

# REFERRAL FORM



**Children's Therapy Network of Manitoba**

## 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: \_\_\_\_\_

**Audiology | Occupational Therapy | Physiotherapy | Speech-Language Pathology**

### Churchill-Winnipeg CTNM

SSCY Centre – 1155 Notre Dame, Winnipeg, MB R3E 3G1  
 Phone: 204-258-6550 | Toll-free: 204-258-6799  
 Email: CTNMCentralIntake@rcinc.ca

Contact information for other CTNM regions can be found at [manitoba.ca/fs/ctnm](http://manitoba.ca/fs/ctnm)

## REFERRAL SOURCE

Name & Designation: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

## 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
<input type="checkbox"/>				
<input type="checkbox"/>				

## 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):

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

FOR OFFICE USE ONLY	
Date received at Intake:	Audiology: _____ OT: _____ PT: _____ SLP: _____