Referral Criteria – Neuromotor Team

Ambulatory Care

The Neuromotor team works with clients who require an assessment where a primary concern is motor-based or physical in nature and have complex medical /developmental needs:

To meet the complex needs of these children, youth and their families’ services available include assessment, diagnosis, consultation and intervention by developmental pediatricians, occupational therapists, physiotherapists, psychologists, social workers and speech-language pathologist in collaboration with our community partners to provide a continuum of care.

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 Toronto area
- Is under the age of 19 (at the time of referral)
- Present with specific neuromotor concerns, which could include a query or confirmed diagnosis of cerebral palsy; AND/OR
- With delay in two or more areas of development (includes a motor delay)

*The client/family must be aware of the referral*

Please use the referral form online at: hollandbloorview.ca/referrals
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)

CLIENT INFORMATION:

Client Name: ___________________________________________  Last Name  First Name  Middle Initial

Date of Birth: ___________________________  ☐ Male  ☐ Female

Day / Month / Year

Is an interpreter required?  ☐ Yes  ☐ No  Language spoken: ____________________________

Client Address: ___________________________________________  City: __________________________

Province: ___________________________  Postal Code: ___________________________  Tel.: __________________________

Health Card Number: ___________________________  Version Code: ___________________________

☐ Interim Federal Health Program (IFHP)  ☐ Health Card In Process

Client lives with:  ☐ Both parents  ☐ Father  ☐ Mother  ☐ Guardian  ☐ Independent  ☐ Group Home  ☐ Other:

PARENT(S) OR GUARDIAN(S):  (if different from client address)

Parent/Guardian: ____________________________________________________________________________

Address: ___________________________________________ ___________________________________________

Email: ___________________________________________ ___________________________________________

Tel. (home): ___________________________  Tel. (work): ___________________________  Tel. (cell): ______________

Parent/Guardian: ____________________________________________________________________________

Address: ___________________________________________ ___________________________________________

Email: ___________________________________________ ___________________________________________

Tel. (home): ___________________________  Tel. (work): ___________________________  Tel. (cell): ______________

AGENCIES/PROFESSIONALS CURRENTLY INVOLVED:

Agency (eg. Child Protection, Community)  Professional (eg. OT, SLT, Psychologist)

1. _______________________________________________________________________________________

2. _______________________________________________________________________________________

3. _______________________________________________________________________________________

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

Holland Bloorview
Kids Rehabilitation Hospital

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