CWAS’s Writing Aids (WA) service works with clients with physical disabilities who speak, but need tools to assist them to complete written work. This service is specific to clients who require written communication support.

In order to be eligible for referral, the client must meet all of the following criteria:

- Client is verbal
- Is under the age of 19 (at the time of referral)
- Has difficulty with handwriting because of a physical condition
- Has regular writing needs at home
- Can compose ideas in writing
- Does not have a writing aid that is meeting his/her needs at home
- Has the ability/potential to use a writing aid to increase speed and/or legibility of writing

*If the referral is being made on behalf of a client, the client/family must be aware of the referral.*
# HEALTH PROFESSIONAL REFERRAL FORM – OUTPATIENT SERVICES

**Referral Source:**
- ☐ Health Care Professional
- ☐ Client and Family
- ☐ Other

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:

<table>
<thead>
<tr>
<th>Client Name: ___________________________________</th>
<th>Surname</th>
<th>First Name</th>
<th>Middle Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth: _________________________________</td>
<td>☐ Male</td>
<td>☐ Female</td>
<td>Day / Month / Year</td>
</tr>
<tr>
<td>Is an interpreter required? ☐ Yes ☐ No</td>
<td>Languages spoken: ________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client Address: __________________________________</td>
<td>City: ________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Province: ___________________________________</td>
<td>Postal Code: ________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tel.: ________________________________________</td>
<td>Version Code: ________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Health Card Number:</strong> _______________________</td>
<td>Interim Federal Health Program (IFHP) ☐ Yes ☐ No</td>
<td>Health Card In Process ☐</td>
<td></td>
</tr>
<tr>
<td>Client lives with: ☐ Both parents ☐ Father ☐ Mother ☐ Guardians ☐ Independent ☐ Group Home ☐ Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Primary Contact(s) – Parent/Legal Guardian:

| Address: ___________________________________ |
| Email: ___________________________________ |
| Tel. (home): _______________________ Tel. (work): ___________________ Tel. (cell): ___________________

### Secondary Contact(s) – Parent/Legal Guardian:

| Address: ___________________________________ |
| Email: ___________________________________ |
| Tel. (home): _______________________ Tel. (work): ___________________ Tel. (cell): ___________________

### PRIMARY CARE PHYSICIAN:

| Name: ___________________________________ |
| Address: ___________________________________ |
| Tel.: ___________________ Fax: ___________________ |
COMMUNITY AGENCIES/PROFESSIONALS CURRENTLY INVOLVED:

<table>
<thead>
<tr>
<th>Agency(s) (e.g. Child Protection, Community)</th>
<th>Professional (e.g. OT, 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>

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:

____________________________________________________

Specialized Services:

- □ Aquatic Therapy
- □ Augmentative & Alternative Communication (AAC)
- □ Writing Aids
- □ Clinical Seating
- □ Infant Development Services
- □ Life Skills Services
- □ Music Therapy
- □ Nursery Schools (Holland Bloorview)
- □ Orthotics (including protective headwear)
- □ Post-Secondary Transition Service
- □ Prosthetics (including myoelectric & cosmetic)
- □ Therapeutic Recreation Services

Dental Services:

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

REFERRING PROFESSIONAL/CLIENT OR FAMILY:

Name: ____________________________________________

Organization: ______________________________________

Telephone: ___________________________ Fax: _______________________

Email: ______________________________________________

Signature: ____________________________________________

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