COMMUNITY THERAPY SERVICES INC.

Referral for Occupational Therapy and/or Physiotherapy

101-1555 St. James Street
Winnipeg, Manitoba
R3H 1B5

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 #:** _____

WINNIPEG REGIONAL HEALTH AUTHORITY (WRHA) HOME CARE – AUTHORIZATION FOR SERVICES

Case Coordinator_____ Office_____ Phone_____ Fax_____

Is Client and/or Family Aware of the Referral: Yes ☐ No ☐ Care Plan Summary Attached: Yes ☐ No ☐

Safe Visit Plan in Place: (If yes, please attach) Yes ☐ No ☐ Priority 1 ☐ Priority 2 ☐ Priority 3 ☐ _____

REFERRAL SOURCE OTHER THAN WRHA HOME CARE PROGRAM

Person Initiating Referral (name/designation) _____

Organization _____ Phone _____ Fax _____

CLIENT INFORMATION (if not included on label)

Last Name_____ First Name_____ Date of Birth_____ (dd/mm/yyyy) Gender ____

Address_____ Phone_____ Client PHIN _____ MHSC # _____
(Include Postal Code)

Next of Kin/Contact _____ Phone _____ Relationship to Client_____

Physician Name _____ Address _____

Client has third party funding: ☐EIA ☐FNIHB ☐WCB ☐MPI ☐VAC ☐Victim's Services ☐Other: _____

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) (Self-care)
☐ ASSIST WITH COMPLEX HOSPITAL DISCHARGE
☐ FOLLOW-UP POST HOSPITAL DISCHARGE
☐ BEHAVIOURAL MANAGEMENT
☐ PASSIVE RANGE OF MOTION
☐ RESPIRATORY
☐ INSTRUMENTAL ADL
☐ PRESSURE MANAGEMENT
☐ ENVIRONMENTAL
☐ COGNITIVE ASSESSMENT
☐ EXERCISE PROGRAM
☐ OTHER: _____
☐ SWALLOWING
☐ WHEELCHAIR / SEATING
☐ EQUIPMENT ASSESSMENT
☐ PAIN MANAGEMENT
☐ BRACES/SPLINTS

☐ 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

COMMENTS:

CTS use only: DIAGNOSTIC CODES____, ____ SERVICE CODES ____, ____, ____, _____, ____ , REFERRAL CODE _____RE-OPEN____CROSS REFERRAL____