OCCUPATIONAL THERAPY / PHYSIOTHERAPY REFERRAL
COMMUNITY THERAPY SERVICES INC.
101-1555 St. James Street - Winnipeg, Manitoba - R3H 1B5
Phone: (204) 949-0533   Fax: (204) 942-1428

| CTS USE ONLY |
| CTS CHART # _____ |

Client Name: _____
PHIN: _____
Address: _____
City/Postal Code: _____
Phone #: _____
Date of Birth (dd/mmm/yyyy): _____
MHSC: _____
Sex: _____   Pronouns: _____

REFERRAL DATE: _____ (dd/mmm/yyyy)

*Referrals from hospital sites may be faxed to CTS directly.

***Home Care Case Coordinators may proceed to Referral Source section.
All other referral sources must complete the Eligibility section below.**

ELIGIBILITY: Items below must apply. Fax completed referral to Home Care Central Intake - **204.940.2227**

☐ Client resides within the WRHA   ☐ Requires OT/PT assessment and short-term intervention

☐ Assessment required in home/community   ☐ Client cannot attend an appointment outside the home

☐ Client is not eligible for home-based therapy by another program

REFERRAL SOURCE - Referral source may be contacted for additional information

Community CC name and Community Area Office (if applicable) _____

Person Initiating Referral (If not the above) _____ Designation _____

Organization _____ Phone _____ Fax _____

Is Client and/or Family aware of the Referral: Yes ☐ No ☐   Priority Level Requested by Referral Source*

Safe Visit Plan in Place: Yes ☐ No ☐   Priority 1 ☐ Priority 2 ☐ Priority 3 ☐
                                                    Subject to CTS Intake review

ADDITIONAL INFORMATION

Alternate contact _____ Relationship _____ Phone _____

Appointment to be scheduled with   ☐ Client   ☐ Alternate Contact

Client has third party funding   ☐ EIA   ☐ NIHB   ☐ WCB   ☐ MPI
*Note – If client presently has an open claim with WCB or MPI, the referral may not be processed

CLIENT HEALTH INFORMATION

Primary Care Provider _____ Address _____ Phone _____

Diagnosis 1) _____   2) _____

If client recently hospitalized, provide reason _____ Date of discharge _____

SERVICES REQUESTED (Check all that apply)

☐ ACTIVITIES OF DAILY LIVING (ADL)   ☐ INSTRUMENTAL ADL   ☐ SWALLOWING*
☐ ASSIST WITH COMPLEX HOSPITAL DISCHARGE ☐ PRESSURE MANAGEMENT   **Attach swallowing screen*
☐ FOLLOW-UP POST HOSPITAL DISCHARGE   ☐ ENVIRONMENTAL ASSESSMENT   ☐ WHEELCHAIR / SEATING
☐ COGNITIVE ASSESSMENT   ☐ PAIN MANAGEMENT   ☐ EQUIPMENT ASSESSMENT
☐ PASSIVE RANGE OF MOTION   ☐ EXERCISE PROGRAM
☐ RESPIRATORY   ☐ OTHER _____
☐ SAFE CLIENT HANDLING
☐ TRANSFERS ____ Toilet ____ Commode ____ Bed ____ Tub/Shower ____ Wheelchair ____ Chair ____ Mechanical Lift
☐ REPOSITIONING ____ Bed ____ Wheelchair ____ Commode ____ Other: (Specify) _____
☐ MOBILITY ____ Bed ____ Wheelchair ____ Ambulation ____ Stairs
   ____ Falls Management (date of most recent fall) _____

COMMENTS: