



**CHILDREN'S THERAPY INITIATIVE  
Central Region**

**Referral for provision of  
Therapy Services**

**Services Requested:**      OT       PT       SLP       **AUDIOLOGY**

Child's Name: \_\_\_\_\_ Male:       MHSC #: \_\_\_\_\_  
 Female:   
 Birthdate:      Month      Day      Year      PHIN #: \_\_\_\_\_  
 Parent(s) \_\_\_\_\_ Phone: (h) \_\_\_\_\_  
 Alternate Caregiver(s) \_\_\_\_\_ Phone: (w) \_\_\_\_\_  
 Home Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Legal Guardian and Agency: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_ Fax: \_\_\_\_\_  
 \*Family Doctor/Pediatrician: \_\_\_\_\_  
 (required information)  
 Address: \_\_\_\_\_

Child is enrolled in:      Home Support Program       Child Care Centre       Nursery School   
 Public School       Private School       Home School       First Nation School   
 School or Child Care Centre: \_\_\_\_\_ Phone: \_\_\_\_\_ School Division: \_\_\_\_\_

**Developmental concerns and/or diagnosis:** \_\_\_\_\_

**Other pertinent information:** \_\_\_\_\_  
 (For school use only)  
 Student Services Authorization Signature: \_\_\_\_\_

Referral Source: \_\_\_\_\_ Date: \_\_\_\_\_  
 Contact person & address: \_\_\_\_\_ Phone #: \_\_\_\_\_

<p><b>Consent for Referral:</b> I am in agreement with a referral to the Children's Therapy Initiative partner agencies for provision of the above-identified therapy services for my child as defined in the CTI-C information pamphlet.</p>	<p>_____</p> <p style="text-align: center;"><i>Signature of Parent or Legal Guardian</i>      <i>Date</i></p>
	<p>_____</p> <p style="text-align: center;"><i>Signature of Witness</i>      <i>Date</i></p>
	<p><input type="checkbox"/> I have received a copy of the information pamphlet telling me about this program.</p>

For Office Use Only:

Date Received at intake:	OT / PT: <input type="checkbox"/> RHA <input type="checkbox"/> RCC SLP: <input type="checkbox"/> RHA <input type="checkbox"/> SMD <input type="checkbox"/> S.D. Audiology: <input type="checkbox"/> RHA	Date Forwarded to provider:	Provider Agency Parent contact date:
--------------------------	---	-----------------------------	--------------------------------------