REFERRAL FORM

Date of Referral Request: _____
dd / mm / yyyy

CLIENT INFORMATION

This request is being submitted with the knowledge and consent of named parents/legal guardians.

Have parents provided implied consent to information collection as per ErinoakKids Privacy Policy available at:
http/www.erinoakkids.ca/About Us/Accountability/Privacy and Confidentiality

Consent Received: ☐ Yes ☐ No If No, ErinoakKids will not process this referral.

Child's Name:

_____
Last *First* *Middle*

☐ M ☐ F Date of Birth: _____
dd / mm / yyyy

Health Card #: _____ Version Code: _____

Address:

_____
Unit # *Street #* *Street Name* *City* *Postal Code*

Parent/Legal Guardian Names:

1. Person to Notify: *(primary contact – will be the only person notified for services)*

_____
Last *First* *Relationship*

Phone #1:_____ Phone #2: _____ Email: _____

2. Next of Kin *(secondary contact)*

_____
Last *First* *Relationship*

Phone #1:_____ Phone #2: _____ Email: _____

Client Lives with: ☐ Both Parents ☐ One Parent
☐ Foster Parent ☐ Other *(specify):* _____

Children's Protective Services, Agency Name: _____

Caseworker's Name: _____ Phone #: _____

Name any Siblings who are receiving services at ErinoakKids: *first and last name of sibling(s)*

(1) _____ (2) _____

Identify School Board*, if applicable:* _____

Primary Language(s) spoken in the home: _____

Are Interpreter Services required? ☐ Yes ☐ No

If Yes, state language / ASL _____

Allergies: ☐ Yes ☐ No If yes, specify: _____

Epipen required? ☐ Yes ☐ No If yes, specify the allergy: _____

ERINOAKKiDS
Centre for Treatment and Development

REFERRAL FORM

Child's Name: _____

Is this child receiving or waiting for services in the community? ☐ Yes ☐ No

If Yes, identify the service(s) and the Agency name(s): _____

_____

_____

Diagnosis: ☐ Yes ☐ No *If Yes, identify:*

Identified Issues/Areas of Concern: _____

_____

_____

_____

SERVICE(S) REQUESTED

Services are provided for children with Physical or Developmental Disabilities, Autism and/or impairments with Communication, Hearing or Vision. Family must live in the catchment area of service.

Please visit our website at www.erinoakkids.ca/ourservices for detailed eligibility criteria and questionnaires where indicated.

☐ **Assistive Devices Resource Service (ADRS):** *(Technology for home, or home and school use. If technology is needed only for school, please follow-up with your school for options).*

Please complete the required questionnaire for each requested ADRS service: www.erinoakkids.ca/adrs

- ☐ Face-to-Face Communication *(attach Face-to-Face Questionnaire)*
- ☐ Written Communication *(attach Writing Aid Questionnaire)*
- ☐ Adapted Access: for Face-to-Face Communication Technology *(attach Adapted Access Questionnaire)*
- ☐ Adapted Access: to computer for non-writing activities (e.g. mouse control, switch access) *(attach Adapted Access Questionnaire)*
- ☐ Adapted Access: for toys, Environmental Aids for Daily Living (EADL) *(attach Adapted Access Questionnaire)*

☐ **Audiology Services:**

- ☐ Infant Hearing Audiology
- ☐ Infant Hearing Screening
  - Birth - 4 months (parent referral accepted)
- ☐ Audiology – Fee for Service:
  - Birth to age 19 and/or not eligible through the Infant Hearing Program

☐ **Autism Services:**

- ☐ Fee for Service - Autism Behavioural Intervention Services (*Only for families receiving transition funding*)

☐ **Medical Services:** *(Physician referral required)*

- ☐ Medical Developmental Assessment *(please include any relevant reports, lab results, etc.)*
- ☐ Query Autism Assessment/ASD Diagnostic Clinic
- ☐ Physical Medicine and Rehabilitation *(please include any relevant reports, lab results, etc.)*

Clinics:

- ☐ Botox
- ☐ Orthopaedic

REFERRAL FORM

Child's Name: _____

- ☐ **Occupational Therapy**
- ☐ **Coordinated Service Planning**
- ☐ **Physiotherapy**
- ☐ **OHIP Pediatric Physiotherapy Clinic for the following diagnoses** ***(Physician referral required)***
  - ☐ Torticollis
  - ☐ Tendinitis/Tendinosis
  - ☐ Muscle, ligament and tendon tears
  - ☐ Ligament sprains
  - ☐ Joint stiffness and pain
  - ☐ Repetitive strain injuries
  - ☐ Rheumatological issues ex. Juvenile Rheumatoid Arthritis
  - ☐ Rehabilitation after fracture
  - ☐ Sports and recreation injuries
- ☐ **Preschool Speech and Language**
- ☐ **Respite Services -** refer to our website for information and the referral process for day and overnight Respite opportunities **– www.erinoakkids.ca/respite** *(attach the applicable Questionnaire.)*
- ☐ **Vision Services** *(attach diagnostic report of visual impairment)*

Referral Source:

☐ Parent/Guardian ☐ Medical ☐ Community Agency ☐ Other

Referral Source Name and Contact Information:

_____

_____

_____

Physician's Referral Requirements:

A physician's referral is required for all Medical Services, OHIP Pediatric Physiotherapy Clinic and for an Infant Hearing Screening *(4 – 24 months and not previously screened)***.**

****Supporting documentation is required to support and proceed with a medical referral, i.e. reports, test/results, medical investigations, questionnaires****

Physician's Name: _____ **Physician's Signature:** _____

(please print)

Tel #: _____ **Fax #:** _____ **Billing #:** _____

Please Fax the completed 'ErinoakKids Referral Form' and all supporting documentation to:

ErinoakKids Intake Service: Fax 905.855.9451