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| **Legend**  EIA – Employment and Income Assistance PHIN – Personal Health Information Number  CSW – Community Service Worker MDC- Manitoba Developmental Centre  SDM – Substitute Decision Maker |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Client Demographic Information** *Please provide all applicable information*  *Note: Client must be enrolled in Community Living disAbility Services or Children disAbility Services* | | | | | | | | | | | | | | |
| Last Name: Click here to enter text. | | | | | First Name: Click here to enter text. | | | | | | | | | |
| Date of Birth (DD/MMM/YYYY): Click here to enter a date. | | | | | Gender: Click here to enter text. | | | | | | | | | |
| Address: Click here to enter text. | | | | | | | | | | | | | | |
| Tel. (home): Click here to enter text. | | | | | EIA Number: Click here to enter text. | | | | | | | | | |
| Tel. (cell): Click here to enter text. | | | | | Band Name: Click here to enter text. | | | | | | | | | |
| Email:Click here to enter text. | | | | | Metis Status and Number: Click here to enter text. | | | | | | | | | |
| PHIN (9 digit): Click here to enter text. | | | | | Treaty Number: Click here to enter text. | | | | | | | | | |
| Diagnoses: Click here to enter text. | | | | | | | | | | | | | | |
| Is this client leaving high school at the end of the current school year? Yes  No | | | | | | | | | | | | | | |
| Is this referral for a person transitioning from Manitoba Developmental Centre to community?  Yes  No | | | | | | | | | | | | | | |
| **Primary Language** English  French Other: Click here to enter text. | | | | | | | | | | | | | | |
| Request service in French? Yes  No | | | | | Interpreter needed?  Yes  No | | | | | | | | | |
|  | | | | | Interpreter Language: Click here to enter text. | | | | | | | | | |
| **Care Team Contact Information** *Please provide all applicable contact information.* | | | | | | | | | | | | | | |
| **Referral Source: CSW Other:** | | | | | **Physician / Nurse Practitioner** | | | | | | | | | |
| Name: Click here to enter text. | | | | | Name: Click here to enter text. | | | | | | | | | |
| Address: Click here to enter text. | | | | | Address: Click here to enter text. | | | | | | | | | |
| Tel.: Click here to enter text. | | | | | Tel.: Click here to enter text. | | | | | | | | | |
| Email: Click here to enter text. | | | | | Email: Click here to enter text. | | | | | | | | | |
| Fax: Click here to enter text. | | | | | Fax: Click here to enter text. | | | | | | | | | |
| **CSW Contact Information (if different from referral source):** | | | | | | | | | | | | | | |
| Name: Click here to enter text. | | | | | Tel.: Click here to enter text. | | | | | | | | | |
| Address: Click here to enter text. | | | | | Email: Click here to enter text. | | | | | | | | | |
| Fax: Click here to enter text. | | | | | | | | | |
| **Contact for Appointment (if different from referral source)** | | | | | | | | | | | | | | |
| Name: Click here to enter text. | | | Agency Name: Click here to enter text. | | | | | | | | Tel.: Click here to enter text. | | | |
| Email: Click here to enter text. | | | Relationship to client: Click here to enter text. | | | | | | | | | | | |
| **St.Amant Program/Service Requested** *Please select all that apply* | | | | | | | | | | | | | | |
| Clinical Dietitian | | | Family Care Program (Only CSW can refer) | | | | Feeding Swallowing Nutrition Team | | | | | | | |
| Nurse Consultation  (MDC Transitions Only) | | | Occupational Therapy | | | | Physiotherapy | | | | | | | |
| Psychology- behaviour services (MDC transitions only) | | | Psychological Testing\*  CLDS Eligibility  SDM Application | | | | | | | | | | | |
| Seating Mobility Clinic | | | Speech-Language Pathology | | | | | | | | | | | |
| \*For Psychological Testing referrals: please provide signed Authorization to Share Information form and any available copies of previous Psychology reports. Please see additional notes on last page. | | | | | | | | | | | | | | |
| **Reason for referral (for all programs requested):** Click here to enter text. | | | | | | | | | | | | | | |
| **Health and Function** | | | | | *Please provide all applicable information* | | | | | | | | | |
| **Mobility:** | Ambulant (walking) | | Power wheelchair | | | Manual Wheelchair | | | | | | | | Other: |
| **Vision:** | Functional | | Impairment | | | Visual Aides | | | | | | | | |
| **Hearing:** | Functional | | Hearing loss (aided) | | | Hearing loss (unaided) | | | | | | | | |
| **Mode of Communication (select all that apply):** | | | | | | | | | | | | | | |
| Speech | Sign Language | | Gesture | | | Augmentative (symbol-based) | | | | | | | | |
| **Legal Status of client** *Please provide all applicable contact information.* | | | | | | | | | | | | | | |
| **Child** (Please check box to indicate which parent/caregiver this child lives with) | | | | | | | | | | | | | | |
| Parent/Primary Caregiver | | | | | Parent/Primary Caregiver | | | | | | | | | |
| Name: Click here to enter text. | | | | | Name: Click here to enter text. | | | | | | | | | |
| Address: Click here to enter text. | | | | | Address: Click here to enter text. | | | | | | | | | |
| Tel.: Click here to enter text. | | | | | Tel.: Click here to enter text. | | | | | | | | | |
| Email: Click here to enter text. | | | | | Email: Click here to enter text. | | | | | | | | | |
| Relationship to Child: Click here to enter text. | | | | | Relationship to Child:Click here to enter text. | | | | | | | | | |
| In custody of: Parent(s) Child and Family Services Other: Click here to enter text. | | | | | | | | | | | | | | |
| **Legal Guardian Information (if other than parents)** | | | | | | | | | | | | | | |
| Legal Guardian: Click here to enter text. | | | | | Agency Name (if applicable): Click here to enter text. | | | | | | | | | |
| Address: Click here to enter text. | | | | | Tel.: Click here to enter text. | | | | | | | Fax: Click here to enter text. | | |
| **Adult** | | | | | | | | | | | | | | |
| Consents for self/no decision maker | | | | Committee  Personal Property | | | | | | SDM  Personal Property | | | | |
| Committee/SDM Contact: Click here to enter text. | | | | | | | | | | | | | | |
| Relationship to Individual: Click here to enter text. | | | | | | | | | | | | | | |
| Address: Click here to enter text. | | | | | Email: Click here to enter text. | | | | | | | | | |
| Tel.: Click here to enter text. | | | | | Fax: Click here to enter text. | | | | | | | | | |
| Daytime Activities: | | Day Program | | | Employment | | | | | | | | School | |
| Name: Click here to enter text. | | | | | Primary Contact: Click here to enter text. | | | | | | | | | |
| Address: Click here to enter text. | | | | | Phone: Click here to enter text. | | | | | | | | | |
| Email: Click here to enter text. | | | | | | | | | | | | | | |
| **Referral Awareness**  *To be completed by referral source. We ask these questions in the spirit of person-centred care. The answers below will not impact the decision to accept or decline the referral.* | | | | | | | | | | | | | | |
| Is the CSW aware of the referral? (For Adults only) | | | | | | | | | | | | | | Yes No |
| Did you inform the individual of this referral? | | | | | | | | | | | | | | Yes No |
| Does the individual support this referral? | | | | | | | | | | | | | | Yes No |
| Did you inform the legal decision maker (if other than the individual) of this referral? | | | | | | | | | | | | | | Yes No |
| Does the legal decision maker (if other than the individual) support this referral? | | | | | | | | | | | | | | Yes No |
| Referral Source (signature): | | | | | | | |  | Date:Click here to enter a date. | | | | | |

**Please return completed form to St.Amant Central Intake by Fax: 204-258.7066**

**For information, please call 204-258.7041**

**\*Please submit signed original copy for Psychological Testing**