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

REFERRAL DATE: _____ (dd/mmm/yyyy)

Fax completed referral to Home Care Central Intake - 204.940.2227*
***Exceptions:**
- Hospital sites fax to CTS directly.
- WRHA Home Care proceed to *Referral Source* section, fax completed referral to CTS directly

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

ELIGIBILITY: All Items must apply.

☐ 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 ☐
If yes, specify _____ *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 _____, _____, _____, _____, _____