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

Referral Date: _____ (dd/mmm/yyyy) **CTS CHART #:** _____

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

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
☐ 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 _____, _____, _____, _____, _____