REFERRAL FORM

Children's Therapy Network of Manitoba

Audiology | Occupational Therapy | Physiotherapy | Speech-Language Pathology

Northern CTNM

Thompson and Area:
867 Thompson Drive
Thompson, MB R8N 1Z4
Fax: 204-785-4031

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

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): ______________________

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SERVICES REQUESTED (check all that apply):

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

FOR OFFICE USE ONLY

Date received at Intake:

Audiology:
OT:
PT:
SLP:

This form is available in alternate formats upon request.