

STUDENT SUPPORT SERVICES
External Referral Form

Referral Date: _____

Bloorview Chart # _____

Client Name: _____ D.O.B. _____

Address: _____

Telephone: _____

Mother's name (Home#) (Business#)

Father's name (Home#) (Business#)

Interpreter's Name (if necessary) (Phone#)

Diagnosis: _____

Referred by: _____

Has parent given consent for this referral: Yes ___ No ___

Therapy services required: Occupational ___ Physio ___ Speech ___

Other Therapists Involved: _____
(Bloorview therapists, CCAC, TDSB, etc.)

REASON FOR REFERRAL: (Please be specific)

School Name: _____

School Address: _____

Phone: _____

Principal: _____ Teacher: _____ Other Personnel: _____

School Board: Toronto District School Board ___ Toronto Catholic District School Board ___ Private ___

Please return to:
Martha Pilkington, Manager
Student Support Services, Bloorview Kids Rehab
Fax: 416-422-7038 Mail: 150 Kilgour Road, Toronto, Ontario, M4G 1R8