PATIENT REFERRAL FORM

SPROUT (Specialized Pediatric Rehabilitation OUTpatient)

Sunny Hill Health Centre at BC Children's Hospital
4500 Oak St, Vancouver BC V6H 3N1
Phone: **(236) 427-9235** ext. **459235**
Email: **SPROUT@cw.bc.ca** ***emails are preferred***

Patient Sticker here (or add MRN/PHN below)

MRN:

PHN:

Referring physician: [BCCH Only] **Form completed by:** **Date of referral:**

Patient full name: Date of birth:

Preferred name (optional): *Preferred Pronouns (optional):*

Primary address:

Lives with: ☐ Guardian 1 Relationship: Name:

Phone #: Email:

☐ Guardian 2 Relationship: Name:

Phone #: Email:

Interpreter needed? ☐ No ☐ Yes, please specify language:

Attending school? ☐ No ☐ Yes, name: Grade:

☐ Family physician & contact info:

☐ Pediatrician & contact info:

☐ Medical history attached? ☐ Clinic notes ☐ Imaging ☐ Other:

Primary diagnosis:

Primary reason for referral: ☐ Pre-habilitation ☐ Post-op rehabilitation

☐ Post ARU ☐ Functional optimization

Detailed reason(s) for referral:

Medical/developmental needs or sensory concerns:

☐ Autism ☐ Epilepsy/Seizure

☐ Intellectual or cognitive issues:

☐ Pressure sores/skin issues:

☐ Weight bearing or other activity restrictions:

☐ Cardiac compromise:

☐ Anticipated respiratory needs:

☐ Contact precautions:

☐ Swallowing or special dietary needs:

☐ Other:

☐ Psychosocial/behavioural concerns (i.e. wandering):

☐ strategies in place?

Current mobility level

Walking: ☐ Walks independently in all settings ☐ Difficulties with long distances & uneven surfaces
☐ Uses hand-held assistive devices in most indoor settings ☐ Unable to walk, uses mobility devices

Climbing stairs ☐ Independent ☐ With railing support
☐ May manage with railing & assistance ☐ Unable to climb stairs even with railing & assistance

Other ways of mobility (i.e., rolling, crawling):

GMFCS Level (if known): ☐ I ☐ II ☐ III ☐ IV ☐ V ☐ N/A

Predictable bowel control for aquatic therapy? ☐ Yes ☐ No ☐ Uncertain ☐ N/A

Uses assistive devices: ☐ Walker ☐ Crutches/Canes
☐ Standing frame ☐ Manual wheelchair, self-propelled
☐ Power wheelchair/scooter ☐ Manual wheelchair, propelled by others
☐ Orthotics:

☐ Vision aids ☐ Hearing aids ☐ Feeding aids ☐ Dressing aids

Therapy needed, and the associated rehab goals:

☐ PT:

☐ OT:

☐ Rec/Pool Therapy*:

**Please note that for safety reasons, participants cannot have open wounds or cuts during pool therapy sessions.*

☐ SLP:

Community team & their contact info *(email, phone or fax)*:

☐ PT:
☐ OT:
☐ SLP:
☐ Orthotist:
☐ Other:

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☐ Referral received & acknowledgement sent by , on

☐ Referral reviewed for intake by , on

☐ Referral accepted ☐ Family contacted Overall approx. length of stay: week(s). Team needed & respective frequency: ☐ OT: session(s) per week, for week(s). ☐ PT: session(s) per week, for week(s). ☐ Pool: session(s) per week, for week(s). ☐ SLP: session(s) per week,for week(s).	☐ Referral declined ☐ Redirect letter sent Reason for decline:

Revised on May 2, 2024