CHILD'S INFORMATION

LAST NAME _____

FIRST NAME _____

BIRTH DATE _____ ☐ **MALE** ☐ **FEMALE**
(DD-MMM-YYYY)

ADDRESS _____

CITY _____ **POSTAL CODE** _____

PHIN# _____ **MHSC#** _____

MET# (School Use Only) _____

PRIMARY LANGUAGE _____

DIAGNOSIS (If Known) _____

FAMILY DOCTOR/PEDIATRICIAN _____

DOCTOR'S PHONE _____

NORTH EASTMAN CHILDREN'S THERAPY INITIATIVE
Audiology Occupational Therapy Physiotherapy Speech-Language Pathology

REFERRAL FORM

Box 550 Beausejour, Manitoba R0E 0C0
Phone: (204) 268-7465 Fax: (204) 268-2153

NORTH EASTMAN CHILDREN'S THERAPY INITIATIVE PARTNER AGENCIES:
Interlake Eastern Regional Health Authority
Rehabilitation Centre for Children
Society for Manitobans with Disabilities - Outreach Therapy Program
Frontier School Division Sunrise School Division Whiteshell School Division

REFERRAL SOURCE

Name and Designation _____

Signature _____

Address _____

City _____ Postal Code _____

Phone _____ Fax _____

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	EMAIL ADDRESS

☐ Parent(s)/Legal Guardian(s) have been informed and are in agreement with this referral

PARENT/LEGAL GUARDIAN SIGNATURE _____ **DATE** _____

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 _____ Postal Code _____

REASON FOR REFERRAL (Check all that apply)

☐ **AUDIOLOGY (Children 0-21 Yr)**
- ☐ Neonatal Risk Factors for Hearing Loss
- ☐ Syndrome Associated with Hearing Loss
- ☐ Parental Concern
- ☐ Ear Infections
- ☐ Family History of Childhood Hearing Loss
- ☐ Speech Delay/No Speech
- ☐ Failed School Screening

☐ **SPEECH-LANGUAGE PATHOLOGY**
- ☐ Cleft Lip & Palate
- ☐ Not Talking
- ☐ Talking in Single Words
- ☐ Immature Grammar
- ☐ Difficulty Understanding Information
- ☐ Difficulty Interacting with Others
- ☐ Stutters (3 or More Repeats of Word/Sound)
- ☐ Avoids Speaking
- ☐ Difficult to Understand
- ☐ Delayed Developmental Milestones

☐ **OCCUPATIONAL THERAPY**
- ☐ Feeding Concerns
  - ☐ At Risk for Choking
  - ☐ Texture Aversions
  - ☐ Saliva Control
- ☐ Delayed Adaptive Play Skills
- ☐ Delayed Fine Motor Skills
- ☐ Decreased Attention Organization
- ☐ Difficulty with Self-Care Skills
- ☐ Difficulty with Peer Interactions
- ☐ Sensory Processing Concerns
- ☐ Environmental Access Needs
- ☐ Delayed Developmental Milestones

☐ **PHYSIOTHERAPY**
- ☐ Decreased Coordination
- ☐ Decreased Balance
- ☐ Frequent Falls
- ☐ Decreased Strength
- ☐ Limited Joint Range of Motion
- ☐ Not Walking/Walks Awkwardly
- ☐ Difficulty Running
- ☐ Difficulty Going Up/Down Stairs
- ☐ Difficulty Throwing/Catching Ball
- ☐ Plagiocephaly/Torticollis
- ☐ Delayed Developmental Milestones
- ☐ Musculoskeletal Concerns, Specify

COMMENTS:

Date referral received: _____