**NOR-MAN REGION**

**CHILDREN’S THERAPY INITIATIVE – NOR-MAN REGION**

Occupational Therapy Physiotherapy Speech-Language Pathology Audiology



**Rehabilitation Services- The Pas Health Complex**

**67 1st Street West, Box 240**

**The Pas, Manitoba R9A 1K4**

**Phone: 204-623-9223 Fax: 204-623-2487**

**NOR-Man Children’s Therapy Initiative partners:**

Northern RHA Rehabilitation Centre for Children Society for Manitobans with Disabilities Frontier School Division Flin Flon School Division Kelsey School Division

**Exchange of Information Form**

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| --- | --- |
| **Child’s Name:** | **Birthdate: (day/ month/ year)** |

***EXCHANGE OF INFORMATION:***

I give permission for the Children’s Therapy Initiative providers to collect and exchange personal information and personal health information about my child with the services identified below. I understand that the information collected and distributed will be used for the purposes of assessment, planning, and developing programs for my child and used in collecting non-identifiable data for planning, program evaluation and research related to the provision of therapy services in collaboration with other service providers in Manitoba.

# Name of Resource Service Name, Address & Telephone #

Family Doctor or Pediatrician Child Development Clinic Northern Regional Health Authority Rehabilitation Centre for Children (RCC) \_ Society for Manitobans with Disabilities \_ Speech-Language Pathologist \_ Occupational Therapist Physiotherapist

Audiology \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child & Family Services (specify agency) Service Coordinator (CDS, SMD, CFS) \_ Child Development Counselor (CDS)

Child Care Center, Nursery School or School School Division/Education Support Services Foster Parents Others*:* \_

Any other person(s) not authorized under the Act who wishes to receive information or a copy of a report is required to obtain written consent from the individual or their authorized legal representative.

In the process of obtaining/gathering information about your child, it may be necessary to provide a copy of this form to a provider listed above. By doing this, they will become aware of other service providers named on the list.

# Initials

This consent for exchange of information is valid for the duration of program participation unless otherwise specified.

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| Signature of parent or legal guardian | Date | Signature of Witness |