



**Referral for Therapy Services**

Send referral to:  
Intake Coordinator  
Assiniboine North – Children's Therapy  
c/o Beautiful Plains School Division  
Box 700 Neepawa, MB R0J 1H0  
P: (204)476-2388 F: (204) 476-3606

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

Child's Name: \_\_\_\_\_ Male:  MET #: \_\_\_\_\_  
 Female:  School Use Only \_\_\_\_\_  
 Birthdate: \_\_\_\_\_ Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_ PHIN #: \_\_\_\_\_

Parent(s) Mother: \_\_\_\_\_ Phone:(h) \_\_\_\_\_ (w) \_\_\_\_\_ (c) \_\_\_\_\_  
 Foster Family Father: \_\_\_\_\_ Phone:(h) \_\_\_\_\_ (w) \_\_\_\_\_ (c) \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Box \_\_\_\_\_ Town \_\_\_\_\_ Postal Code: \_\_\_\_\_

Street Address: \_\_\_\_\_

Legal Guardian and Agency: \_\_\_\_\_ Phone: \_\_\_\_\_

Mailing Address of Agency: \_\_\_\_\_ Fax: \_\_\_\_\_

Family Doctor/Pediatrician: \_\_\_\_\_

My child is enrolled in:	Pre-school <input type="checkbox"/>	Child Care Centre <input type="checkbox"/>	Nursery School <input type="checkbox"/>	First Nation School <input type="checkbox"/>	Student Services Administrator Authorization:
	Public School <input type="checkbox"/>	Private School <input type="checkbox"/>	Home School <input type="checkbox"/>	N/A <input type="checkbox"/>	
School my child attends:		Year Eligible for School Entry:		Phone #:	

**Area of concern or reason for referral (Include diagnosis if known):**  Developmental Assessment/Report Attached

**Referral Source:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Contact Person:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

<p><b>CONSENT: Please check the box that applies</b></p> <p><input type="checkbox"/> I agree to this referral for my child to receive services from a Children's Therapy Initiative (CTI) partner agency. I understand that my child's referral information will be:</p> <ul style="list-style-type: none"> <li>Recorded at the regional CTI Intake for service coordination</li> <li>Forwarded to a therapy provider service / agency</li> <li>Used in collecting non-identifiable data for program evaluation</li> </ul> <p><input type="checkbox"/> Parent / legal guardian informed of above and verbal consent obtained for referral and data collection.</p>	
	<p><b>Signature of Parent or Legal Guardian</b> <span style="float: right;"><b>Date</b></span></p> <p>(Legal Guardian Signature required for children in care of any CFS agency.)</p>
	<p><b>Signature of Witness</b> <span style="float: right;"><b>Date</b></span></p> <p><b>OR Signature of person obtaining verbal consent</b></p>

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 #: Letter Sent to Parents:
--------------------------	--	---------------------	------------------------------------



**Consent for exchange of information**

Child's Name:	Birthdate: (M/D/Y)
---------------	--------------------

**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:**

Release Reports to:	Resource or Service	Name, Address & Phone
<input type="checkbox"/>	Physician(s)	_____
<input type="checkbox"/>	Public Health Nurse	_____
<input type="checkbox"/>	Foster Parent(s)	_____
<input type="checkbox"/>	Speech-Language Pathologist	_____
<input type="checkbox"/>	Audiologist	_____
<input type="checkbox"/>	Physiotherapist	_____
<input type="checkbox"/>	Occupational Therapist	_____
<input type="checkbox"/>	Case Manager, CdS	_____
<input type="checkbox"/>	Day Care Centre/ Nursery School	_____
<input type="checkbox"/>	School Division and School	_____
<input type="checkbox"/>	Developmental Team	<input type="checkbox"/> Beautiful Plains <input type="checkbox"/> Park West <input type="checkbox"/> Rolling River
<input type="checkbox"/>	Other:	_____

**I do not want my reports shared with:** \_\_\_\_\_

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

**The following apply:**

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_