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	☐ High Risk Infant	☐ High Risk Infant	☐ Not talking
☐ Risk Factors for Hearing Loss, Specify: _____	☐ Feeding	☐ Plagiocephaly / Torticollis	☐ Talking in Single Words
☐ Ear Infections ☐ Drainage	☐ Risk of Choking	☐ Delayed Basic Motor Skills, e.g., sitting, crawling, walking	☐ Difficult to Understand
☐ Trauma to Ear or Head	☐ Texture Aversion	☐ Gross Motor Skills, e.g., ball skills, running, bike riding	☐ Difficulty Understanding Information
☐ No Speech ☐ Speech Delay	☐ Other: _____	☐ Walking concerns, e.g., in-toeing	☐ Difficulty Interacting with Others
☐ Refer from Screening:	☐ Play Skills	☐ Balance / Coordination	☐ Difficulty with Forming Sentences
☐ UNHS ☐ Preschool ☐ School	☐ Fine Motor Skills	☐ Strength	☐ Swallowing
☐ Parent Concerns	☐ Self-care Skills	☐ Musculoskeletal, Specify: _____	☐ Stutters
☐ Sudden Onset/Change in Hearing	☐ Social Skills		☐ Voice, e.g., strained, hoarse, breathy
☐ Second Opinion	☐ Sensory Processing		☐ Delayed Developmental Milestones
☐ Other:	☐ Attention & Behavior	☐ Other:	☐ Specify: _____
	☐ Delayed Developmental Milestones		☐ Other:

FOR OFFICE USE ONLY

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

This form is available in alternate formats. Please contact the CTI listed above to request this.

Revised September 13, 2019