CHILDREN'S THERAPY INITIATIVE – NOR-MAN REGION
Occupational Therapy Physiotherapy Speech-Language Pathology Audiology
Box 4700
The Pas, Manitoba R9A 1R4
Fax: 204-623-7818
NOR-Man Children's Therapy Initiative partners:
Northern RHA Rehabilitation Centre for Children Society for Manitobans with Disabilities
Frontier School Division Flin Flon School Division Kelsey School Division

Exchange of Information Form

Child's Name:	**Birthdate: (day/ month/ year)**

EXCHANGE OF INFORMATION:

I give permission for the Children's Therapy Initiative providers to collect and exchange personal information and personal health information about my child with the services identified below. I understand that the information collected and distributed will be used for the purposes of assessment, planning, and developing programs for my child and used in collecting non-identifiable data for planning, program evaluation and research related to the provision of therapy services in collaboration with other service providers in Manitoba.

Name of Resource Service *Name, Address & Telephone #*

Family Doctor or Pediatrician ____
Child Development Clinic ____
Northern Regional Health Authority ____
Rehabilitation Centre for Children (RCC) ____
Society for Manitobans with Disabilities ____
Speech-Language Pathologist ____
Occupational Therapist ____
Physiotherapist ____
Child & Family Services (specify agency) ____
Service Coordinator (CDS, SMD, CFS) ____
Child Development Counselor (CDS) ____
Child Care Center, Nursery School or School ____
School Division/Education Support Services____
Foster Parents ____
Others:____
____

Any other person(s) not authorized under the Act who wishes to receive information or a copy of a report is 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 the list.
___________ *Initials*

This consent for exchange of information is valid for the duration of program participation unless otherwise specified.

______________________________ ________________ __________________________
Signature of parent or legal guardian Date Signature of Witness