MATC NEURODEVELOPMENTAL SERVICES
REQUEST FOR SERVICE

REFERRAL DATE:		REF. NO.:	MATC #:
NAME:		DATE OF BIRTH:	
MHSC #:	PHIN #:	TREATY/OTHER #:	
MOTHER/GUARDIAN:		FATHER/GUARDIAN:	
ADDRESS:		ADDRESS:	
CITY:	P.C.:	CITY:	P.C.:
PHONE (H):	(W):	PHONE (H):	(W):

REFERRAL SOURCE:	PH #:	FAX:
AGENCY (CSS/CFS):	PH #:	FAX:
LEGAL GUARDIAN:	IF CFS INVOLVEMENT, PLEASE INDICATE STATUS:	VPA/TW/PW/UA

FAMILY PHYSICIAN OR PEDIATRICIAN:		
ADDRESS:	PH #:	FAX:

SCHOOL:	CONTACT NAME:	
ADDRESS:	PH #:	FAX:

PREVIOUS DIAGNOSIS:

IF DIAGNOSIS INCLUDES AUTISM/ASD/PDD/ASPERGER'S, PLEASE INDICATE PREVIOUS SERVICES INVOLVED:

HAVE THERE BEEN PREVIOUS ASSESSMENTS FROM THE FOLLOWING AGENCIES:

Child Development/Genetics/Neurology/School Clinician/Psychology/Occupational Therapy/Speech and Language/Physiotherapy/Other Psychiatry Services (e.g. Anxiety Clinic). Please attach any appropriate reports.

DO YOU REQUIRE A PSYCHIATRIC ASSESSMENT OR MEDICATION REVIEW?

WHAT ARE THE SPECIFIC DIFFICULTIES LEADING TO THIS REFERRAL?

COMPLETED BY:	DATE:

Please forward referral to Centralized Intake Service at 848 William Avenue Winnipeg, MB R3E 0Z6
Phone: (204) 958-9660 Fax: (204) 958-9626

MATC

Mental Health Services for Children, Youth & Families

AUTHORIZATION
FOR REQUEST & COLLECTION OF INFORMATION
and
FOR RELEASE & DISCLOSURE OF INFORMATION

Client Name: _____

Date of Birth (MM/DD/YYYY): _____

The Manitoba Adolescent Treatment Centre and Montcalm School is authorized to:

1. ☐ request and collect reports or findings relevant to the treatment of the above-named

and

The Manitoba Adolescent Treatment Centre is authorized to:

2. ☐ release and disclose MATC reports or findings to the below named person/facility/organization.

Service Providers (please list): _____

_____

_____

_____

_____

_____

_____

REFER TO THE INFORMED CONSENT POLICY REGARDING COMPETENCY

_____ _____

Signature of Client Date

Name of Legal Guardian/Proxy (PRINT) _____

_____ _____

Signature of Legal Guardian/Proxy Date

Name of Witness (PRINT): _____

_____ _____

Signature of Witness Date

(This consent form expires after a two year period)

☐ 120 Tecumseh Street, Winnipeg, Manitoba R3E 2A9 Phone: (204) 477-6391 Fax: 783-0948
☐ 228 Maryland Street, Winnipeg, Manitoba R3G 1L5 Phone: (204) 958-9600 Fax: 958-9618
☐ 700 Elgin Avenue, Winnipeg, Manitoba R3E 1B2 Phone: (204) 786-7841 Fax: 775-8908
☐ 170 Doncaster Street, Winnipeg, Manitoba R3N 1X9 Phone: (204) 958-9654 Fax: 958-9633

MATC

Mental Health Services for Children, Youth & Families

CONSENT FOR ASSESSMENT/TREATMENT/CONSULTATION – LEGAL GUARDIAN/PROXY (Refer to Informed Consent Policy)

CLIENT NAME (PRINT): _____

ADDRESS: _____
(Apt., Street Number, Street Name)

_____
(City, Postal Code)

DATE OF BIRTH (MM/DD/YYYY): _____

MH#: 6 DIGIT: _____ 9 DIGIT: _____

As the legal guardian/proxy of the above-named, I hereby give my permission for the Manitoba Adolescent Treatment Centre (MATC) and its staff to effect therapeutic assessments and/or treatments and/or interventions to assist in the health care of the above-named.

Legal Guardian/Proxy Name (PRINT): _____

Relationship: _____

Signature: _____ Date: _____

Witness Name (PRINT): _____

Signature: _____ Date: _____

H:\FORMS\CHART\Consent for Assess Tx Consult- Legal Guardian & Proxy.doc

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226 Maryland Street, Winnipeg, Manitoba R3G 1L6 Phone: (204) 958-9600 Fax: 958-9018
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