# REFERRAL FORM

Children's Therapy Network of Manitoba

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

**Division scolaire franco-manitobaine (DSFM) CTNM**
Educational services DSFM
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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 #: _____

Primary Language: ☐ English ☐ French
☐ Other: _____ ☐ Interpreter

Child's Doctor: _____ Phone: _____

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 |
|---|---|---|---|
| | | | |
| | | | |

## 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
- ☐ 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

### ☐ 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.