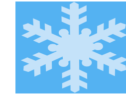
Referral Form
Children and Youth Rehabilitation Services

☐ CTI-Central
Box 2000 Station Main
Winkler, MB R6W 1H8
Phone: 1-204-331-8833
Toll Free: 1-800-958-3076
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

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: ____________________________

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
☐					
☐					

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**
☐Known hearing loss R L ☐Ear infections/fluid ☐Family history childhood loss ☐Vertigo/Dizziness ☐Neonatal risk factors ☐Syndrome associated with hearing loss:________________ ☐Pre or Post Op Evaluation ☐Speech delay ☐Failed screening ☐ Tinnitus ☐ Trauma to ear or head ☐ Sudden change in hearing ☐ Requires hearing aid ☐ Requires earmolds/swimmolds ☐Parental concern	☐High risk infant ☐Delayed developmental milestones ☐Feeding concerns o At risk for choking o Texture aversion o Saliva control ☐Delayed fine motor skills ☐Sensory processing ☐Attention and organizing ☐Self-help skills ☐Environmental access needs ☐Adaptive play skills ☐Difficult peer interactions ☐Other:	☐High risk infant ☐Delayed developmental milestones ☐Torticollis o Right o Left ☐Plagiocephaly ☐Balance ☐Strength ☐Walking/Running ☐Coordination ☐Musculoskeletal concerns Specify:_____________________ ☐Other:	☐ High risk infant ☐ Delayed developmental milestones ☐ Talking in single words ☐ Not talking ☐ Avoids speaking ☐ Sentence structure concerns ☐ Difficulty understanding information ☐ Difficulty interacting with others ☐ Stuttering ☐ Voice ☐ Swallowing concerns ☐Other:

Additional Information: ____

____

FOR OFFICE USE ONLY Date received at intake:	OT ☐ RHA ☐ RCC PT ☐ RHA ☐ RCC	AUD ☐ RHA	Date forwarded to provider:	For Provider Use: 1st attempt to contact:__________ 2nd attempt to contact:__________ 3rd attempt to contact:__________
	S-LP ☐ RHA ☐ SMD ☐ DSFM ☐ Other		Date received by provider:	