PROMISE Years Referral Form for Therapy Services

CHILD'S INFORMATION ***(Please Print)***

Name _____

Birth Date_____ ☐**Male** ☐**Female**
(DD-MMM-YYYY)

MHSC#_____

PHIN#_____

Address (mailing & street) _____

City _____

Postal Code _____

Email address _____

Doctor _____

School or Child Care Centre _____

Language spoken at home: ☐**English**

☐**Other (Please specify)** _____

Mail or Fax to the division office nearest to your home address:

Fort la Bosse SD
Box 1420
Virden MB R0M 2C0
Fax (204) 748-2436

Turtle Mountain SD
Box 280
Killarney MB R0K 1G0
Fax (204) 523-7269

Prairie Spirit SD
Box 130
Swan Lake MB R0G 2S0
Fax (204) 836-2356

Southwest Horizon SD
Box 370
Melita MB R0M 1L0
Fax (204) 522-3776

REFERRAL SOURCE

Name & Designation_____

Address_____

Phone _____ **Fax** _____

Signature

PARENT(S) or GUARDIAN(S) (Please check box to indicate which parent/caregiver this child lives with and circle the preferred contact number)

	Parent/Caregiver name(s)	Relationship	Home Phone	Work Phone	Cell Phone
☐					
☐					

☐ **CONSENT:** I consent to my child receiving the identified service(s) from the Children's Therapy Initiative providers.
I understand that my child's information will be:
- Recorded at the regional CTI intake for service coordination
- Forwarded to a therapy provider/service agency
- Used in collecting non-identifiable date for program evaluation

PARENT/LEGAL GUARDIAN SIGNATURE _____ **DATE** _____

IF THIS CHILD RESIDES WITH SOMEONE OTHER THAN HIS OR HER 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 _____

Diagnosis (if any): _____
Previous assessment by OT/PT/SLP/AUD_____ No_____ Yes
Presenting Problems:/Request for Services: _____
Please check the appropriate box(s):

☐ **Speech-Language Therapy**	☐ **Occupational Therapy**	☐ **Physiotherapy**	**Other Referrals Made**
☐ Cleft Lip & Palate	☐ Feeding Concerns	☐ Gross Motor Coordination	☐ Child Development Clinic
☐ Not Talking	☐ At Risk for choking	☐ Balance	☐ Children's disabilities
☐ Talking in Single Words	☐ Texture aversions	☐ Strength	☐ Child & Family Services
☐ Immature Grammar	☐ Saliva control	☐ Walking	☐ Audiology
☐ Difficulty Understanding Information	☐ Adaptive Play Skills	☐ Running	☐ Other
☐ Difficulty Interacting with Others	☐ Fine Motor Skills (explain pls)	☐ Throwing and Catching a ball	
☐ Stutters (3 or more repetitions of Word or sound)	☐ Attention and Organization	☐ Riding a Trike or Bike	
☐ Avoids Speaking	☐ Self-Care Skills	☐ Delayed Developmental Milestones	
☐ Difficult to Understand	☐ Peer Interactions		
☐ Delayed Developmental Milestones	☐ Sensory Processing		
☐ Hearing loss	☐ Environmental Access Needs		
	☐ Delayed Developmental Milestones		
	☐ Equipment Needs		
	☐ Visual perceptual challenges		

Referral redirected to: _____

_____

Date: _____