COMMUNITY THERAPY SERVICES
Community Living disABILITY Services
Referral for Occupational Therapy / Physiotherapy
(fax to (204)942-1428)

COMMUNITY LIVING DISABILITY SERVICES – AUTHORIZATION FOR SERVICE Date of Referral__________

C.S.W. ______________________ Office_________________________ Phone______________ Fax______________

CLIENT INFORMATION

Last Name__________________________ First Name________________________ Date of Birth______________ (dd/mm/yyyy) Gender ____

Address_______________________________________ Phone______________ Client PHIN _______________________

MHSC#_______________ E.I.A. # (if applicable)______________________ NIHB # (if applicable)___ _______________

Type of Residence: Group Home_______ Family Residence_________ Foster Home____________ Other________________

PREFERRED LOCATION OF VISIT: Residence _______ Day Program__________ Other______________________

CONTACTS:

Next of Kin ___________________________ Phone ______________ Relationship to Client____________________________

Group Home Contact_______________________ Phone___________________ Cell_______________ Fax_________________

Physician Name ____________________________ Address __________________________________Phone ______________

E.I.A Contact (if applicable)__________________________Address_________________________Phone______________________

Public Trustee (if applicable)_________________________Phone____

Other agencies currently involved: ____

CLIENT HEALTH INFORMATION

Diagnosis : 1)____ 2) ____

Other conditions pertinent to therapy:____

If client recently hospitalized, provide reason: ____ Date of Discharge: ___________

SERVICES REQUESTED (Check all that apply)

- ☐ INSTRUMENTAL ACTIVITIES OF DAILY LIVING
- ☐ ACTIVITIES OF DAILY LIVING
- ☐ PERSONAL CARE
- ☐ FEEDING-SWALLOWING ASSESSMENT
- ☐ COGNITIVE ASSESSMENT
- ☐ TRANSFERS
- ☐ REPOSITIONING
- ☐ MOBILITY
- ☐ WHEELCHAIR / SEATING
- ☐ SKIN/ULCER PREVENTION
- ☐ PAIN MANAGEMENT
- ☐ PASSIVE RANGE OF MOTION
- ☐ AMBULATION
- ☐ EXERCISES
- ☐ CARE PROVIDER INJURY

Additional Information regarding current concerns:

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For Community Therapy Services use only:
DIAGNOSTIC CODES____, ____ SERVICE CODES ____, ____, ____, ____, ____TAKEN BY: ________ DATE_________ RE-OPEN_____ CROSS REFERRAL_____

101-1555 St. James Street, Winnipeg, Manitoba R3H 1B5, Phone: (204)949-0533 Fax: (204) 942-1428