BRANDON CHILDREN'S THERAPY TEAM – BRANDON
Occupational Therapy Physiotherapy Speech-Language Pathology Audiology

REFERRAL FORM

c/o Prairie Mountain Health
Therapy Services
150 McTavish Avenue East
Brandon, MB R7A 2B3
Fax: (204) 578-4870

Children's Therapy Initiative – Brandon Partners:
Prairie Mountain Health
Brandon School Division
Society for Manitobans with Disabilities
Manitoba Family Services

CHILD'S INFORMATION *(Please Print)*

Last Name _____

First Name _____

Birth Date _____ ☐**Male** ☐**Female**
(DD-MMM-YYYY)

Address (mailing & street) _____

_____

City _____ **Postal Code** _____

PHIN#_____ **MHSC#**_____

Doctor _____ **Phone**_____

Dr. Address_____

School or Child Care Centre _____**Grade**___

Language spoken at home: _____

REFERRAL SOURCE

Name & designation_____

Address_____

Phone _____ **Fax** _____

Signature_____

PARENT(S) or GUARDIAN(S)

(Please check box to indicate which parent/caregiver this child lives with)

Email Address: _____

	Parent/Caregiver name(s)	Relationship	Home Phone	Work Phone	Cell Phone
☐					
☐					

☐ I am in agreement with my child receiving the identified service(s) from the Children's Therapy Initiative providers.

PARENT/LEGAL GUARDIAN SIGNATURE _____ **DATE** _____

IF THIS CHILD RESIDES WITH SOMEONE OTHER THAN HIS OR HER 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 _____

Diagnosis (if any): _____

Presenting Problem(s)/Request for Services: _____

Previous assessment by OT/PT/SLP/AUD _____ No _____ Yes

Occupational Therapy	**Physiotherapy**	**Pre-School Speech Lang.**	**Audiology**
☐ High Risk Infant	☐ High Risk Infant	☐ High Risk Infant	☐ High Risk Infant
☐ Adaptive functioning	☐ Balance	☐ Speech sound errors	☐ Risk of progressive hearing loss
☐ Feeding	☐ Coordination	☐ Unintelligible	☐ Known Hearing Loss
☐ Fine motor	☐ Strength	☐ Language delay	☐ Both Ears
☐ Perceptual issues	☐ Flexibility	☐ Does not speak	☐ Right Ear ☐ Left Ear
☐ Sensory issues	☐ Range of motion	☐ Stuttering	☐ Suspected Hearing Loss
☐ Equipment needs	☐ Equipment needs	☐ Hearing loss	☐ Both Ears
	☐ Ambulation	☐ Feeding/Swallowing	☐ Right Ear ☐ Left Ear
		☐ Other	

Intake Date:	Referral Redirected to: _____ Date:_____

BRANDON CHILDREN'S THERAPY TEAM

CONSENT FOR: EXCHANGE OF INFORMATION

Child's Name:	Birthdate: (DD/MM/YY)

EXCHANGE OF INFORMATION:

Under Section 22(2)(a) and (g) 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 and further referral.

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

Name of Resource Service	***Name, Address & Telephone # (all information required)***	***Release Reports to:***
Family Doctor/Pediatrician	_____	☐
Psychiatrist/Psychologist	_____	☐
Public Health Nurse	_____	☐
Child Development Clinic	_____	☐
FASD Diagnostic Coordinator	_____	☐
Rehabilitation Centre for Children (RCC)	_____	☐
Speech-Language Pathologist	_____	☐
Audiologist	_____	☐
Physiotherapist	_____	☐
Occupational Therapist	_____	☐
Service Coordinator (CdS, SMD, CFS)	_____	☐
Child Care Centre/Nursery School	_____	☐
School Division/School	_____	☐
Teacher of the Deaf & Hard of Hearing	_____	☐

Other (please provide name, address and telephone number):

_____

_____

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.

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.

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: _____ Date: _____

Revised April 2015