

# Holland Bloorview

Kids Rehabilitation Hospital

Internal Use Only:

Name: \_\_\_\_\_

Health Record No. \_\_\_\_\_

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

## Electronic Aids to Daily Living (EADL) Community Referral-Intake

\*\*\*Clients of all ages and abilities are eligible for our services\*\*\*

Please complete ALL SECTIONS of this form. Incomplete forms will be returned.

**NOTE: This information will be shared with Holland Bloorview Kids Rehabilitation Hospital staff as required**

Referral date: (dd/mm/yy) \_\_\_\_\_

Name of referring agency/person: \_\_\_\_\_

Is client and/or family is aware of this referral?  Yes  No

Telephone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

### Client Information

Name of Client: \_\_\_\_\_

*Surname*

*First Name*

*Middle Initial*

Date of Birth: \_\_\_\_\_

Sex

Female

*Day*

*Month*

*Year*

Male

Diagnosis: \_\_\_\_\_

Languages Understood: \_\_\_\_\_

Interpreter Required:

Yes  No

Client Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Email: \_\_\_\_\_

Postal Code: \_\_\_\_\_

Tel.: ( ) \_\_\_\_\_

Health Card Number: \_\_\_\_\_

Version Code: \_\_\_\_\_

Client lives:

Independent

Guardians

Both parents

Group Home

Mother

Other: (Please specify)

Father

**Client must bring a valid Ontario health card to every visit.**

**Parent(s) or Guardian(s) Information: (if applicable)**

**Mother/Guardian**

Address: \_\_\_\_\_  
\_\_\_\_\_

Email: \_\_\_\_\_

Tel. (home):

( )

Tel. (work/cell):

( )

**Father/Guardian**

Address: \_\_\_\_\_  
\_\_\_\_\_

Email: \_\_\_\_\_

Tel. (home):

( )

Tel. (work/cell):

( )

**Primary Care Physician**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone:

( )

Hospital: \_\_\_\_\_

**Present Abilities**

(e.g., functional body movements, level of independence with activities of daily living)

Present Needs: (Please tick off all activities of interest)

- |                                                    |                                                                        |
|----------------------------------------------------|------------------------------------------------------------------------|
| <input type="checkbox"/> Using the telephone       | <input type="checkbox"/> Using a cell phone                            |
| <input type="checkbox"/> Turning the lights on/off | <input type="checkbox"/> Using an emergency system                     |
| <input type="checkbox"/> Operating a hospital bed  | <input type="checkbox"/> Operating the television/multimedia equipment |
| <input type="checkbox"/> Operating the radio       | <input type="checkbox"/> Calling attendant(s)                          |
| <input type="checkbox"/> Opening/closing doors     | <input type="checkbox"/> Other :                                       |

**Please list existing environmental equipment (at home/school/work):**

(e.g., automatic door opener)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Communication**

Describe speaking voice:  Speaks clearly?  Speaks quietly?

- Is able to communicate needs independently?
- Can sign own name?
- Uses a computer for written communication?
- Uses a speech-generating device for verbal communication?

**Mobility and Seating**

Type of Wheelchair Tilt

Power Model: \_\_\_\_\_ Vendor: \_\_\_\_\_ Yes  No How old is it? \_\_\_\_\_

Manual Model: \_\_\_\_\_ Vendor: \_\_\_\_\_ How old is it? \_\_\_\_\_

Method of driving wheelchair (e.g. joystick, rim control): \_\_\_\_\_

Tray/other supports on chair: \_\_\_\_\_

ECU box on the wheelchair:  Yes  No  Not Sure

**Vision and Hearing**

Is vision within functional limits? \_\_\_\_\_ Do you wear glasses? \_\_\_\_\_

Is hearing within functional limits? \_\_\_\_\_ Do you wear a hearing aid? \_\_\_\_\_

**Community Agencies/Professionals Involved**

Agency (e.g. writing aids)	Profession: e.g. OT, SLP, etc.	Telephone#
_____	_____	_____
_____	_____	_____

**Reason For Referral**

Consult  Assessment  Reassessment

**Internal Use Only**

Date (of)	First Contact:	_____
	Referral Received:	_____
	Sent to Program/Service:	_____
	Referral Accepted:	_____
	Referral Cancelled or Declined:	_____
	Phone contact with client:	_____
	Appointment Date:	_____