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<tr><td>

Deer Lodge Centre (DLC)
2109 Portage Ave.
Winnipeg, MB  R3J 0L3
Tel. (204) 831-3430
Fax (204) 885-2524

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# Assistive Technology
## PRODUCTS AND SERVICES
## Communication Devices Program
## Referral Form

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Winnipeg Regional Health Authority · Office régional de la santé de Winnipeg

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**Date:** ⊔ ⊔ ⊔ ⊔ ⊔ ⊔ ⊔ ⊔
D  D  M  M  M  Y  Y  Y  Y

**Internal use ONLY – Referral Received:** ⊔ ⊔ ⊔ ⊔ ⊔ ⊔ ⊔ ⊔
D  D  M  M  Y  Y  Y  Y

☐ Client/Substitute Decision Maker AWARE and in AGREEMENT of referral to Communication Devices Program
*must be checked to proceed*

## CLIENT INFORMATION
**(PLEASE indicate: ☐ Contact client directly ☐ Contact Alternate Contact listed below)**

**Client Last Name:** _____ **First Name:** _____

**Personal Health Identification Number (PHIN):** ⊔⊔⊔⊔⊔⊔⊔⊔⊔ **MB Health Number:** ⊔⊔⊔⊔⊔⊔

**Date of Birth:** ⊔ ⊔ ⊔ ⊔ ⊔ ⊔ ⊔ ⊔  **Diagnosis:** _____
D  D  M  M  Y  Y  Y  Y

**Address:** _____ **City/Town:** _____

**Postal Code:** _____ **Email:** _____

**Telephone: (Main)** _____ **(Alternate)** _____ **(Work)** _____

**Gender:** ☐ Male ☐ Female ☐ Other: _____ **Preferred Pronouns:** ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs

☐ **Receives 3rd Party Funding – Agency:** _____ **Case #** _____

## ALTERNATE CONTACT
**(PLEASE confirm: ☐ client agrees to have CDP contact the person listed below)**

**Substitute Decision Maker/Next of Kin:** _____ **Relation:** _____

**Contact Address:** _____ **City/Town:** _____

**Postal Code:** _____ **Email:** _____

**Telephone: (Main)** _____ **(Alternate)** _____ **(Work)** _____

## REFERRAL SOURCE and OTHER PROFESSIONALS INVOLVED

**Referred by/Affiliation:** _____ **Employer:** _____

**Email:** _____ **Telephone:** _____ **Fax:** _____

**Current/Recent SLP:** _____ **Employer:** _____

**Email:** _____ **Telephone:** _____ **Fax:** _____

**Current/Recent OT:** _____ **Employer:** _____

**Email:** _____ **Telephone:** _____ **Fax:** _____

## REFERRAL SERVICE OPTIONS

*Please check all areas that apply*:

☐ **Assessment***: ☐ SLP (for Speech Generating Device),
        ☐ OT (for Access and/or Mounting)
☐ **Consultation***: ☐ SLP (for Speech Generating Device),
        ☐ OT (for Access and/or Mounting)
☐ **Clinic Loan ***
☐ **SGD Trial***
☐ **Rental Only**** (No CDP Assessment/ Consultation)

> **PLEASE NOTE:**
>
> *\* For Assessment or Consultation, please attach relevant reports*
>
> *\*\* For Clinic Loan, or SGD trial, complete the Desired Equipment Form (CDP-03).*
>
> *\*\*\*For rental, complete the Speech Generating Device Prescription Form (CDP-05).*
>
> **NOTE: The ELRA (CDP-02) will be required before any equipment can be provided, please send with referral IF available.**

**Description of services requested:** _____
_____

_____