COMMUNITY THERAPY SERVICES INC.

Community Living disABILITY Services

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 #:** _____

COMMUNITY LIVING disABILITY SERVICES (CLdS)- AUTHORIZATION FOR SERVICES

Community Support Worker (CSW)_____ Office_____ Phone_____
Fax_____

Client and/or Substitute Decision Maker is Aware of and in Agreement with the Referral: Yes ☐ No ☐ N/A ☐

Contact Person to Schedule Assessment: Last Name_____ First Name_____

Relationship to Client_____ Phone_____

CLIENT INFORMATION

Last Name_____ First Name_____Date of birth_____Gender_____

Address_____ Phone_____ Client PHIN_____ MHSC_____

Next of Kin Name_____ Phone _____ Relationship to Client _____

Type of Residence: Group Home ☐ Family Residence ☐ Foster Home ☐ Other ☐_____

Preferred Location of Visit: Residence ☐ Day Program ☐ Other ☐ _____

Address_____

Name of Agency for Group Home/Day Program (if applicable) _____

Public Trustee (if applicable): Name_____ Phone_____ Fax_____

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