REFERRAL FORM

Children's Therapy Network of Manitoba

Audiology | Occupational Therapy | Physiotherapy | Speech-Language Pathology

PROMISE Years CTNM
PO Box 1420, Virden MB R0M 2C0
Phone: 204-748-2692 | **Fax:** 204-748-2436
Email: flbsd@flbsd.mb.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:

This form is available in alternate formats upon request.

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