CTS USE ONLY
CTS CHART # _____

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

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
- ☐ Assessment required in home/community
- ☐ Client is not eligible for home-based therapy by another program
- ☐ Requires OT/PT assessment and short-term intervention
- ☐ Client cannot attend an appointment outside the home

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 ☐

Safe Visit Plan in Place: Yes ☐ No ☐
If yes, specify _____

Priority Level Requested by Referral Source*
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 _____
**Note – Referrals from hospital sites may be faxed to CTS directly.*

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
- ☐ SAFE CLIENT HANDLING
- ☐ INSTRUMENTAL ADL
- ☐ PRESSURE MANAGEMENT
- ☐ ENVIRONMENTAL ASSESSMENT
- ☐ PAIN MANAGEMENT
- ☐ EXERCISE PROGRAM
- ☐ OTHER _____
- ☐ SWALLOWING*
  *Attach swallowing screen
- ☐ WHEELCHAIR / SEATING
- ☐ EQUIPMENT ASSESSMENT

- ☐ 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:

CTS use only: **SOURCE CODE:** _____

DIAGNOSTIC CODES _____, _____ SERVICE CODES _____, _____, _____, _____, _____