CHILD INFORMATION

Last Name: _____

First Name: _____

Birthdate: M D Y Gender: _____

Mailing Address: _____

Physical Address: _____

City: _____ Postal Code: _____

PHIN #: _____ MHSC #: _____ Treaty #: _____

Primary Language: ☐ English ☐ French

☐ Other: _____ ☐ Interpreter

Child's Doctor: _____ Phone: _____

Doctor's Address: _____

Daycare/Preschool or School:

Referral Form

Audiology Occupational Therapy Physiotherapy Speech-Language Pathology

Prairie Mountain Children's Therapy Network of Manitoba

Catchment Outside of Brandon, MB:
DRHC
625 3rd Street SW
Dauphin, MB
R7N 1R7

Catchment of Brandon, MB:
BRHC (A1)
150 McTavish Ave East
Brandon, MB
R7A 2B3

Phone: 204-622-2991
Fax: 204-629-3464
Email: childrenstherapy@pmh-mb.ca

REFERRAL SOURCE

Name & Designation: _____

Address: _____

Phone: Fax:

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

	PARENT/CAREGIVER NAME	RELATIONSHIP	PRIMARY PHONE	ALTERNATE PHONE
☐				
☐				

IF THIS CHILD DOES NOT LIVE 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 _____

COMMENTS / PRESENTING CONCERNS / DIAGNOSIS (if known):

Services Requested (check all that apply):

☐ AUDIOLOGY	☐ OCCUPATIONAL THERAPY	☐ PHYSIOTHERAPY	☐ SPEECH-LANGUAGE PATHOLOGY
☐ Pre ☐ Post-op Evaluation	☐ High Risk Infant	☐ High Risk Infant	☐ Delayed Developmental Milestones
☐ Risk Factors for Hearing Loss, Specify: _____	☐ Delayed Developmental Milestones	☐ Plagiocephaly / Torticollis	Specify: _____
☐ Ear Infections ☐ Drainage	☐ Feeding	☐ Delayed Basic Motor Skills	☐ Not talking
☐ Trauma to Ear or Head	☐ Risk of Choking	e.g., sitting, crawling, walking	☐ Talking in Single Words
☐ No Speech ☐ Speech Delay	☐ Texture Aversion	☐ Gross Motor Skills, e.g., ball	☐ Difficult to Understand
☐ Refer from Screening:	☐ Other: _____	skills, running, bike riding	☐ Difficulty Understanding Information
☐ UNHS ☐ Preschool ☐ School	☐ Play Skills	☐ Walking concerns, e.g., in-toeing	☐ Difficulty Interacting with Others
☐ Parent Concerns	☐ Fine Motor Skills	☐ Balance / Coordination	☐ Difficulty with Forming Sentences
☐ Sudden Onset/Change in Hearing	☐ Self-care Skills	☐ Strength	☐ Swallowing / Feeding
☐ Second Opinion	☐ Social Skills	☐ Musculoskeletal, Specify: _____	☐ Stutters
☐ Other:	☐ Sensory Processing		☐ Voice, e.g., strained, hoarse, breathy
	☐ Attention & Behavior	☐ Other:	☐ Other:

FOR OFFICE USE ONLY

Date received at Intake:	Audiology: OT: PT: SLP:

This form is available in alternate formats upon request. .