Interlake Children's Therapy Initiative
Referral for Children's Therapy Services

Referral Source:

Date of Referral: ______________________ Box/Street Address: ______________________

Referral Source: ______________________ Town/City: ______________________

Title / Program: ______________________ Postal Code: ______________________

Phone: ______________________ Fax: ______________________

Service(s) Requested:

☐ Occupational Therapy ☐ Physiotherapy ☐ Speech-Language Pathology

REFERRAL:

☐ Male MHSC #: ______________

CHILD'S NAME: First ______________ Last ______________ ☐ Female PHIN #: ______________

Date of Birth: Day ________ Month __________ Year ________ MET #: ______________

Box / Street Address: ____

Town/City: ______________________________ Postal Code: ______________

Child Resides With: ☐ Parent(s) / Guardian(s) ☐ Foster Parents ☐ Voluntary Placement ☐ Extended Family

Mother: ______________________ **Phone:** Home: __________ Work: __________ Cell: __________

Father: ______________________ **Phone:** Home: __________ Work: __________ Cell: __________

If Address is different than above:

☐ Mother ☐ Father: ____

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: ______________________ Agency: ______________________

Box / Street Address: ____

Town/City: ______________________________ Postal Code: ______________

Phone: ______________________ Fax: ______________________

DIAGNOSIS and/or REASON for REFERRAL:

Diagnosis (if available): ____

Reason for Referral: ____

☐ Report Attached ☐ Concerns Checklist Completed (see back)

Additional Information:

Doctor/Pediatrician: ______________________ Address: ______________________ Phone: ______________

Address: ______________________ Town/City ______________________ Postal Code ______________

Child Attends: ☐ child care agency ☐ home daycare ☐ nursery program ☐ public school ☐ private school ☐ other __________

Name of agency: ______________________ Address ______________________ Phone: ______________

Languages Spoken by Parents: ☐ English ☐ French ☐ Other (specify) ______________________

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 (Required for children in care of any CFS agency.) ______________________ ______________ Signature of Witness — Date Or Signature of person obtaining verbal consent.

Interlake Children's Therapy Initiative

Concerns Checklist

Referral:

Child's Name: ______________________ Date of Birth: ______________________

Referral Source: ______________________ Date of Referral: ______________________

Referral source to complete the section below for each service requested for the child.

SPEECH-LANGUAGE PATHOLOGY:

Language
- ☐ Difficulty comprehending directions
- ☐ Delayed conceptual development
- ☐ Not Talking
- ☐ Talking in single words
- ☐ Talking in 2 word utterances
- ☐ Difficulty expressing ideas verbally
- ☐ Confuses word order in sentences
- ☐ Immature grammatical structures

Dysfluency / Stuttering
- ☐ Exhibits "choppy" speech
- ☐ Speaks at abnormal rate
- ☐ Has difficulty in "starting" to speak
- ☐ Repeats sound, words or phrases
- ☐ Hesitates frequently when speaking

Speech
- ☐ Intelligible / noticeable sound errors
- ☐ Intelligible if listener knows topic
- ☐ Unintelligible to people who are not family
- ☐ Unintelligible
- ☐ Gestures understood

Voice
- ☐ Sounds hoarse
- ☐ Sounds breathy
- ☐ Sounds too loud or too soft
- ☐ Sounds nasal
- ☐ Sounds denasal
- ☐ Sounds too high or too low
- ☐ Sounds monotone

Associated Difficulties
- ☐ Limited eye contact
- ☐ Difficulty interacting socially with peers and/or adults
- ☐ Immature play behaviors

Additional Information:

OCCUPATIONAL THERAPY:

☐ High Risk Infant (specify) ______________________

☐ Delayed development of milestones ______________________

☐ Feeding concerns ☐ At risk for choking ☐ Texture aversions ☐ Saliva control

Concerns with: ☐ Adaptive play skills ☐ Fine motor skills ☐ Attention and organization

☐ Self-care skills ☐ Peer interactions ☐ Sensory processing

☐ Environmental access needs ☐ Home ☐ School ☐ Other (specify) ______________________

Additional Information:

PHYSIOTHERAPY:

☐ High Risk Infant (specify) ______________________

☐ Delayed development of milestones ______________________

Concerns with: ☐ Gross motor coordination ☐ Balance ☐ Strength

☐ Walking ☐ Running ☐ Throwing and catching a ball ☐ Riding a trike or bike

Additional Information:

Forward Form to:

INTERLAKE CTI – Central Intake
201 – 237 Manitoba Ave.
Selkirk, MB R1A 0Y4
Fax: (204) 785-9240
Intake Assistant - Marian Lewis
Phone: (204) 785-7730

A COMPLETED REFERRAL WILL INCLUDE
- Full name of child
- Child's Date of Birth
- A legible diagnosis
- **Consent signed by parent or legal guardian and witness or signature of person obtaining verbal consent**.
- Full name, address, postal code and contact numbers for next of kin or home where child resides, if applicable
- Full name, address, postal code and contact numbers for legal guardian, if applicable
- Full name, address, postal code and contact numbers for referral source

Completed referrals help us process your referrals in a timely manner. Thank you.