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.*
### 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:

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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:

<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>
</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: __________________________________________

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