REFERRAL FORM

Children's Therapy Network of Manitoba

Audiology | Occupational Therapy | Physiotherapy | Speech-Language Pathology

Southern CTNM

365 Reimer Avenue, Steinbach, MB R5G 0R9

Phone: 204-346-9359 | **Toll-free:** 1-800-958-3076 | **Fax:** 204-346-7023

Email: CTNMCentralIntake@southernhealth.ca

Contact information for other CTNM regions can be found at **manitoba.ca/fs/ctnm**

REFERRAL SOURCE

Name & Designation: ______________________________

Address: ______________________________

Phone: ______________ Fax: ______________

CHILD INFORMATION

Last Name: ______________ First Name: ______________

Birthdate: M __________ D _____ Y_____ Gender: __________

Mailing Address: ______________________________

Physical Address: ______________________________

City: ______________ Postal Code: __________

PHIN #: ______________ MHSC #: ______________

Treaty #: ______________________________

Language: English French Other: __________ Interpreter

Child's Doctor: ______________________________

Phone: ______________ Fax: ______________

Name of Doctor's Office: ______________________________

Doctor's Address: ______________________________

Daycare/Preschool or School: ______________________________

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

PARENT/CAREGIVER NAME	RELATIONSHIP	PRIMARY PHONE	ALTERNATE PHONE	EMAIL ADDRESS

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

- Pre Post-op Evaluation
- Risk Factors for Hearing Loss, Specify: __________
- Ear Infections Drainage
- Trauma to Ear or Head
- No Speech Speech Delay
- Refer from Screening:
  - UNHS Preschool School
- Auditory Processing
- Parent Concerns
- Sudden Onset/Change in Hearing
- Second Opinion
- Other: __________

OCCUPATIONAL THERAPY

- High Risk Infant
- Delayed Developmental Milestones
- Feeding
  - Risk of Choking
  - Texture Aversion
  - Other: __________
- Play Skills
- Fine Motor Skills
- Self-care Skills
- Social Skills
- Sensory Processing
- Attention & Behavior
- Other: __________

PHYSIOTHERAPY

- High Risk Infant
- Plagiocephaly / Torticollis
- Delayed Basic Motor Skills e.g., sitting, crawling, walking
- Gross Motor Skills, e.g., ball skills, running, bike riding
- Walking concerns, e.g., in-toeing
- Balance / Coordination
- Strength
- Musculoskeletal, Specify: __________
- Other: __________

SPEECH-LANGUAGE PATHOLOGY

- Delayed Developmental Milestones Specify: __________
- Not talking
- Talking in Single Words
- Difficult to Understand
- Difficulty Understanding Information
- Difficulty Interacting with Others
- Difficulty with Forming Sentences
- Swallowing / Feeding
- Stutters
- Voice, e.g., strained, hoarse, breathy
- Other: __________

FOR OFFICE USE ONLY

Date received at Intake:

Audiology:

OT:

PT:

SLP: