**CHILD’S INFORMATION *(Please Print)***

**PROMISE Years Referral Form for Therapy Services**



**Name**

Mail or Fax to the division office nearest to your home address:

Fort la Bosse SD Turtle Mountain SD

Box 1420 Box 280

Virden MB R0M 2C0 Killarney MB R0K 1G0

Fax (204) 748-2436 Fax (204) 523-7269

Prairie Spirit SD Southwest Horizon SD

Box 130 Box 370

Swan Lake MB R0G 2S0 Melita MB R0M 1L0

Fax (204) 836-2356 Fax (204) 522-3776

**Birth Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Male** **Female**

(DD-MMM-YYYY)

**MHSC#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PHIN#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address (mailing & street)**

**City**

**Postal Code**

**Email address**

**REFERRAL SOURCE**

**Name & Designation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Doctor** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CHILDREN’S THERAPY INITIATIVE – CENTRAL REGION**

Occupational Therapy Physiotherapy Speech-Language Pathology Audiology

**REFERRAL FORM**

**102-143 Main Street**

**School or Child Care Centre** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Language spoken at home:** **English**

**Other (Please specify)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARENT(S) or GUARDIAN(S)** (Please check box to indicate which parent/caregiver this child lives with and circle the preferred contact number)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Parent/Caregiver name(s)** | **Relationship** | **Home Phone** | **Work Phone** | **Cell Phone** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

 **CONSENT:** I consent to my child receiving the identified service(s) from the Children’s Therapy Initiative providers.

I understand that my child’s information will be:

- Recorded at the regional CTI intake for service coordination

- Forwarded to a therapy provider/service agency

- Used in collecting non-identifiable date for program evaluation

**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 \_\_\_\_\_\_\_\_\_

Issued – January 2011

Diagnosis (if any): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous assessment by OT/PT/SLP/AUD\_\_\_\_\_\_ No\_\_\_\_\_\_ Yes

Presenting Problems:/Request for Services: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check the appropriate box(s):

|  |  |  |  |
| --- | --- | --- | --- |
| * **Speech-Language Therapy** | * **Occupational Therapy** | * **Physiotherapy** | **Other Referrals Made** |
| * Cleft Lip & Palate * Not Talking * Talking in Single Words * Immature Grammar * Difficulty Understanding Information * Difficulty Interacting with Others * Stutters (3 or more repetitions of Word or sound) * Avoids Speaking * Difficult to Understand * Delayed Developmental Milestones * Hearing loss | * Feeding Concerns   + At Risk for choking   + Texture aversions   + Saliva control * Adaptive Play Skills * Fine Motor Skills (explain pls) * Attention and Organization * Self-Care Skills * Peer Interactions * Sensory Processing * Environmental Access Needs * Delayed Developmental Milestones * Equipment Needs * Visual perceptual challenges | * Gross Motor Coordination * Balance * Strength * Walking * Running * Throwing and Catching a ball * Riding a Trike or Bike * Delayed Developmental Milestones | * Child Development Clinic * Children’s disabilities * Child & Family Services * Audiology * Other |

Referral redirected to:

Date:

Issued – January 2011