



# Community Living disABILITY Services

## COMMUNITY THERAPY SERVICES INC.

Referral for Occupational Therapy and/or Physiotherapy

101 – 1601 Buffalo Place

Winnipeg, Manitoba R3T 3K7

Phone: (204) 949-0533 Fax: (204) 942-1428

Client Name: _____
PHIN: _____
Address: _____
City/Postal Code: _____
Phone #: _____
Date of Birth (dd/mmm/yyyy): _____
MFRN (MHSC): _____
Gender: _____ (or use client label)

Referral Date: \_\_\_\_\_ (dd/mmm/yyyy) CTS CHART #: \_\_\_\_\_

### COMMUNITY LIVING disABILITY SERVICES (CLdS)- AUTHORIZATION FOR SERVICES

Community Service Worker (CSW) \_\_\_\_\_ Office \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Centralized Finance Authorized CTS Referral (required prior to CTS Visit):

Substitute Decision Maker (if applicable) Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship to Client \_\_\_\_\_

Contact Person to Schedule Assessment Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship to Client \_\_\_\_\_

#### CLIENT INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Gender \_\_\_\_\_

Phone \_\_\_\_\_ PHIN \_\_\_\_\_ MHSC \_\_\_\_\_

Preferred Location of Visit: Residence  Day Program  Other  \_\_\_\_\_

Address \_\_\_\_\_

Name of Agency for Home/Day Program (if applicable) \_\_\_\_\_

Type of Residence: Shift Staffed Home  Family Residence  Home Share  Other  \_\_\_\_\_

#### THIRD PARTY FUNDING INFORMATION (IF APPLICABLE)

Public Guardian & Trustee Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_ PGT# \_\_\_\_\_

EIA # \_\_\_\_\_  FNIHB # \_\_\_\_\_  Other \_\_\_\_\_

Physician Name \_\_\_\_\_ Address \_\_\_\_\_

#### CLIENT HEALTH INFORMATION

Diagnosis 1) \_\_\_\_\_ 2) \_\_\_\_\_

Other conditions pertinent to therapy:

If client recently hospitalized, provide reason \_\_\_\_\_ Date of Discharge \_\_\_\_\_ (dd/mmm/yyyy)

#### SERVICES REQUESTED (Check all that apply)

- ACTIVITIES OF DAILY LIVING (ADL)
- ASSIST WITH COMPLEX HOSPITAL DISCHARGE
- FOLLOW-UP POST HOSPITAL DISCHARGE
- COGNITIVE ASSESSMENT
- PASSIVE RANGE OF MOTION
- RESPIRATORY
- TRANSFERS \_\_\_ Toilet \_\_\_ Commode \_\_\_ Bed \_\_\_ Tub/Shower \_\_\_ Wheelchair \_\_\_ Chair \_\_\_ Mechanical Lift
- REPOSITIONING \_\_\_ Bed \_\_\_ Wheelchair \_\_\_ Commode \_\_\_ Other: \_\_\_\_\_
- MOBILITY \_\_\_ Bed \_\_\_ Wheelchair \_\_\_ Ambulation \_\_\_ Stairs \_\_\_ Falls Management
- SAFE CLIENT HANDLING** - to address staff and/or client safety during provision of assisted tasks
- INSTRUMENTAL ADL
- PRESSURE MANAGEMENT
- ENVIRONMENTAL
- PAIN MANAGEMENT
- EXERCISE PROGRAM
- OTHER
- SWALLOWING
- WHEELCHAIR/SEATING
- EQUIPMENT ASSESSMENT
- BRACES/ SPLINTS

#### COMMENTS:

CTS use only: DIAGNOSTIC CODES \_\_\_\_\_, \_\_\_\_\_ SERVICE CODES \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_