

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	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: