

Referral Form

Children and Youth Rehabilitation Services

CHILD INFORMATION

Last Name: _____
 First Name: _____
 Birth Date: mm dd year Male Female
 PHIN# _____ MHSC: _____
 Mailing Address: _____
 City: _____ Postal Code: _____
 Language(s) spoken at home _____
 Services Preferred: English French Interpreter required
 Child's Doctor: _____ Fax #: _____
 Daycare/Preschool Attending: _____
 School attending or will be attending: _____

CTI-Central
 Box 2000 Station Main
 Winkler, MB R6W 1H8
Phone: 1-204-331-8833
Toll Free: 1-800-958-3706
Fax: 1-204-331-8913



South Eastman CTI
 365 Reimer Ave
 Steinbach, MB R5G 0R9
Phone: 1-204-326-6411,
 extension 2109
Fax: 1-204-320-4176

REFERRAL SOURCE

Name & Designation: _____
 Signature: _____
 Address: _____
 Phone: _____ Fax: _____
 Date of referral: _____

PARENT(S) OR GUARDIAN(S) (Please check box to indicate which parent/caregiver this child lives with)

	Name	Relationship	Home Phone	Work Phone	Cell Phone
<input type="checkbox"/>					
<input type="checkbox"/>					

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

PARENT/LEGAL GUARDIAN SIGNATURE: _____ **Date:** _____

If child does not reside with the 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 known: _____

REASON FOR REFERRAL: (CHECK ALL THAT APPLY)

AUDIOLOGY	OCCUPATIONAL THERAPY	PHYSIOTHERAPY	SPEECH-LANGUAGE PATHOLOGY
<input type="checkbox"/> Known hearing loss R L <input type="checkbox"/> Ear infections/fluid <input type="checkbox"/> Family history childhood loss <input type="checkbox"/> Vertigo/Dizziness <input type="checkbox"/> Neonatal risk factors <input type="checkbox"/> Syndrome associated with hearing loss: _____ <input type="checkbox"/> Pre or Post Op Evaluation <input type="checkbox"/> Speech delay <input type="checkbox"/> Failed screening <input type="checkbox"/> Tinnitus <input type="checkbox"/> Trauma to ear or head <input type="checkbox"/> Sudden change in hearing <input type="checkbox"/> Requires hearing aid <input type="checkbox"/> Requires earmolds/swimmolds <input type="checkbox"/> Parental concern	<input type="checkbox"/> High risk infant <input type="checkbox"/> Delayed developmental milestones <input type="checkbox"/> Feeding concerns <ul style="list-style-type: none"> <input type="checkbox"/> At risk for choking <input type="checkbox"/> Texture aversion <input type="checkbox"/> Saliva control <input type="checkbox"/> Delayed fine motor skills <input type="checkbox"/> Sensory processing <input type="checkbox"/> Attention and organizing <input type="checkbox"/> Self-help skills <input type="checkbox"/> Environmental access needs <input type="checkbox"/> Adaptive play skills <input type="checkbox"/> Difficult peer interactions <input type="checkbox"/> Other: _____	<input type="checkbox"/> High risk infant <input type="checkbox"/> Delayed developmental milestones <input type="checkbox"/> Torticollis <ul style="list-style-type: none"> <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Plagiocephaly <input type="checkbox"/> Balance <input type="checkbox"/> Strength <input type="checkbox"/> Walking/Running <input type="checkbox"/> Coordination <input type="checkbox"/> Musculoskeletal concerns Specify: _____ <input type="checkbox"/> Other: _____	<input type="checkbox"/> High risk infant <input type="checkbox"/> Delayed developmental milestones <input type="checkbox"/> Talking in single words <input type="checkbox"/> Not talking <input type="checkbox"/> Avoids speaking <input type="checkbox"/> Sentence structure concerns <input type="checkbox"/> Difficulty understanding information <input type="checkbox"/> Difficulty interacting with others <input type="checkbox"/> Stuttering <input type="checkbox"/> Voice <input type="checkbox"/> Swallowing concerns <input type="checkbox"/> Other: _____

Additional Information: _____

FOR OFFICE USE ONLY Date received at intake: _____	OT <input type="checkbox"/> RHA <input type="checkbox"/> RCC	AUD <input type="checkbox"/> RHA	Date forwarded to provider: _____	For Provider Use: 1 st attempt to contact: _____ 2 nd attempt to contact: _____ 3 rd attempt to contact: _____
	PT <input type="checkbox"/> RHA <input type="checkbox"/> RCC		Date received by provider: _____	
	S-LP <input type="checkbox"/> RHA <input type="checkbox"/> SMD <input type="checkbox"/> DSFM <input type="checkbox"/> Other			