

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 Attending: _____

**Children's Therapy Initiative (CTI)
Referral Form**

Audiology Occupational Therapy Physiotherapy Speech-Language Pathology

Interlake Children's Therapy Initiative
 201-237 Manitoba Avenue Selkirk, MB R1A 0Y4
 Phone: (204) 785-7730 Fax: (204) 785 4031

Contact information for other CTI regions:
<https://sscy.ca/service-providers-staff/childrens-therapy-initiative/>

REFERRAL SOURCE

Name & Designation: _____
 Address: _____
 Phone: _____ Fax: _____

PARENT(S) OR GUARDIAN(S) (Please check box to indicate which parent/caregiver this child lives with)

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):**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 Parent Concerns Sudden Onset/Change in Hearing Second Opinion Other: _____	High Risk Infant Feeding Risk of Choking Texture Aversion Other: _____ Play Skills Fine Motor Skills Self-care Skills Social Skills Sensory Processing Attention & Behavior Delayed Developmental Milestones	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: _____	Not talking Talking in Single Words Difficult to Understand Difficulty Understanding Information Difficulty Interacting with Others Difficulty with Forming Sentences Swallowing Stutters Voice, e.g., strained, hoarse, breathy Delayed Developmental Milestones Specify: _____ Other: _____

FOR OFFICE USE ONLY

Date received at Intake:	Audiology: OT: PT: SLP:
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