

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 #: _____
Language: English French Other: _____ Interpreter
Child's Doctor: _____
Phone: _____ Fax: _____
Name of Doctor's Office: _____
Doctor's Address: _____
Daycare/Preschool or School: _____

Audiology | Occupational Therapy | Physiotherapy | Speech-Language Pathology

Northern CTNM

Thompson and Area:

867 Thompson Drive | Thompson, MB R8N 1Z4

Phone: 204-677-5385 | Fax: 204-778-1453

Email: rpittman@nrha.ca

The Pas/Flin Flon and Area:

67 1st Street West Box 240

The Pas, MB R9A 1K4

Phone: 204-623-9223 | Fax: 204-623-2487

Email: rhayes@nrha.ca

Contact information for other CTNM regions can be found at 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	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	OCCUPATIONAL THERAPY	PHYSIOTHERAPY	SPEECH-LANGUAGE PATHOLOGY
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: _____	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: _____	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: _____	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: