Winnipeg Regional Health Authority | Office régional de la santé de Winnipeg

Assistive Technology

PRODUCTS AND SERVICES

Communication Devices Program Referral Form

Deer Lodge Centre (DLC)
2109 Portage Ave.
Winnipeg, MB R3J 0L3
Tel. (204) 831-3430
Fax (204) 885-2524
email: cdp@wrha.mb.ca
Web: deerlodge.mb.ca/cdp

NAME: **PHIN:**

Date: D D M M M Y Y Y Y **Internal use ONLY – Referral Received:** D D M M M Y Y Y Y

PRIOR to proceeding please indicate if: ☐ **Applicant/ Legal Decision Maker aware of/ agree to referral**

DEMOGRAPHIC INFORMATION

Last Name: _____ **First Name:** _____

Date of Birth: D D M M M Y Y Y Y **PHIN:** _____ **MB Health Number:** _____

Diagnosis & Relevant Medical History: _____

_____

_____

Mailing Address: _____ **City/Town:** _____

Physical Address: _____ **Postal Code:** _____

Preferred Contact method: ☐ **Phone:** _____ ☐ **email:** _____

Pronouns: ☐ **He/Him/His** ☐ **She/Her/Hers** ☐ **They/Them/Theirs** ☐ **Other:** _____

Primary Language: ☐ **English** ☐ **French** ☐ **Other:** _____ **Interpreter Required:** ☐ **Yes** ☐ **No**

☐ **Receives Funding:** _____ **Case #:** _____

Client ID # (Treaty, status or N number), or Band #: _____

LEGAL STATUS Applicant legally responsible for making their own decisions? ☐ Yes ☐ No (please complete below)

Legal Decision Maker: _____ **Role:** _____

Address: _____ **City/Town:** _____ **Postal Code:** _____

Telephone: _____ **Fax:** _____ **Email:** _____

TEAM CONTACT INFORMATION

Next of Kin/ Alternate Contact: _____ **Relation:** _____

Telephone: _____ **Email:** _____

Current/Recent SLP: _____ **Employer:** _____

Telephone: _____ **Fax:** _____ **Email:** _____

Current/Recent OT: _____ **Employer:** _____

Telephone: _____ **Fax:** _____ **Email:** _____

Case Manager: _____ **Employer:** _____

Telephone: _____ **Fax:** _____ **Email:** _____

Community Supports: (please check/ complete all that apply)

☐ **School:** _____ **Contact (Name/ Number):** _____

☐ **Day Program:** _____ **Contact (Name/ Number):** _____

☐ **Residence:** _____ **Contact (Name/ Number):** _____

☐ **Other:** _____ **Contact (Name/ Number):** _____

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NAME: **PHIN:**

SERVICE OPTIONS REQUESTED (*Please ensure you provide required paperwork as per below)*

Please check all areas that apply:

- ☐ **Assessment*:** ☐ **SLP (for Speech Generating Device),** ☐ **OT (for Access and/or Mounting)**
- ☐ **Consultation*:** ☐ **SLP (for Speech Generating Device),** ☐ **OT (for Access and/or Mounting)**
- ☐ **Clinic Loan ****
- ☐ **SGD Trial****
- ☐ **Rental Only*** (No CDP Assessment/ Consultation)**

Required Paperwork:

**** For Assessment or Consultation, please attach relevant reports***

***** For Clinic Loan, or SGD trial, please complete and attach the Desired Equipment Form (CDP-03).***

******For rental, please complete and attach the Speech Generating Device Prescription Form (CDP-05).***

NOTE: The ELRA (CDP-02) will be required before any equipment can be provided, please complete and attach to referral IF available.

ADDITIONAL INFORMATION

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

FOR APPOINTMENTS PLEASE CONTACT

Name: _____ **Contact information:** ☐ **As Above** ☐ **See Below**

Address: _____ **City/Town:** _____ **Postal Code:** _____

Telephone: _____ **Fax:** _____ **Email:** _____

REFERRAL SOURCE

Name: _____ **Contact information:** ☐ **As Above** ☐ **See Below**

Address: _____ **City/Town:** _____ **Postal Code:** _____

Telephone: _____ **Fax:** _____ **Email:** _____

Signature: _____ **DATE:** _____

For more information or assistance completing referral please contact 204-831-3430 or see our guide online