Pediatric Outpatient Rehab Clinic Referral Guidelines

The pediatric outpatient rehab clinic is a tertiary care team that will assess and manage children/ youth with acute or chronic conditions that result in physical and/or cognitive disabilities and functional impairments. The team consists of physiatry (MD), physiotherapy, occupational therapy, speech language pathology, social work, therapy assistant, nursing coordinator, and rehab coordinator as appropriate for each individual case.

Referral Requirements: A letter of referral must be written by a Physician or Nurse Practitioner.

The Pediatric Rehab clinic works with children/youth who live with conditions such as:

- Moderate to severe brain injury
- Spinal cord injury
- Stroke
- Congenital or genetic neurological disorders (ex: cerebral palsy, spina bifida, Rett syndrome, etc.)
- Profound or progressive neuromuscular disorders (ex: DMD, SMA, etc.)

Due to capacity, we may not accept referrals for children/youth whose primary concerns are:

- Concussion
- Developmental Coordination Disorder (DCD)
- Learning disabilities
- Mental health issues
- Behavioral difficulties

Outpatient Rehab Therapy Referral

Referral to Rehab Clinic therapy only does not require an MD or NP for referral.

- The Rehab Clinic Therapists work with children/youth with functional goals who would benefit from increased therapy frequency for a finite amount of time. For example, following an acute medical event/hospitalization, following medical/ surgical procedures, for blocks of constraint induced movement therapy (CIMT), or post serial casting.

If you have questions about a referral please contact us at (306) 655-8409.

Saskatchewan Health Authority

PEDIATRIC OUTPATIENT REHAB CLINIC

Kinsmen Children's Centre

Pediatric Outpatient Rehab Team Referral Form

Please fill out and send by fax: (833) 527-3233

SECTION 1: CLIENT ID		
Last Name:	First Name:	Middle Name:
DOB:	HSN:	MRN (if applicable):
Parents/Guardians:		
Address:		
Phone # / Alt. Phone #		Email: Consent to email contact? □Y □N
Family Doctor/Pediatrician:		Languages Spoken in the home: Interpreter needed? □Y □N

SECTION 2: REASON FOR REFERRAL
Why is this child being referred? **Therapies only referral:** ☐Yes ☐No *(no MD/NP signature required)* What goal are you hoping to achieve with therapy?
Is the child being followed by current members of a healthcare or therapies team? ☐ Attached
Is this referral urgent? □ Yes □ No

Section 3: MEDICAL HISTORY/INFORMATION
List Relevant Diagnoses and Medical History: ☐ Attached

Any other relevant information (Child's preferences/interests, specific family goals/concerns)
Patient/family aware of the this referral: ☐ Yes ☐ No

Completed by: Name:	Signature:	Designation: Date: