



Referral for Therapy Services

Send referral to:
Intake Coordinator
Assiniboine North – Children's Therapy
Neepawa Health Unit
Box 1240
Neepawa, MB R0J 1H0

Service(s) Requested: **Speech-Language Therapy**
 Occupational Therapy **Physiotherapy**

Child's Name: _____ Male: MHSC #: _____
 Female: _____
 Birthdate: Month Day Year PHIN #: _____
 Parent(s) (M) _____ Phone: (h) _____
 Foster Family (F) _____ Phone: (w) _____
 Mailing Address: _____ Postal Code: _____
 Street Address: _____ Phone: _____
 Legal Guardian and Agency: _____ Phone: _____
 Mailing Address: _____ Fax: _____
 Family Doctor/Pediatrician: _____
 Address: _____

My child is enrolled in:	Pre-school <input type="checkbox"/>	Child Care Centre <input type="checkbox"/>	Nursery School <input type="checkbox"/>
	Public School <input type="checkbox"/>	Private School <input type="checkbox"/>	Home School <input type="checkbox"/>
			First Nation School <input type="checkbox"/>
My child attends or will attend:	School: _____	Phone #: _____	

Area of concern or reason for referral: _____

Student Services
Administrator Authorization:

Referral Source: _____ **Date:** _____

Contact Person: _____ **Phone #:** _____

<p>Consent for Referral: I am in agreement with a referral to the Children's Therapy Initiative partner agencies for provision of the above-identified therapy services for my child.</p>	<p>_____ <i>Signature of Parent or Legal Guardian</i> <i>Date</i></p> <p>_____ <i>Signature of Witness</i> <i>Date</i></p>
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For Office Use Only:

Date Received at intake:	OT: <input type="checkbox"/> RCC P.T. <input type="checkbox"/> RCC SLP: <input type="checkbox"/> RHA <input type="checkbox"/> SMD <input type="checkbox"/> Priv. Date sent to provider agency:	Service Agency box:	File #:
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Consent for exchange of information

Child's Name: _____	Birthdate: (M/D/Y) _____
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EXCHANGE OF INFORMATION:

Under Section 22(2)(a) of the Personal Health Information Act (PHIA) (legislation in the province of Manitoba), referring agencies and other services may exchange information for the purpose of assessment, treatment, further referral and evaluation.

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 child or family. This information may be shared verbally or through written reports.

I understand that information will be exchanged with the individuals I have specified below:

<i>Name of Resource or Service</i>	<i>Name, Address & Telephone # (all information required)</i>	<i>Release Reports to:</i>
Family Doctor _____	_____	<input type="checkbox"/>
Pediatrician _____	_____	<input type="checkbox"/>
Public Health Nurse _____	_____	<input type="checkbox"/>
Child Development Clinic _____	_____	<input type="checkbox"/>
Foster Parent(s) _____	_____	<input type="checkbox"/>
Assiniboine Regional Health Authority _____	_____	<input type="checkbox"/>
Rehabilitation Centre for Children (RCC) _____	_____	<input type="checkbox"/>
Speech-Language Pathologist _____	_____	<input type="checkbox"/>
Audiologist _____	_____	<input type="checkbox"/>
Physiotherapist _____	_____	<input type="checkbox"/>
Occupational Therapist _____	_____	<input type="checkbox"/>
Service Coordinator (CSS, SMD, CFS) _____	_____	<input type="checkbox"/>
Child Development Counsellor (CSS) _____	_____	<input type="checkbox"/>
Day Care Centre/Nursery School _____	_____	<input type="checkbox"/>
School Division and School _____	_____	<input type="checkbox"/>
Other: _____	_____	<input type="checkbox"/>
Other: _____	_____	<input type="checkbox"/>
Other: _____	_____	<input type="checkbox"/>

Any other person(s) not authorized under the Act who wish to receive information or a copy of a report are required to obtain written consent from the individual or their authorized legal representative.

In the process of obtaining/gathering information about your child, it may be necessary to provide a copy of this form to a provider listed above. By doing this, they will become aware of other service providers named on this list

Valid for the duration of program participation. Parents/ legal guardian may request changes at any time.

