



CHILDREN/YOUTH REFERRAL INFORMATION (<18yrs.)

REFERRAL TO: INPATIENT STAY / REHABILITATION

(For Youth 16 – 18 years of age, choose the category (Child/Adult) which will best meet their needs.)

Referring Service Provider to Complete

Client's Name:(Last)_____	Mandatory Information (First)_____	Date of Birth (Y)____/(M)____/(D)____
Client's Current Location: _____	Phone #: _____	
Expected Discharged Date : (Y)____/(M)____/(D)_____		

Referral Destination: COMPLETE ONLY ONE FORM FOR EACH REFERRAL DESTINATION

- Children's Hospital of Eastern Ontario (CHEO)
- Elisabeth Bruyère (Brain Injury Rehab Unit)
- The Rehabilitation Centre (Behaviour Rehabilitation Services)
- Pembroke General Hospital (Generic Rehab Unit)
- Name of Acute Care Hospital / Other facility: (No Rehab Unit)

Reason for Referral: Check all that apply

Inpatient rehab

- Physical Assessment
- Behavioural Assessment
- Cognitive Assessment
- Treatment/Therapy

Inpatient stay

- Assessment
- Treatment/Therapy
- Surgery
- Medication Review/Management
- Waiting Placement

Please complete and include with referral the most recent outcome measures: Wee FIM FIM Other n/available

* Mandatory Response Required: You must provide either an e-mail address [preferable], or fax #.

I authorize a referral to this facility / agency / provider as specified:

*From (Facility):	*To (Facility):
*Contact Name:	Contact Name:
*Phone: _____ Fax: _____	*Phone : _____ Fax: _____
Email:	Email:

This page completed by (Print Name): _____	Date: (Y) _____ (M) _____ (D) _____
--	-------------------------------------

This information contained herein is confidential and no unauthorized person will have access to the information without the consent of the client or substitute decision-maker.

Please send or fax the completed TBI Client Referral to

TBI Clinical Coordinator/Educator, TBI Centralized Coordination and Referral Tracking Office
c/o The Rehabilitation Centre • 505 Smyth Road • Rm. 2502 • Ottawa • ON • K1H 8M2
Phone: (613) 737-7350 ext. 5243 Fax: (613) 739 – 3273



CHILDREN/YOUTH REFERRAL CONFIRMATION (<18yrs.)

INPATIENT STAY / REHABILITATION

Receiving Service Provider To Complete

Return by fax to the address below within 2 days

Mandatory Information (This box only)		
Client's Name:_(Last) _____	(First) _____	Date of Birth: (Y) ____/(M) ____/(D) ____

Intake Process
Planned date of assessment/consult: (Y) ____/(M) ____/(D)____ <input type="checkbox"/> N/A Actual date of assessment/consult: (Y) ____/(M) ____/(D)____ <input type="checkbox"/> N/A Accepted by Receiving Service Provider: <input type="checkbox"/> Yes <input type="checkbox"/> No Planned date of admission: (Y) ____/(M) ____/(D)____ If no, check reason: <input type="checkbox"/> Physical Needs <input type="checkbox"/> Medical Needs <input type="checkbox"/> Cognitive Needs <input type="checkbox"/> Behavioural Needs <input type="checkbox"/> Other Comment:

- Mandatory Response Required (You must provide either [preferably] an e-mail address or fax #)

*Name of Receiving Service Provider:	*Name of Organization:
*Phone:	E-mail: Fax:

Complete when known

Client Acceptance: Yes No

If no, give reason:

Actual Date of Admission/Assessment: (Y) ____/(M) ____/(D)____

This page completed by (Print Name):	Date: (Y) : (M) : (D)
---	-----------------------

This information contained herein is confidential and no unauthorized person will have access to the information without the consent of the client or substitute decision-maker.

FOR TBI INTEGRATION PROJECT - OFFICE USE ONLY

Date referral received: (Y) ____/(M) ____/(D)____ Date referral reviewed: (Y) ____/(M) ____/(D)____ Reviewer: _____

Please send the completed TBI Client Referral Confirmation to:

TBI Clinical Coordinator/ Educator, TBI Centralized Referral Tracking Office
 C/o The Rehabilitation Centre • 505 Smyth Road • Rm. 2502 • Ottawa • ON • K1H 8M2
 Phone: 737-7350 ext. 5243 Fax: 739-3273



CHILDREN/YOUTH REFERRAL INFORMATION (<18yrs.)

REFERRAL DESTINATION: COMMUNITY / AMBULATORY (All “non inpatient)

(For Youth 16 – 18 years of age, choose the category (Child/Adult) which will best meet their needs.)

Referring Service Provider to Complete

Client's Name: (Last) _____ (First) _____	Date of Birth:(Y)____/(M)____/(D)____
Client's Current Location: _____	Phone #: _____
Expected Discharged Date : (Y)____/(M)____/(D)_____	

Referral Destination: COMPLETE ONLY ONE REFERRAL FORM PER DESTINATION

<input type="checkbox"/> Children's Hospital of Eastern Ontario Children's Rehabilitation Programs of Eastern Ontario - Specify: <input type="checkbox"/> Hawkesbury and District General Hospital <input type="checkbox"/> Cornwall General Hospital Community Care Access Centre: <input type="checkbox"/> Ottawa <input type="checkbox"/> Renfrew County <input type="checkbox"/> 5 Eastern Counties <input type="checkbox"/> Family/Social Service Agency - Specify: _____ <input type="checkbox"/> Head Injury Association (Ottawa-Valley) <input type="checkbox"/> Home Health Services – Specify: _____ Infant Developmental Program –Specify: <input type="checkbox"/> Renfrew <input type="checkbox"/> Eastern Counties <input type="checkbox"/> Ottawa-Carleton Association of Persons with Developmental Disabilities <input type="checkbox"/> Ontario Disability Support Program <input type="checkbox"/> Other - Specify: _____ <input type="checkbox"/> Ottawa Rotary Home	Ottawa Children's Treatment Centre <input type="checkbox"/> Behaviour Management Program of O-C <input type="checkbox"/> Child Development Service <input type="checkbox"/> Clinic for Augmentative Communication <input type="checkbox"/> Developmental and Behavioural Support Program <input type="checkbox"/> Infant Developmental Program - Ottawa <input type="checkbox"/> Eastern Counties <input type="checkbox"/> Pediatric Rehabilitation Program <input type="checkbox"/> Seating and Mobility Program <input type="checkbox"/> Special Education Program <input type="checkbox"/> Pembroke General Hospital Outpatient <input type="checkbox"/> Private Provider - Specify (contact name & email or tel:#) _____ <input type="checkbox"/> Recreation Program (Special Needs) - Specify: _____ <input type="checkbox"/> The Rehabilitation Centre: BRS Outreach <input type="checkbox"/> The Rehabilitation Centre: <input type="checkbox"/> Outpatient The Robin Easey Centre: <input type="checkbox"/> Residential <input type="checkbox"/> Day Program <input type="checkbox"/> Outreach Program <input type="checkbox"/> Renfrew County Children's Developmental Services <input type="checkbox"/> School Board-Specify: _____ Services for Children and Adults Prescott - Russell (Child Developmental Services) - Specify: <input type="checkbox"/> Hawkesbury <input type="checkbox"/> Embrun
---	--

Reason for Referral: Check all boxes that apply

Behavioural Rehabilitation <input type="checkbox"/> Assessment <input type="checkbox"/> Education <input type="checkbox"/> Treatment/Behaviour Management	Caregiver/Peer Support <input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Group	<input type="checkbox"/> Case Management
Clinical Dietitian <input type="checkbox"/> Assessment <input type="checkbox"/> Treatment <input type="checkbox"/> Education	Life Skills Training <input type="checkbox"/> Assessment <input type="checkbox"/> Treatment/Training	Long Term Living <input type="checkbox"/> 24 hour care and supervision
Medical Specialist <input type="checkbox"/> Assessment/Consult <input type="checkbox"/> Treatment <input type="checkbox"/> Medication Review <input type="checkbox"/> Follow- Up	Nursing <input type="checkbox"/> Assessment <input type="checkbox"/> Treatment <input type="checkbox"/> Education	Occupational Therapy <input type="checkbox"/> Driving Assessment <input type="checkbox"/> Equipment <input type="checkbox"/> Functional Assessment <input type="checkbox"/> Treatment <input type="checkbox"/> Education

This page completed by (Print Name): _____	Date: (Y) : (M) : (D)
--	-----------------------

This information contained herein is confidential and no unauthorized person will have access to the information without the consent of the client or substitute decision-maker.

