CHILD'S INFORMATION

Last Name _____

First Name _____

Birth Date _____ ☐**Male** ☐**Female**
(DD-MMM-YYYY)

Address (Box #) _____

City _____ **Postal Code** _____

PHIN#_____ **MHSC#**_____

Diagnosis (If Known) _____

Family Doctor / Pediatrician _____

Doctor's Phone _____

School _____ **Grade** _____

Teacher _____

Preschool/ Child Care _____

CHILDREN'S THERAPY INITIATIVE – NOR-MAN REGION
Occupational Therapy Physiotherapy Speech-Language Pathology Audiology

Children's Therapy Initiative
NOR-MAN REGION

REFERRAL FORM

SEND TO:
Box 4700
The Pas, Manitoba R9A 1R4
Fax: 204-623-7818

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

REFFERAL SOURCE

Name _____

Designation _____

Signature _____

Phone _____ Fax _____

Student Services Coordinator Signature: _____
(Required for school referrals only)

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

	Parent/Caregiver name(s)	Relationship	Home Phone	Work Phone	Cell Phone
☐					
☐					

I am in agreement with my child receiving the identified service(s) from the Children's Therapy Initiative providers.

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 boxes that apply) **Diagnosis (if known)** _____

☐ **AUDIOLOGY** ☐ Pre-op assessment ☐ Second opinion ☐ Syndrome ☐ Family History ☐ Ear infections ☐ Visual impairment
☐ Speech Delay ☐ Failed School screen ☐ Neonatal Risk Factors - please Specify:

☐ **SPEECH-LANGUAGE PATHOLOGY** ☐ Delayed developmental milestones ☐ Cleft lip & palate ☐ Not talking
☐ Stuttering ☐ Talking in single words ☐ Avoids speaking ☐ Immature grammar ☐ Difficult to understand
☐ Difficulty understanding information ☐ Difficulty interacting with others ☐ Voice ☐ Dysphagia

☐ **OCCUPATIONAL THERAPY** ☐ Developmental milestones ☐ Feeding concerns ☐ Delayed Fine motor skills
☐ Difficulty using toys as intended ☐ Difficulty with Attention and organization ☐ Difficulty with Peer interactions
☐ Difficult Behavior (tantrums, hitting etc) ☐ Difficulty with Self-care skills ☐ Equipment and adaptive technology needs

☐ **PHYSIOTHERAPY** ☐ Delayed developmental milestones ☐ Plagiocephaly ☐ Torticollis ☐ Coordination ☐ Balance
☐ Delayed walking ☐ Difficulty running or jumping ☐ Musculoskeletal Concerns (specify)

Additional Information:

For office use only:

Date received at Intake	Date forwarded to provider	Acknowledgement letter sent