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| Please fill out this form in full and send it to: Parkland Children’s Therapy Initiative- Central Intake, Dauphin Regional Health Centre, 625 3rd Street S.W., Dauphin, MB. R7N 1R7, Phone (204) 638-2164 Fax (204) 629-3430 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ***Request for:*   Audiology  Occupational Therapy**  **Physiotherapy  Speech-Language Pathology** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **CHILD’S INFORMATION** | Child’s Name: | | | First:       Last: | | | | | | | | | | | | | | | | Male: | | | PHIN #:  MHSC #: | | |  | |
| Female: | | |  | |
| Date of Birth: | | | Day:       Month:       Year : | | | | | | | | | | | | | | | | MET # (school use) : | | | |  | | | |
| Doctor or Pediatrician: | | | |  | | | | | | | | | | | | | | | Phone: |  | | | | | | |
| **CONTACT INFORMATION** | ***Child Resides With:*** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | | | | | | | | | Phone #s: Home: | | | | | | Work: | | | | | | | Cell: | | | |
| Relationship to Child: | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| Name: | | | | | | | | | | Phone #s: Home: | | | | | | Work: | | | | | | | Cell: | | | |
| Relationship to Child: | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| Address: | | Street: | | | | | | | | Box: | | | | | | Town: | | | | | | | PC: | | | |
| **LEGAL GUARDIAN** | ***Child’s Legal Guardian if different from above:*** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Legal Guardian / Agency Name: | | | | | | | | | | | | | | | | | | | Phone: | | | | | | | |
| Address: | | | | | | | | | | | | | | | | | | | Fax: | | | | | | | |
| **DIAGNOSIS/CONCERN** | Diagnosis (if available): | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Reason for referral: | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Additional Information Attached:  N/A  Report attached  Concerns checklist attached | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **REFERRAL SOURCE** | PRINT Name and Designation of person referring: | | | | |  | | | | | | | | | | | | | | | | | | Date: | | | |
| Address: |  | | | | | | | | | | | | | Phone: | | |  | | | | | | Fax: | | |  |
| **CHILD IS ENROLLED IN** | N/A | child care facility | | | | | nursery program | | | CSS | | | School: | | | public | | | private | | | home | | | First Nation | | |
| Name & address of school or facility: | | | | | | |  | | | | | | | | | | | | | | | | Phone: | | | |
| **CONSENT** | **CONSENT: Please check the box that applies**  I agree to this referral for my child to receive services from the Parkland Children’s Therapy Initiative (CTI) partner agency.  I understand that my child’s referral information will be:   * Recorded at the Parkland 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*** | | | | | | | | | | | | | | | | |
| **FOR OFFICE**  **US E ONLY** | Date Received at Intake: | | | | | | Date Sent to Provider: | | | | | | | | | | | | | Date Letter Sent  to Referral Source: | | | | Date Letter Sent  to Parents/L.G.: | | | |
| OT | |  | | | Audio | |  | | | | | |
| PT | |  | | | SLP | |  | | | | | |

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| **Concerns Checklist** | | | |
| **Child’s Name:** | | **Birthdate: (D/M/YY)** | |
| ***Referral source to complete the sections below for each area of service child is being referred to:*** | | | |
| AUDIOLOGY | | | |
| High-risk infant (Please specify): | | | |
| Baseline screening / assessment | | | |
| At risk for progressive hearing loss (Please specify): | | | |
| Known hearing loss | both ears | | 1 ear – R  L |
| Suspected hearing loss | both ears | | 1 ear – R  L |
| Previous testing results attached | Date of test: | | Done by: |
| **Additional Information:** | | | |
| SPEECH-LANGUAGE PATHOLOGY | | | |
| High-risk infant  Delayed speech development  Cleft lip & palate | | | |
| Not talking  Talking in single words  Talking in 2-word phrases  Immature grammar | | | |
| Difficulty understanding information  Difficulty interacting with others | | | |
| Stutters (3 or more repetitions of word or sound)  Child avoids speaking | | | |
| Child has difficulty producing sounds and words  Child is difficult to understand | | | |
| **Additional Information:** | | | |
| OCCUPATIONAL THERAPY | | | |
| High-risk infant | | | |
| 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 | | | |
| 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:** | | | |

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| Consent for Exchange of Information | | | | | | | | | | | | | | | | | | | | | | |
| Child’s Name: | | |  | | | | | | | | | | | | Birthdate: (D/M/Y) | | |  | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| For service coordination, I give permission for the Children’s Therapy service partner(s) to exchange personal information and personal health information about my child with the services identified below.  Personal information is protected under *The Freedom of Information and Protection of Privacy Act* (FIPPA). Personal health information is protected under *The Personal Health Information Act* (PHIA). If you have any questions about the collection, use or disclosure of your personal information or your personal health information, please contact (the Parkland Regional Health Authority Privacy Officer at (204) 638-2166.). | | | | | | | | | | | | | | | | | | | | | | |
| Name of Resource or Service | | | | | | | | | ***Name, Address & Telephone #*** | | | | | | | | | | ***Release Reports to:*** | | |
| Family Doctor | |  | | | | | | | | | | | | | | | | | |  | |
| Pediatrician | |  | | | | | | | | | | | | | | | | | |  | |
| Medical Specialist | | | |  | | | | | | | | | | | | | | | |  | |
| Child Development Clinic | | | | |  | | | | | | | | | | | | | | |  | |
| Foster Parent(s) | | | |  | | | | | | | | | | | | | | | |  | |
| Regional Health Authority (RHA) - Therapy Services | | | | | | | | | | | |  | | | | | | | |  | |
| RHA – Public Health / Families First | | | | | | |  | | | | | | | | | | | | |  | |
| Society for Manitobans with Disabilities (SMD) | | | | | | | | | | |  | | | | | | | | |  | |
| Rehabilitation Centre for Children (RCC) | | | | | | | |  | | | | | | | | | | | |  | |
| St. Amant Centre | | | |  | | | | | | | | | | | | | | | |  | |
| Family Services & Housing (FSH) Children’s Special Services (CSS) | | | | | |  | | | | | | | | | | | | | |  | |
| Child Care Centre | | | |  | | | | | | | | | | | | | | | |  | |
| Nursery School | | | |  | | | | | | | | | | | | | | | |  | |
| School and/or School Division | | | | | | |  | | | | | | | | | | | | |  | |
| Educational Consultant (Hard of hearing, Vision) | | | | | | | | | |  | | | | | | | | | |  | |
| Hospital |  | | | | | | | | | | | | | | | | | | |  | |
| Other: |  | | | | | | | | | | | | | | | | | | |  | |
| Other: |  | | | | | | | | | | | | | | | | | | |  | |
| Other: |  | | | | | | | | | | | | | | | | | | |  | |
| **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 purpose of assessment, planning developing programs and/or strategies that will benefit my child or family. This information may be shared verbally or through written reports.**  **I understand that this consent to the exchange of information is valid as long as my child receives therapy from a CTI partner and that I can have changes made to this consent at any time.** | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | |  |  | |  |  | | | |
| *Signature of Parent or Legal Guardian* | | | | | | | | | | | | | Date | | | | *Signature of Witness* | | | |

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