The Infant Development Services use an interprofessional approach to provide opportunities for optimal development for a child and their family but supporting families in their efforts to be active participants in their child’s care.

Early Childhood Educators and Physiotherapists provide early interventions to reduce risk using both in-home and centre based models.

In order to be eligible for this service a **referral is required**. Referrals are accepted from parents, doctors, hospitals, neonatal follow-up programs, therapists, community programs and other agencies who provide services for young children. The client must meet **all** the following criteria:

- Live in the Toronto (postal code begins with M)
- Is between birth and 5 years of age (at the time of referral)
- Has been identified as having developmental delays and disabilities including physical markers or prematurity
- Is not receiving Infant Developmental Services in Toronto from any of the following agencies; Centennial Nursery School Infant Development Centre, Surrey Place Centre, Mothercraft or Centre Francophone de Toronto
- Is not enrolled in the following services; Holland Bloorview Nursery Schools (Scarborough site or Play & Learn site), a childcare or day care centre

*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:

Client Name: ______________________________________________________________

Surname First Name Middle Initial

Date of Birth: ___________________________ □ Male □ Female

Day / Month / Year

Is an interpreter required? □ Yes □ No Languages spoken: ______________________

Client Address: ________________________________________________________________

City: ____________________________ Province: _____________________________ Postal Code: _____________________________

Tel.: ________________________________

Health Card Number: ____________________________ Version Code: _____________________________

Interim Federal Health Program (IFHP) □ Yes □ No Health Card In Process □

Client lives with: □ Both parents □ Father □ Mother □ Guardians □ Independent □ Group Home □ Other:

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:

Agency(s) (e.g. Child Protection, Community)  Professional (e.g. OT, Psychologist)
1. ____________________________________________  __________________________________________
2. ____________________________________________  __________________________________________
3. ____________________________________________  __________________________________________

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

Holland Bloorview
Kids Rehabilitation Hospital