# St.Amant Clinical Services
# Community Referral Form

**440 River Road, Winnipeg, MB R2M 3Z9**

Date Received: _____

**Legend**

EIA – Employment and Income Assistance
CSW – Community Service Worker
SDM – Substitute Decision Maker
PHIN – Personal Health Information Number
FSW – Family Services Worker

| **Client Demographic Information** *Please provide all applicable information* | |
|---|---|
| *Note that the client must be enrolled in Community Living disAbility Services or Children disAbility Services* | |
| Last Name: | First Name: |
| Date of Birth (DD/MMM/YYYY): | Gender: |
| Address: | |
| Tel. (home): | EIA Number: |
| Tel. (cell): | Band Name: |
| Email: | Metis Status and Number: |
| PHIN (9 digit): | Treaty Number: |
| Diagnoses: | |
| Is this client leaving high school at the end of the current school year? ☐ Yes ☐ No | |
| **Primary Language** ☐ English ☐ French ☐ Other: | |
| Request service in French? ☐ Yes ☐ No | Interpreter needed? ☐ Yes ☐ No<br>Interpreter Language: |

| **Care Team Contact Information** *Please provide all applicable contact information.* | |
|---|---|
| **Referral Source: ☐ CSW ☐ FSW ☐ Other:** | **Physician / Nurse Practitioner** |
| Name: | Name: |
| Address: | Address: |
| Tel.: | Tel.: |
| Email: | Email: |
| Fax: | Fax: |
| **CSW/FSW Contact Information (if different from referral source):** | |
| Name: | Tel.: |
| Address: | Email: |
| | Fax: |

| **Contact for Appointment (if different from referral source)** | | |
|---|---|---|
| Name: | Agency Name: | Tel.: |
| Email: | Relationship to client: | |

**St.Amant Program/Service Requested** *Please select all that apply*

☐ Clinical Dietitian
☐ Family Care Program (CSW/FSW only)
☐ Feeding Swallowing Nutrition Team
☐ Occupational Therapy
☐ Physiotherapy
☐ Psychological Testing
☐ Eligibility
☐ Seating Mobility Clinic
☐ Speech-Language Pathology
☐ SDM Application

*For Psychological Testing referrals: please provide signed Authorization to Share Information form and any available copies of previous Psychology reports. Please see additional notes on last page.

**Reason for referral (for all programs requested):**

**St.Amant Clinical Services Referral Form**

Client Name (Last, First): DOB: Client PHIN:

| **Health and Function** | *Please provide all applicable information* | | | |
|---|---|---|---|---|
| **Mobility:** | ☐ Ambulant (walking) | ☐ Power wheelchair | ☐ Manual Wheelchair | ☐ Other: |
| **Vision:** | ☐ Functional | ☐ Impairment | ☐ Visual Aides | |
| **Hearing:** | ☐ Functional | ☐ Hearing loss (aided) | ☐ Hearing loss (unaided) | |
| **Mode of Communication (select all that apply):** | | | | |
| ☐ Speech | ☐ Sign Language | ☐ Gesture | ☐ Augmentative (symbol-based) | |

| **Legal Status of client** | *Please provide all applicable contact information.* | |
|---|---|---|
| ☐ **Child** (Please check box to indicate which parent/caregiver this child lives with) | | |
| ☐Parent/Primary Caregiver | ☐Parent/Primary Caregiver | |
| Name: | Name: | |
| Address: | Address: | |
| Tel.: | Tel.: | |
| Email: | Email: | |
| Relationship to Child: | Relationship to Child: | |
| In custody of: ☐ Parent(s) ☐ Child and Family Services ☐ Other: | | |
| **Legal Guardian Information (if other than parents)** | | |
| Legal Guardian: | Agency Name (if applicable): | |
| Address: | Tel.: | Fax: |

| ☐ **Adult** | | |
|---|---|---|
| ☐ Consents for self/no decision maker | ☐ Committee<br>☐ Personal ☐ Property | ☐ SDM<br>☐ Personal ☐ Property |
| Committee/SDM Contact: | | |
| Relationship to Individual: | | |
| Address: | Email: | |
| Tel.: | Fax: | |
| Daytime Activities: ☐ Day Program | ☐ Employment | ☐ School |
| Name: | Primary Contact: | |
| Address: | Phone: | |
| Email: | | |

| **Referral Awareness**<br>*To be completed by referral source. We ask these questions in the spirit of person-centred care. The answers below will not impact the decision to accept or decline the referral.* | |
|---|---|
| Is the CSW aware of the referral? (For Adults only) | ☐ Yes ☐ No |
| Did you inform the individual of this referral? | ☐ Yes ☐ No |
| Does the individual support this referral? | ☐ Yes ☐ No |
| Did you inform the legal decision maker (if other than the individual) of this referral? | ☐ Yes ☐ No |
| Does the legal decision maker (if other than the individual) support this referral? | ☐ Yes ☐ No |

Referral Source (signature): Date:

## Please return completed form to St.Amant Central Intake by Fax: 204-258.7066
## For information, please call 204-258.7041

***Please submit signed original copy for Psychological Testing and Feeding Swallowing Nutrition referrals**