Signature of Parent or Legal Guardian: _____ *Date:* _____

Signature of Witness: _____ *Date:* _____



PRE-SCHOOL CONCERNS CHECKLIST

Please fill out for all pre-school children referred for OT, PT and/or SLP services.

Child's Name:	Birthdate: (M/D/Y)
Date:	For Office use only:

Your child has been referred for therapy services (physiotherapy, occupational therapy and/or speech/ language therapy). The following list of concerns will help us identify which therapist(s) need to be involved with your child.

Please check the statements that apply to your concerns about your child.

I am concerned that my child cannot...

- Dress him or herself
- Bath him or herself
- Feed him or herself
- Use the toilet

- Play constructively with toys
- Use building toys (e.g.: duplo or lego)
- Use scissors or pencils
- Draw and colour
- Print letters

- Roll and sit up
- Change positions
- Crawl
- Walk
- Climb

- Speak
- Be understood by others
- Understand what I say
- Follow directions

I am concerned that my child....

- Dislikes getting his or her hands messy
- Is bothered by the feel of his or her clothing
- Is distracted by sounds or light
- Has a short attention span
- Is a fussy eater
- Drools excessively
- Chews on his or her clothing or fingers
- Has trouble socializing with friends or family
- Has trouble playing in an organized way

- Loses his or her balance often
- Has trouble throwing and catching a ball
- Cannot ride a tricycle or bicycle
- Is clumsy or slow when running
- Has weak muscles
- Has joints that feel stiff

- Does not speak clearly
- Does not talk in sentences
- Uses words the wrong way
- Doesn't seem to hear me
- Is not talking as much as other children his/her age

Things I would like my child to be able to do: _____



SCHOOL CONCERNS CHECKLIST

Please fill out for all students referred for school services
from the Physiotherapist and/or Occupational Therapist.

Child's Name:	Birthdate: (M/D/Y)
Date:	School:
Teacher:	Grade:

Please check the statements that apply to your concerns about this student.

has trouble with:

- | | |
|---|---|
| <input type="checkbox"/> Knowing which hand to use
<input type="checkbox"/> Holding a pencil in a typical grasp
<input type="checkbox"/> Forming letters and numbers
<input type="checkbox"/> Writing fast enough
<input type="checkbox"/> Copying from the board
<input type="checkbox"/> Following verbal instructions
<input type="checkbox"/> Drawing, colouring, cutting or pasting
<input type="checkbox"/> Participating in messy art projects
<input type="checkbox"/> Putting on, tying, buttoning or zipping clothes
<input type="checkbox"/> Using building toys (lego) | <input type="checkbox"/> Getting his or her hands dirty
<input type="checkbox"/> The feel of his or her clothing
<input type="checkbox"/> Being bothered by sounds or light
<input type="checkbox"/> Paying attention and staying focused
<input type="checkbox"/> Completing work
<input type="checkbox"/> Playing cooperatively
<input type="checkbox"/> Making and keeping friends
<input type="checkbox"/> Managing emotions
<input type="checkbox"/> Being in close quarters with other children
<input type="checkbox"/> Feeding or swallowing
<input type="checkbox"/> Using eye-contact as expected |
|---|---|

The following apply:

- | | |
|---|--|
| <input type="checkbox"/> Has awkward physical coordination
<input type="checkbox"/> Trips and fall easily
<input type="checkbox"/> Avoids playground equipment
<input type="checkbox"/> Has not learned to ride a bike
<input type="checkbox"/> Weak running and jumping skills | <input type="checkbox"/> Has trouble with ball handling skills
<input type="checkbox"/> Avoids participation in gym
<input type="checkbox"/> Tires or becomes short of breath easily compared to peers
<input type="checkbox"/> Has poor posture
<input type="checkbox"/> Seems not to know the rules of games |
|---|--|

Please rate this student's frustration level with his or her problem areas:

1	2	3	4	5
Not noticeably frustrated				Extremely frustrated

Additional Comments: _____
