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.

- 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 (Semi Private)

When: Mondays
- 4:15pm – 4:45pm
- 4:50pm – 5:20pm
- 5:25pm – 5:55pm
- 6:00pm – 6:30 pm
(times assigned based on appropriate grouping)

Cost: $90.00 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
Aquatic Therapy Self-Referral Form

Please complete all of the sections of this form. Incomplete forms cannot be processed.

**Date:** __________ (dd/mm/yy)

**Please tell us how you heard about our program:** __________________________

Please note that completion of this form does not guarantee a place in the Aquatic Therapy Program. All application forms will be reviewed to ensure applicants are safe to participate in the water. Due to limited spaces, applicants may be placed on a wait list until a space in the program becomes available.

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**CLIENT INFORMATION:**

Client Name: ___________________________________________________ __________

<table>
<thead>
<tr>
<th></th>
<th>Surname</th>
<th>First Name</th>
<th>Middle Initial</th>
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Date of Birth: _____________________________ □ Male □ Female Age: _______

(dd/mm/yy)

Primary Language: __________________________

Client Address: ___________________________ City: ______________________

Province: ___________________________ Postal Code: ______________________

Telephone Number: ___________________________

Health Care Number: ______________________ Version Code: ________________

Client Lives With: □ Both Parents □ Father □ Mother □ Guardians □ Independent

□ Group Home □ Other

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**Parent(s)/Guardian(s) Information:**

Mother/Guardian's Name: __________________________________________

Address: ________________________________________________________

Telephone Number: ___________________________ (Home) (Work) (Cell)

Email: __________________________

Father/Guardian's Name: __________________________________________

Address: ________________________________________________________

Telephone Number: ___________________________ (Home) (Work) (Cell)

Email: __________________________
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