REFERRAL FOR ACCESSING PROGRAMS AND CLINICAL SERVICES AT MANITOBA DEVELOPMENTAL CENTRE

(Services for Adults-Department of Families)

The following personal health information is being collected so that we can provide you with the appropriate service and we only collect what we need to accomplish for that purpose. Privacy will be protected in accordance with the Personal Health Information Act (PHIA).

Administrative Use Only
Date Received:

Name: _____

Address: _____

City: _____ **Postal Code:** _____

E-mail: _____ **Phone Number:** _____

Primary Language: _____ **Interpreter Needed:** **Yes** ☐ **No** ☐

Birthdate: _____ ***PHIN #*** _____

CONTACT FOR APPOINTMENTS IF DIFFERENT THAN ABOVE:

Name: _____ *Address:* _____ *Postal Code:* _____

Phone: _____ *Email:* _____ *Fax:* _____

DAY PROGRAM:

Agency/Program: _____ *Address:* _____ *Postal Code:* _____

Primary Contact: _____ *Email:* _____ *Phone:* _____

Fax: _____

COMMUNITY SERVICE WORKER:

Name: _____ *Address:* _____ *Postal Code:* _____

Phone: _____ *Email:* _____ *Fax:* _____

CASE MANAGER:

Name: _____ *Address:* _____ *Postal Code:* _____

Phone: _____ *Email:* _____ *Fax:* _____

List any Emergency Health Needs/ Safety Concerns (including High Risk Behaviours) below:
(If not enough space, attach additional information)

- _____
- _____
- _____

BACKGROUND INFORMATION (SPECIAL FACTORS TO CONSIDER IN THE PLANNING AND/OR INTERVENTION PROCESS):

Note: Please ensure you have emergency identification when attending any events at the Manitoba Developmental Centre.
Manitoba Developmental Centre reserves the right to discontinue programs and services for operational requirements as necessary.

_____ _____

Signature of Community Living disABILITY Services/ Referrer or Registrant (whichever applies) Date

PLEASE MAIL ORIGINAL REFERRAL AND CONSENT TO: **OR** **EMAIL SCANNED REFERRAL AND CONSENT TO:** MDCOUTREACH@GOV.MB.CA

HEALTH INFORMATION SERVICES, MANITOBA DEVELOPMENTAL CENTRE
840 3RD STREET N.E.
PORTAGE LA PRAIRIE MB R1N 3C6

PROGRAMS/CLINICAL SERVICES AVAILABLE *(Assessment, Consultation, Treatment)*

Please note that existing medical history, diagnostic information and specialist's reports may be required.)

☐ **OCCUPATIONAL THERAPY**

- ☐ Environmental Assessment *(home, school, leisure and vocational)*
- ☐ Vocational / Leisure Assessment
- ☐ Self-Care/Daily Living Skills Assessment
- ☐ Sensory Processing
- ☐ Equipment Prescription
  - ☐ Adaptive Equipment
- ☐ Transfers / Lifting
  - ☐ Training
  - ☐ Assessment
- ☐ Fine Motor Skills
- ☐ Assistive Technology (ECU) / Communication Devices
- ☐ Seating and Mobility
  - ☐ Manual Wheelchair Seating
  - ☐ Wheelchair Assessment for Complex Seating
  - ☐ Skin Breakdown / Pressure Sore Prevention/ Management
  - ☐ Positioning and Comfort
  - ☐ Power Mobility – Assessment and Drive Controls
  - ☐ Integration of Environmental Controls and Mobility
- ☐ Fall Management *(Prevention, Strategies, and Safety Equipment)*
- ☐ Sleep Surface Prescription

☐ **DENTAL**

☐ **MUSIC THERAPY SERVICES**

- ☐ Sensory Stimulation / Integration Experiences
- ☐ Means of Non-Verbal Communication
- ☐ Unable to leave Unit / Social Isolation
- ☐ Pain Management / Distraction
- ☐ End-of-Life Care
- ☐ Cognitive Skills
- ☐ Self-Expression
- ☐ Behaviour Challenges
- ☐ Anxiety
- ☐ Physical / Movement
- ☐ Other: _____

☐ **DYSPHAGIA ASSESSMENT**

(Feeding/Swallowing/Dysphagia within a natural setting i.e. residence, work placement, day program)

- ☐ Choking/Gagging
- ☐ Swallowing Difficulties
- ☐ Texture Aversion
- ☐ Suspected Aspiration/History
- ☐ Weight Loss due to Dysphagia
- ☐ History of Pneumonia
- ☐ Food/Fluid Refusal
- ☐ Feeding Skills
- ☐ Length of Time for Eating/Feeding
- ☐ Adapted Equipment
- ☐ Exercises for strengthening Muscles of Mastication and Swallowing
- ☐ Education Session (Dysphagia Orientation, Proper Oral Consumption Management, Everyone C.A.R.E.S.)
- ☐ Other: _____

☐ **SPEECH & COMMUNICATION THERAPY SERVICES**

- ☐ Speech / Language / Communication / AAC *(Augmentative and Alternative Communication)* Assessment
- ☐ Provide Reinforcement (Visual / Literary) to Support Comprehension and/or Expressive Language in a Variety of Settings.
- ☐ Creation of Task Analysis for Activities *(to promote independence)*
- ☐ Baseline Augmentative and Alternative Communication Assessment with recommendations.
- ☐ No Tech / Low Tech Augmentative and Alternative Communication Systems *(visual schedules / Picture Communication Symbols [PCS] / Communication Boards, etc.)*
- ☐ Stuttering
- ☐ Relationship / Rapport Building *(informal / breaching personal space for purposes of intervention / trust building)*
- ☐ Creation of Social Stories
- ☐ Introduction and Access to MDC's Communication Services' Adapted Library
- ☐ Other: _____

MANITOBA DEVELOPMENTAL CENTRE

Consent for Provision of Outreach Services and Exchange of Information

Name of Individual:	**Birthdate:**

Consent for Referral & Provision of MDC Outreach Services:

☐ I am in agreement with a referral for services and the provision of services through the Programs and Clinical Services at the Manitoba Developmental Centre

Consent for Exchange of Information:

MDC is required to protect the accuracy, integrity and security of personal health information that it collects. Unless the individual instructs MDC not to, disclosure will be made to a doctor, hospital, or other health professional who will be providing or has provided health care to the individual in accordance with Section (22)(2)(a) of the Personal Health Information Act (PHIA) and/or immediate family member (23)(1.1) without consent.

Other person(s) not authorized under the Act and who wish to receive information or a copy of a report, are required to obtain written consent below from the individual or the authorized legal representative or legal guardian.

☐ I hereby request the Manitoba Developmental Centre to disclose Personal Health Information to the following individuals for the purpose of assessment, treatment, and further referral in accordance with Section 22 of PHIA.

Please sign below and complete the following in full (consider key individuals when providing consent for exchange of information or reports, for instance, family members who are not SDM, case managers/community service workers, day programs etc.)

NAME	TITLE	AGENCY	ADDRESS/POSTAL CODE	PHONE #

- I understand that the information collected and exchanged will be used for the purposes of assessment, planning, developing programs and /or strategies that will benefit the individual or family.
- I understand the risks and benefits of consenting or refusing to consent
- This consent is valid for the duration of program participation unless otherwise specified by the consenter.
- The consenter is advised to provide updated information or changes as these occur.
- Other person(s) not identified above and not authorized under the Act, and who wish to receive information or a copy of a report are required to obtain written consent from the individual or the authorized representative or legal guardian.

CONSENT FROM INDIVIDUAL OR PERSON PERMITTED TO EXERCISE THE RIGHTS OF AN INDIVIDUAL

Relationship of Signing Authority:

☐Self ☐SDM Personal ☐Joint ☐Alternate ☐Committee ☐Other, specify: _____

_____	_____	_____
Date	Print Name of Individual/Legal Representative/Guardian	*Signature of Individual/Legal Representative/Guardian*
_____	_____	_____
Date	Print Name of Joint/Alternate Representative (if applicable)	*Signature of Joint/Alternate Representative (if applicable)*
_____	_____	_____
Date	Print Name of Witness	*Signature of Witness*