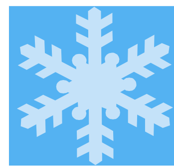

Thompson Northern Region
CENTRAL INTAKE – Children's Therapy Referral Form

Northern Regional Health Authority
867Thompson Dr. South, Thompson MB R8N 1Z4
Phone (204) 677-5385 Fax (204) 778-1453

Audiology
Physiotherapy
Occupational Therapy
Speech-Language Pathology

CHILDS INFORMATION

LAST NAME ______________________

FIRST NAME ______________________

BIRTH DATE D ____ M ____ Y ____ ☐ MALE ☐ FEMALE

ADDRESS ______________________

CITY ____________ PC ____________

PHIN ____________ MHSC# ____________

MEd# (School Use Only) ______ SCHOOL: ______ GRADE: ______

Primary Language ENGLISH ___ CREE ___ DENE ___ FRENCH ___ ASL ___

INTERPRETER ☐ CREE ☐ DENE ☐ ASL ☐ OTHER ___________

FAMILY DOCTOR/PED ______________________

DOCTOR'S PHONE ______________________

DOCTOR'S ADDRESS ______________________

REFERRAL SOURCE

NAME & DESIGNATION ______________________

SIGNATURE ______________________

ADDRESS ______________________

PHONE ____________ FAX ____________

HAS THE FAMILY/CAREGIVER BEEN INFORMED ABOUT THIS REFERRAL? ☐ YES ☐ NO

DO YOU WANT A COPY OF THE REPORT AND RECOMMENDATIONS? ☐ YES ☐ NO

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

	PARENT/CAREGIVER NAME	RELATIONSHIP	HOME PHONE	WORK PHONE	CELL PHONE
☐					
☐					

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 ____________ PC ____________

DIAGNOSIS (If known) ______________________

OTHER REFERRALS MADE
(That require a different method or referral form other than this CTI form)

- ☐ Paediatrics
- ☐ Children's Disability Services-CdS
- ☐ Manitoba Possible
- ☐ Child Welfare Agency ____________
- ☐ Other (Specify) ____________

REASON FOR REFERRAL
(Check all that apply)

☐ AUDIOLOGY

- ☐ Parental Concerns
- ☐ Ear Infections
- ☐ Family History of Childhood Hearing Loss
- ☐ Speech Delay
- ☐ No Speech
- ☐ Failed School Screening(Provide School Name) ____________
- ☐ Neonatal Risk Factors for Hearing Loss ____________
- ☐ Syndrome Associated with Hearing Loss ____________
- ☐ Visual Impairment
- ☐ Auditory Processing Assessment (Child must be 8 years or older)
- ☐ Second Opinion (Include background info & previous audio results) ____________

☐ OCCUPATIONAL THERAPY

- ☐ Feeding Concerns
  - ☐ At Risk for Choking
  - ☐ Texture Aversions
  - ☐ Saliva Control
- ☐ Adaptive Play Skills
- ☐ Fine Motor Skills
- ☐ Attention and Organization
- ☐ Self-Care Skills
- ☐ Peer Interactions
- ☐ Sensory Processing
- ☐ Environmental Access Needs
- ☐ Visual-motor skills
- ☐ Visual – perceptual skills
- ☐ Delayed Developmental Milestones

☐ PHYSIOTHERAPY

- ☐ Gross Motor Coordination
- ☐ Balance
- ☐ Strength
- ☐ Walking
- ☐ Running
- ☐ Throwing and Catching a Ball
- ☐ Riding a Trike or Bike
- ☐ Delayed Developmental Milestones
- ☐ Plagiocephaly / Torticollis
- ☐ Musculoskeletal Concerns, Specify ____________
- ☐ Orthopaedic Concerns, Specify ____________

☐ SPEECH-LANGUAGE PATHOLOGY

- ☐ Cleft Lip & Palate
- ☐ Not Talking
- ☐ Talking in Single Words
- ☐ Immature Grammar
- ☐ Difficulty Understanding Information
- ☐ Difficulty Interacting with Others
- ☐ Stutters (3+ Repetitions of Word/Sound)
- ☐ Avoids Speaking
- ☐ Difficult to Understand
- ☐ Delayed Developmental Milestones

COMMENTS

We will endeavor to coordinate appointments as best as possible, although we cannot make any guarantees.

Revised: Dec 1, 2020

DATE RECEIVED	INTAKE USE ONLY			
	Audiology	**Occupational Therapy**	**Physiotherapy**	**Speech Language Pathology**
	☐ NRHA(East) ☐ MB. P ☐ MFNERC	☐ NRHA(East) ☐ OTC/RCC ☐ SDML ☐ MFNERC	☐ NRHA(East) ☐ OTC/RCC ☐ SDML ☐ MFNERC	☐ NRHA(East) ☐ SDML ☐ MFNERC ☐ DSFM ☐ FSD Area 1 ☐ OTC/MB. P ☐ OTC/RCC ☐ Speechworks/JPI

TO AVOID DELAYS IN YOUR PATIENT'S CARE PLEASE COMPLETE ALL SECTIONS OF THIS FORM BEFORE SUBMITTING