

# Electronic Aids to Daily Living (EADL)

## Community referral and intake form

**Please remember:**

- To bring a valid Ontario health card to each visit.
- To complete **all sections** of this form (incomplete forms will be returned).

**Internal Use Only:**

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

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

<b>Reason for referral:</b> <input type="checkbox"/> Consult <input type="checkbox"/> Assessment <input type="checkbox"/> Reassessment		Referral date: (dd/mm/yy)	
Name of referring agency/person:		Telephone:	Fax:
Is client and/or family is aware of this referral? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is client currently an inpatient at Holland Bloorview? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Client information</b>			
Name:		Date of birth: (dd/mm/yy)	Sex: M F
Address:	Postal code:	Telephone:	
Health card number:	Version code:	Email address:	
Languages understood:		Interpreter Required: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Diagnosis:			
Client Lives: <input type="checkbox"/> Independent <input type="checkbox"/> Both parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Guardians <input type="checkbox"/> Group Home <input type="checkbox"/> Other: (please specify) _____			
<b>Parent or guardian information:</b> (if applicable)			
<b>Mother/guardian name:</b>		Home telephone:	Work telephone:
Address:		Email address:	
<b>Father/guardian name:</b>		Home telephone:	Work telephone:
Address:		Email address:	
<b>Primary care physician</b>			
Name: _____		Hospital: _____	
Address: _____		Telephone: (    ) _____	
<b>Present abilities</b> (e.g., functional body movements, level of independence with activities of daily living)			
<b>Present needs:</b> Please tick off all activities of interest			

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<input type="checkbox"/> Using the telephone	<input type="checkbox"/> Using a cell phone	<input type="checkbox"/> Using an emergency system
<input type="checkbox"/> Turning the lights on/off	<input type="checkbox"/> Opening/closing doors	<input type="checkbox"/> Calling attendant(s)
<input type="checkbox"/> Operating a hospital bed	<input type="checkbox"/> Operating the radio	<input type="checkbox"/> Other :
<input type="checkbox"/> Operating the television/multimedia equipment		
<b>Please list existing environmental equipment:</b> (at home/school/work - e.g., automatic door opener)		
_____		
_____		
_____		
<b>Communication</b>		
<b>Describe speaking voice:</b> <input type="checkbox"/> Speaks clearly? <input type="checkbox"/> Speaks quietly? <input type="checkbox"/> Can sign own name?		
<input type="checkbox"/> Is able to communicate needs independently?	<input type="checkbox"/> Uses a speech-generating device for verbal communication?	
<input type="checkbox"/> Uses a computer for written communication?		
<b>Mobility and seating</b>		
Type of Wheelchair:		
<input type="checkbox"/> Power    Model:	Vendor:	How old is it?    Tilt: <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure		
<b>Vision and hearing</b>		
Is vision within functional limits? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is hearing within functional limits? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you wear a hearing aid? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Community agencies or professionals involved</b>		
Agency: (e.g. writing aids)	Profession: (e.g. OT, SLP, etc)	Telephone:

The personal information you give us on this form helps us provide you with services at Holland Bloorview. We collect, use and share this information in keeping with the Public Hospitals Act. If you have questions, please contact the privacy office at 416-425-6220 ext. 3467 or [privacy@hollandbloorview.ca](mailto:privacy@hollandbloorview.ca).

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Date (of)	First contact:	
	Referral received:	
	Sent to program/service:	
	Referral accepted:	
	Referral cancelled or declined:	
	Phone contact with client:	
	Appointment date:	