

REFERRAL FORM



Children's Therapy Network of Manitoba

CHILD INFORMATION

Last Name: _____
 First Name: _____
 Birthdate: M ___ D ___ Y ___ Gender: _____
 Mailing Address: _____
 Physical Address: _____
 City: _____ Postal Code: _____
 PHIN #: _____ MHSC #: _____ Treaty #: _____
 Primary Language: English French
 Other: _____ Interpreter
 Child's Doctor: _____ Phone: _____
 Doctor's Address: _____
 Daycare/Preschool or School: _____

Audiology | Occupational Therapy | Physiotherapy | Speech-Language Pathology

Southern CTNM

365 Reimer Avenue, Steinbach, MB R5G 0R9
 Phone: 204-346-9359 | Toll-free: 1-800-958-3076 | Fax: 204-346-7023
 Email: CTNMcentralintake@southernhealth.ca

Contact information for other CTNM regions can be found at manitoba.ca/fs/ctnm

REFERRAL SOURCE

Name & Designation: _____
 Address: _____
 Phone: _____ Fax: _____

PARENT(S) OR GUARDIAN(S) (Please check box to indicate parent/caregiver with whom this child lives)

PARENT/CAREGIVER NAME	RELATIONSHIP	PRIMARY PHONE	ALTERNATE PHONE

IF THIS CHILD DOES NOT LIVE WITH THE LEGAL GUARDIAN, OR IS IN THE CARE OF A CHILD & FAMILY SERVICES AGENCY, THE FOLLOWING SECTION MUST BE COMPLETED

Legal Guardian: _____ Phone: _____ Fax: _____
 Agency Name: _____ Address: _____ Postal Code: _____

COMMENTS / PRESENTING CONCERNS / DIAGNOSIS (if known): _____

SERVICES REQUESTED (check all that apply):

<input type="checkbox"/> AUDIOLOGY <input type="checkbox"/> Pre <input type="checkbox"/> Post-op Evaluation <input type="checkbox"/> Risk Factors for Hearing Loss, Specify: _____ <input type="checkbox"/> Ear Infections <input type="checkbox"/> Drainage <input type="checkbox"/> Trauma to Ear or Head <input type="checkbox"/> No Speech <input type="checkbox"/> Speech Delay <input type="checkbox"/> Refer from Screening: <input type="checkbox"/> UNHS <input type="checkbox"/> Preschool <input type="checkbox"/> School <input type="checkbox"/> Parent Concerns <input type="checkbox"/> Sudden Onset/Change in Hearing <input type="checkbox"/> Second Opinion <input type="checkbox"/> Other: _____	<input type="checkbox"/> OCCUPATIONAL THERAPY <input type="checkbox"/> High Risk Infant <input type="checkbox"/> Delayed Developmental Milestones <input type="checkbox"/> Feeding <input type="checkbox"/> Risk of Choking <input type="checkbox"/> Texture Aversion <input type="checkbox"/> Other: _____ <input type="checkbox"/> Play Skills <input type="checkbox"/> Fine Motor Skills <input type="checkbox"/> Self-care Skills <input type="checkbox"/> Social Skills <input type="checkbox"/> Sensory Processing <input type="checkbox"/> Attention & Behavior	<input type="checkbox"/> PHYSIOTHERAPY <input type="checkbox"/> High Risk Infant <input type="checkbox"/> Plagiocephaly / Torticollis <input type="checkbox"/> Delayed Basic Motor Skills e.g., sitting, crawling, walking <input type="checkbox"/> Gross Motor Skills, e.g., ball skills, running, bike riding <input type="checkbox"/> Walking concerns, e.g., in-toeing <input type="checkbox"/> Balance / Coordination <input type="checkbox"/> Strength <input type="checkbox"/> Musculoskeletal, Specify: _____ <input type="checkbox"/> Other: _____	<input type="checkbox"/> SPEECH-LANGUAGE PATHOLOGY <input type="checkbox"/> Delayed Developmental Milestones Specify: _____ <input type="checkbox"/> Not talking <input type="checkbox"/> Talking in Single Words <input type="checkbox"/> Difficult to Understand <input type="checkbox"/> Difficulty Understanding Information <input type="checkbox"/> Difficulty Interacting with Others <input type="checkbox"/> Difficulty with Forming Sentences <input type="checkbox"/> Swallowing / Feeding <input type="checkbox"/> Stutters <input type="checkbox"/> Voice, e.g., strained, hoarse, breathy <input type="checkbox"/> Other: _____
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FOR OFFICE USE ONLY Date received at intake: _____	OT <input type="checkbox"/> RHA <input type="checkbox"/> RCC PT <input type="checkbox"/> RHA <input type="checkbox"/> RCC	AUD <input type="checkbox"/> RHA	Date forwarded to provider: _____	For Provider Use: 1 st attempt to contact: _____ 2 nd attempt to contact: _____ 3 rd attempt to contact: _____
	S-LP <input type="checkbox"/> RHA <input type="checkbox"/> SMD <input type="checkbox"/> DSFM <input type="checkbox"/> Other	Date received by provider: _____		