

# REFERRAL FORM



Children's  
Therapy Network  
of Manitoba

[Audiology](#) | [Occupational Therapy](#) | [Physiotherapy](#) | [Speech-Language Pathology](#)

## Interlake-Eastern CTNM

100 Easton Drive, Selkirk, MB R1A 2M2

Phone: 204-785-7730 | Fax: 204-785-4031

Email: [ctnmierhaintake@ierha.ca](mailto:ctnmierhaintake@ierha.ca)

Contact information for other CTNM regions can be found at [manitoba.ca/fs/ctnm](http://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	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: