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| **Legend**EIA – Employment and Income Assistance PHIN – Personal Health Information NumberCSW – 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**