Send or fax the completed TBI Client Referral to

TBI Clinical Coordinator/Educator, TBI Centralized Coordination and Referral Tracking Office
c/o The Rehabilitation Centre • 505 Smyth Road • Rm. 2502 • Ottawa • ON • K1H 8M2
Phone: 737-7350 ext. 5243 Fax: 739 – 3273



CHILDREN/YOUTH REFERRAL INFORMATION (<18yrs.)

REFERRAL DESTINATION: COMMUNITY / AMBULATORY (All "non inpatient)

Referring Service Provider to Complete

Client's Name: (Last) _____ (First) _____	Date of Birth(Y)____/(M)____/(D)____
Client's Current Location: _____	Phone #: _____
Expected Discharged Date : (Y)____/(M)____/(D)_____	

Reason for Referral con't.: Check all boxes that apply		
Physiatry <input type="checkbox"/> Assessment/Consult <input type="checkbox"/> Treatment <input type="checkbox"/> Medication Review <input type="checkbox"/> Follow- Up	Physiotherapy <input type="checkbox"/> Assessment <input type="checkbox"/> Treatment <input type="checkbox"/> Education	Psychology <input type="checkbox"/> Assessment(neuropsychological) <input type="checkbox"/> Assessment (mood) <input type="checkbox"/> Individual Therapy <input type="checkbox"/> Treatment <input type="checkbox"/> Education
Medical Specialist <input type="checkbox"/> Assessment/Consult <input type="checkbox"/> Treatment <input type="checkbox"/> Medication Review <input type="checkbox"/> Follow- Up	Nursing <input type="checkbox"/> Assessment <input type="checkbox"/> Treatment <input type="checkbox"/> Education	Occupational Therapy <input type="checkbox"/> Driving Assessment <input type="checkbox"/> Equipment <input type="checkbox"/> Functional Assessment <input type="checkbox"/> Treatment <input type="checkbox"/> Education
Physiatry <input type="checkbox"/> Assessment/Consult <input type="checkbox"/> Treatment <input type="checkbox"/> Medication Review <input type="checkbox"/> Follow- Up	Physiotherapy <input type="checkbox"/> Assessment <input type="checkbox"/> Treatment <input type="checkbox"/> Education	Psychology <input type="checkbox"/> Assessment(neuropsychological) <input type="checkbox"/> Assessment (mood) <input type="checkbox"/> Individual Therapy <input type="checkbox"/> Treatment <input type="checkbox"/> Education
Recreational Program <input type="checkbox"/> Social Reintegration <input type="checkbox"/> Fitness/Leisure	Respite Care <input type="checkbox"/> In-Home <input type="checkbox"/> Out of Home	Social Work <input type="checkbox"/> Individual Assessment <input type="checkbox"/> Individual Counseling <input type="checkbox"/> Family /Couple Assessment <input type="checkbox"/> Family counseling/ Support/Education <input type="checkbox"/> Resources
Speech Language Pathology <input type="checkbox"/> Cognitive Communication Assessment <input type="checkbox"/> Treatment <input type="checkbox"/> Education	In Home Support/Supportive Independent Living <input type="checkbox"/> Attendant Care <input type="checkbox"/> Home Support <input type="checkbox"/> Activities of Daily Living	
Transitional Living <input type="checkbox"/> Cognitive Assessment <input type="checkbox"/> Education <input type="checkbox"/> A.D.L./Self Care Assessment <input type="checkbox"/> Treatment/Training/Therapy	Vocational Rehabilitation <input type="checkbox"/> Assessment <input type="checkbox"/> Assistance with Job Readiness <input type="checkbox"/> Liaison/Resources	Other: (Specify)

* Mandatory Response Required: You must provide either an e-mail address [preferable], or fax #.

I authorize a referral to this facility / agency / provider as specified:			
*From (Facility):		*To (Facility):	
*Contact Name:		Contact Name:	
*Phone:	Fax:	*Phone :	Fax:
Email:		Email:	

This page completed by (Print Name): _____	Date: (Y) _____ (M) _____ (D) _____
--	-------------------------------------

This information contained herein is confidential and no unauthorized person will have access to the information without the consent of the client or substitute decision-maker.

Send or fax the completed TBI Client Referral to

TBI Clinical Coordinator/Educator, TBI Centralized Coordination and Referral Tracking Office
c/o The Rehabilitation Centre • 505 Smyth Road • Rm. 2502 • Ottawa • ON • K1H 8M2
Phone: 737-7350 ext. 5243 Fax: 739 – 3273

