinence: Yes No Describe: _____

G-tube/NG tube: Yes No Describe: _____

Thickened Liquid Diet: Yes No Describe: _____

Neurological

History of seizures: Yes No Describe (please include type and typical duration):

Trigger if known: _____

Skin

Open wounds/skin break down: Yes No Describe:

Skin infection: Yes No Describe:

Abnormal/decreased sensation: Yes No Describe:

Allergy/sensitivity to chlorine: Yes No Describe:

Other

Other medical conditions (please describe): _____

Other external lines or tubes (please describe): _____

Mobility:

- Walks independently Walks independently with equipment Requires supervision
 Requires assistance Dependent on others for mobility
 Additional information: _____

Transfers:

- Transfers independently with or without equipment Requires supervision
 Requires assistance – one person transfer Requires assistance – two person transfer
 Requires assistance – more than two persons or lift required
 Additional information: _____

Is your child **currently** enrolled in any other program at the hospital (Eg. therapeutic program or research study) that would prevent them from participating in the Aquatic Therapy Program at this time?

- Yes No

Additional Information:

Is there any additional information you would like to provide us regarding your client's participation in the Aquatic Therapy Program at Holland Bloorview?

Consent to Contact:

I hereby give Holland Bloorview Kids Rehabilitation Hospital consent to contact the above listed Care Providers to discuss my child's health information if necessary.

Yes No

Signature

Date

Please choose one:

I would like to participate in the pool with my child

I would prefer to have a volunteer participate in the pool with my child*

* Please note that if we are short of volunteers on any given week, you will need to accompany your child in the pool.

Thank You for your Application!

How to return this form:

BY MAIL or IN PERSON:

Holland Bloorview Kids Rehabilitation Hospital
150 Kilgour Rd.
Toronto, ON
M4G 1R8
Attention: Krysta Pigden

BY FAX: 416-422-7036

To protect your privacy, please do not email this form

**If you have any questions please feel free to contact the
Krysta Pigden at 416-425-6220 ext. 3707**