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______________ Gender ____
(dd/mm/yyyy)

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_____