Referral for Therapy Services

Send referral to:
Intake Coordinator
Assiniboine North – Children's Therapy
Neepawa Health Unit
Box 1240 Neepawa, MB R0J 1H0
Fax: (204) 476-3552

Service(s) Requested: **Preschool Speech-Language Therapy** ☐ **Audiology** ☐
Physiotherapy ☐ **Occupational Therapy** ☐

Child's Name: ______ Male: ☐ Female: ☐ *MET #: School Use Only* ______

Birthdate: Month Day Year ______ PHIN #: ______

☐ Parent(s) ☐ Foster Family
Mother: ______ Phone:(h) (w) (c)
Father: ______ Phone:(h) (w) (c)

Mailing Address: Box Town ______ Postal Code: ______

Street Address: ______

Legal Guardian and Agency: ______ Phone: ______

Mailing Address of Agency: ______ Fax: ______

Family Doctor/Pediatrician: ______

My child is enrolled in:	Pre-school ☐	Child Care Centre ☐	Nursery School ☐	First Nation School ☐	Student Services Administrator Authorization:
	Public School ☐	Private School ☐	Home School ☐	N/A ☐	
School my child attends:		Year Eligible for School Entry:		Phone #:	

Area of concern or reason for referral (Include diagnosis if known): ☐ Developmental Assessment/Report Attached

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Referral Source: ______ **Date:** ______

Contact Person/ Mailing Address: ______ **Phone:** ______

CONSENT: Please check the box that applies	
☐ I agree to this referral for my child to receive services from a Children's Therapy Initiative (CTI) partner agency. I understand that my child's referral information will be: • Recorded at the regional CTI Intake for service coordination • Forwarded to a therapy provider service / agency • Used in collecting non-identifiable data for program evaluation ☐ Parent / legal guardian informed of above and verbal consent obtained for referral and data collection.	***Signature of Parent or Legal Guardian*** ***Date*** (Legal Guardian Signature required for children in care of any CFS agency.) ***Signature of Witness*** ***Date*** ***OR Signature of person obtaining verbal consent***

Date Received at Intake:	OT: ☐ RCC P.T. ☐ RCC SLP: ☐ RHA ☐ SMD ☐Priv. Date sent to provider agency:	Service Agency box:	File #: Letter Sent to Parents:

Consent for exchange of information

Child's Name:	Birthdate: (M/D/Y)

EXCHANGE OF INFORMATION:
Under Section 22(2)(a) of the Personal Health Information Act (PHIA) (legislation in the province of Manitoba), referring agencies and other services may exchange information for the purpose of assessment, treatment, further referral and evaluation.

I understand that the information collected and exchanged will be used for the purposes of assessment, planning, developing programs and/or strategies that will benefit the child or family. This information may be shared verbally or through written reports.

I understand that information will be exchanged with the individuals I have specified below:

Release Reports to:	Resource or Service	Name, Address & Phone
☐	Physician(s)	
☐	Public Health Nurse	
☐	Foster Parent(s)	
☐	Speech-Language Pathologist	
☐	Audiologist	
☐	Physiotherapist	
☐	Occupational Therapist	
☐	Case Manager, CdS	
☐	Day Care Centre/ Nursery School	
☐	School Division and School	
☐	Developmental Team	☐ Beautiful Plains ☐ Park West ☐ Rolling River
☐	Other:	

I do not want my reports shared with: ______________________

Any other person(s) not authorized under the Act who wish to receive information or a copy of a report are required to obtain written consent from the individual or their authorized legal representative.

In the process of obtaining/gathering information about your child, it may be necessary to provide a copy of this form to a provider listed above. By doing this, they will become aware of other service providers named on this list

Valid for the duration of program participation. Parents/ legal guardian may request changes at any time.

Signature of Parent or Legal Guardian: ______________________ Date: ____________

Signature of Witness: ______________________ Date: ____________

PRE-SCHOOL CONCERNS CHECKLIST

Please fill out for all pre-school children referred for OT, PT and/or SLP services.

Child's Name:	Birthdate: (M/D/Y)
Date:	For Office use only:

Your child has been referred for therapy services (physiotherapy, occupational therapy and/or speech/ language therapy). The following list of concerns will help us identify which therapist(s) need to be involved with your child.

Please check ☒ the statements that apply to your concerns about your child.

I am concerned that my child cannot…

- ☐ Dress him or herself
- ☐ Bath him or herself
- ☐ Feed him or herself
- ☐ Use the toilet

- ☐ Play constructively with toys
- ☐ Use building toys (e.g.: duplo or lego)
- ☐ Use scissors or pencils
- ☐ Draw and colour
- ☐ Print letters

- ☐ Roll and sit up
- ☐ Change positions
- ☐ Crawl
- ☐ Walk
- ☐ Climb

- ☐ Speak
- ☐ Be understood by others
- ☐ Understand what I say
- ☐ Follow directions

I am concerned that my child….

- ☐ Dislikes getting his or her hands messy
- ☐ Is bothered by the feel of his or her clothing
- ☐ Is distracted by sounds or light
- ☐ Has a short attention span
- ☐ Is a fussy eater
- ☐ Drools excessively
- ☐ Chews on his or her clothing or fingers
- ☐ Has trouble socializing with friends or family
- ☐ Has trouble playing in an organized way

- ☐ Loses his or her balance often
- ☐ Has trouble throwing and catching a ball
- ☐ Cannot ride a tricycle or bicycle
- ☐ Is clumsy or slow when running
- ☐ Has weak muscles
- ☐ Has joints that feel stiff

- ☐ Does not speak clearly
- ☐ Does not talk in sentences
- ☐ Uses words the wrong way
- ☐ Doesn't seem to hear me
- ☐ Is not talking as much as other children his/her age

Things I would like my child to be able to do: ______________________________

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SCHOOL CONCERNS CHECKLIST

Please fill out for all students referred for school services from the Physiotherapist and/or Occupational Therapist.

Child's Name:	Birthdate: (M/D/Y)
Date:	School:
Teacher:	Grade:

Please check ☒ the statements that apply to your concerns about this student.

has trouble with:

- ☐ Knowing which hand to use
- ☐ Holding a pencil in a typical grasp
- ☐ Forming letters and numbers
- ☐ Writing fast enough
- ☐ Copying from the board
- ☐ Following verbal instructions
- ☐ Drawing, colouring, cutting or pasting
- ☐ Participating in messy art projects
- ☐ Putting on, tying, buttoning or zipping clothes
- ☐ Using building toys (lego)
- ☐ Getting his or her hands dirty
- ☐ The feel of his or her clothing
- ☐ Being bothered by sounds or light
- ☐ Paying attention and staying focused
- ☐ Completing work
- ☐ Playing cooperatively
- ☐ Making and keeping friends
- ☐ Managing emotions
- ☐ Being in close quarters with other children
- ☐ Feeding or swallowing
- ☐ Using eye-contact as expected

The following apply:

- ☐ Has awkward physical coordination
- ☐ Trips and fall easily
- ☐ Avoids playground equipment
- ☐ Has not learned to ride a bike
- ☐ Weak running and jumping skills
- ☐ Has trouble with ball handling skills
- ☐ Avoids participation in gym
- ☐ Tires or becomes short of breath easily compared to peers
- ☐ Has poor posture
- ☐ Seems not to know the rules of games

Please rate this student's frustration level with his or her problem areas:

1 **2** **3** **4** **5**

Not noticeably frustrated — Extremely frustrated

Additional Comments: ______________________________

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