Deer Lodge Centre (DLC)
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Assistive Technology

PRODUCTS AND SERVICES

Communication Devices Program
Referral Form – Completion Guide

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

Date: Date form is filled out (D D M M M Y Y Y Y)

Internal use ONLY – Referral Received: INTERNAL use only - Date form is received (D D M M M Y Y Y Y)

☐ **Client/Substitute Decision Maker AWARE and in AGREEMENT of referral to Communication Devices Program (*must be checked to proceed*)** If this box isn't checked, referral will be sent back as incomplete

CLIENT INFORMATION

Indicate who the client would like CDP to contact by checking box

(PLEASE indicate: ☐ Contact client directly ☐ Contact Alternate Contact listed below)

Client Last Name: Client Last Name **First Name:** Client First Name

Personal Health Identification Number (PHIN): 9 digit PHIN **MB Health Number:** 6 digit MB Health Number

Date of Birth: Client Date of Birth (D D M M M Y Y Y Y) **Diagnosis:** Primary diagnosis

Address: Home street address preferred **City/Town:**

Postal Code: **Email:** Optional

Telephone: (Main) Provide preferred # **(Alternate)** **(Work)**

Gender: ☐ **Male** ☐**Female** ☐**Other:** **Preferred Pronouns:** ☐**He/Him/His** ☐**She/Her/Hers** ☐**They/Them/Theirs**

☐ **Receives 3rd Party Funding – Agency:** Check ***if*** 3rd party funding available, report agency (i.e. EIA) and case number

ALTERNATE CONTACT

Please ask client if they agrees to CDP contacting the Alternate Contact

(PLEASE confirm: ☐ client agrees to have CDP contact the person listed below)

Substitute Decision Maker/Next of Kin: Contact First and Last Name **Relation:** Parent/Spouse, etc

Contact Address: Home street address preferred **City/Town:**

Postal Code: **Email:** Optional

Telephone: (Main) Provide preferred # **(Alternate)** **(Work)**

REFERRAL SOURCE and OTHER PROFESSIONALS INVOLVED

Referred by/Affiliation: First and Last Name/SLP, OT, CSW, etc ***Signature:*** Must be signed

Email: Work related **Telephone:** Work related **Fax:** Work related

Current/Recent SLP: If different from above, or recent, if no current **Employer:** Facility (i.e. DLC), Department (i.e. MND)

Email: Work related clinician available **Telephone:** Work related **Fax:** Work related

Current/Recent OT: If different from above, or recent, if no current **Employer:** Facility (i.e. DLC), Department (i.e. MND)

Email: Work related clinician available **Telephone:** Work related **Fax:** Work related

SERVICES REQUESTED

Please check ALL desired options, (i.e. Assessment OT & Consultation SLP)

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)**

PLEASE NOTE:

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

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

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

NOTE: The ELRA (CDP-02) will be required before any equipment can be provided, please send with referral IF available.

Description of services requested:

Space to provide additional written information about services OR specific equipment being requested.

See routing instructions for next steps with referral