The Brain Injury rehab outpatient team (BIRT) serves clients and families who require rehabilitation following **an acquired brain injury** and are recovering at home. Depending on the injury, people may experience a variety of emotional, behavioural, learning, physical, psychological and social difficulties.

In order to be eligible for this service a **Physician referral is required** and the client must meet all the following criteria:

- Live in the Greater Toronto Area where similar services are not available
- Is under the age of 19
- Has a diagnosis of an acquired brain injury
- Is willing to participate in setting goals with the support of the brain injury rehab team
- Has family members who are willing to become involved in the therapy process

*The client/family must be aware of the referral*
PHYSICIAN REFERRAL FORM – OUTPATIENT SERVICES

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.

Family is aware of this referral: Yes ☐ (must be checked)  Referral Date: ________________(dd/mm/yy)

<table>
<thead>
<tr>
<th>CLIENT INFORMATION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Name: _____________________________</td>
</tr>
<tr>
<td>Date of Birth: __________________________</td>
</tr>
<tr>
<td>Day / Month / Year</td>
</tr>
<tr>
<td>Is an interpreter required? ☐ Yes ☐ No</td>
</tr>
<tr>
<td>Client Address: __________________________</td>
</tr>
<tr>
<td>Province: ______________</td>
</tr>
<tr>
<td>Health Card Number: ______________</td>
</tr>
<tr>
<td>☐ Interim Federal Health Program (IFHP) ☐ Health Card In Process</td>
</tr>
<tr>
<td>Client lives with: ☐ Both parents ☐ Father ☐ Mother ☐ Guardian ☐ Independent ☐ Group Home ☐ Other:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PARENT(S) OR GUARDIAN(S): (if different from client address)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/Guardian: ____________________________________________________________________________</td>
</tr>
<tr>
<td>Address: ____________________________________________________________________________________</td>
</tr>
<tr>
<td>Email: ______________________________________________________________________________________</td>
</tr>
<tr>
<td>Tel. (home): __________________________ Tel. (work): __________________________ Tel. (cell): __________________________</td>
</tr>
</tbody>
</table>

| Parent/Guardian: ____________________________________________________________________________ |
| Address: ____________________________________________________________________________________ |
| Email: ______________________________________________________________________________________ |
| Tel. (home): __________________________ Tel. (work): __________________________ Tel. (cell): __________________________ |

AGENCIES/PROFESSIONALS CURRENTLY INVOLVED:

<table>
<thead>
<tr>
<th>Agency (eg. Child Protection, Community)</th>
<th>Professional (eg. OT, SLT, Psychologist)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ________________________________</td>
<td>________________________________</td>
</tr>
<tr>
<td>2. ________________________________</td>
<td>________________________________</td>
</tr>
<tr>
<td>3. ________________________________</td>
<td>________________________________</td>
</tr>
</tbody>
</table>

September 2017
MEDICAL INFORMATION:

Primary Diagnosis:

____________________________________________________________________________________

Other Diagnoses:

____________________________________________________________________________________

Does this client require any special infectious disease precautions? Yes No

If yes, what for: _________________________________________________________________

Medical History/Allergies:

____________________________________________________________________________________

____________________________________________________________________________________

Taking Medication: ☐ Yes ☐ No

Risks (i.e. frequent falls)

____________________________________________________________________________________

Reason for Referral/Concern/Goals:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Use check box for referral:

☐ Query Autism
☐ Acquired Brain Injury Rehabilitation
☐ Concussion Clinic
☐ Cleft Lip & Palate Speech Language Pathology
☐ Infant Development Services
☐ Neuromotor (e.g. cerebral palsy, global developmental delay, Retts)
☐ Psychopharmacology* (additional forms required)
☐ Neuromuscular (e.g. muscular dystrophy)
☐ Feeding* (additional forms required)
☐ Spina Bifida
☐ Spinal Cord Injury
☐ Augmentative & Alternative Communication (AAC)
☐ Writing Aids
☐ Orthotics (including protective headwear)
☐ Prosthetics (including myoelectric & cosmetic)
☐ Clinical Seating

Dental Services:

☐ Cleft Lip & Palate (general anesthesia available for qualifying clients)
☐ Special Needs Dentistry (general anesthesia available for qualifying clients)

*Pre-assessment forms are required with the referral. Click here:

Feeding: http://hollandbloorview.ca/programsandservices/programsservicesaz/feedingservices
Psychopharmacology: http://hollandbloorview.ca/programsandservices/ProgramsServicesAZ/Psychopharmacologyclinic

REFERRING M.D./D.D.S. Name: _________________________________________________________

OHIP Billing Number: ______________________________

Hospital: ________________________________________________________________

Telephone: _______________________________ Fax: ________________________________

Email: ________________________________

Signature: _______________________________________________________________________

Please fax your completed Referral Form to Appointment Services: (416) 422-7036