Centre intégré
de santé
et de services sociaux
de la Montérégie-Ouest
Québec

Dossier :	
Nom, Prénom :	
Date de naissance : (aaaa-mm-jj)	☐ F ☐ M
NAM :	Exp. (yyyy-mm)
Nom, Prénom de la mère :	

PHYSICAL DISABILITY SERVICE REQUEST
SPECIALIZED OUTPATIENT SERVICES[i]

Guidelines for the technical aids service **(TAS) only**, for technical aids related to positioning and mobility, or an orthosis, with **no need for rehabilitation**	Fill out the service request at this link: Référence au service des aides techniques (french version only) Visit the web page Technical aids service (TAS) - positioning and mobility for full details.
Guidelines for the Comptoir des aides de suppléance à l'audition (CASA)- assistive listening device **only**, for assistive listening devices, based on the rules established by the RAMQ, with **no need for rehabilitation**.	Fill out sections 1-2-3-4-5-8 of this request form and attach the three following documents: 1. RAMQ form 3485 entitled Recommandation – aide de suppléance à l'audition, filled out by an audiologist within the past year. 2. An audiogram report issued by an audiologist within the past year. 3. A medical certificate signed by an ear, nose and throat (ENT) doctor within the past year or indicating that the deafness is permanent. Preferably email the request to casa.cisssmo16@ssss.gouv.qc.ca or send by fax to 450-676-2043.

SECTION 1

USER IDENTIFICATION AND CONTACT INFORMATION

Complete the box in the top right corner of the page, but leave the line Dossier blank

Language(s) spoken: ☐ French ☐ English ☐ Langue des signes du Québec (LSQ) ☐ Other(s):

Preferred language of written communications: ☐ French ☐ English

User's email if 14 years and over :

Occupation: ☐ Worker ☐ Student ☐ Retired ☐ Income security ☐ Other:

CURRENT PLACE OF RESIDENCE

☐ **At home** ☐ Alone ☐ With :	☐ **At a resource** ☐ Intermediate resource or family-type resource (IR-FTR) ☐ Residential and Long-term care centre (CHSLD) ☐ Private seniors' residence (PSR) ☐ Other:

Address :	**City :**	**Postal code :**
Tel. no : ☐ TDD/TTY **Home :**	**Mobile :**	**Work :**

I HAVE DIFFICULTY COMMUNICATING BY PHONE ☐ Not applicable

Choose you preference: ☐ Use my email **OR** ☐ I authorize you to contact the following person

Last name :	**First name :**
Relationship :	**Tel. no :**

Last name, First name: File:

SECTION 2

CONTACT INFORMATION OF PARENTS OR REPRESENTATIVE (IF APPLICABLE) ☐ **Not applicable**	
First name, last name :	**First name, last name :**
Relationship to user :	**Relationship to user :**
Email :	**Email :**
☐ Same address as user **Address :**	☐ Same address as user ☐ Same address as other representative **Address :**
City : **Postal code :**	**City :** **Postal code :**
Tel. Home : **Mobile :**	**Tel. Home :** **Mobile :**
Tel. Work :	**Tel. Work :**
Language: ☐ French ☐ English ☐ Other:	**Language:** ☐ French ☐ English ☐ Other:
Type of custody: ☐ Legal ☐ Shared ☐ Other :	
If legal guardian, specify :	

LEGAL FRAMEWORK (IF APPLICABLE) ☐ **Not applicable**	
☐ ARHSSS (*Act respecting health services and social services)*	☐ YPA (*Youth Protection Act*)
☐ YCJA (*Youth Criminal Justice Act*)	
First name and last name of case worker :	
Email :	**Tel. no :**

SECTION 3

PROTECTIVE SUPERVISION REGIME ☐ **Not applicable**				
☐ Private	☐ Public	☐ Property	☐ Person	☐ Property and person
Protection mandate:	☐ Yes, is it homologated? ☐ No	→ ☐ Yes, file no. (if known) : ___________________ → ☐ Not homologated		
First name and last name of respondent :			**Tel. no :**	
Address :		**City :**	**Postal code :**	

SECTION 4

PAYING AGENT (RELATED TO THE NEEDS EXPRESSED IN THIS REQUEST) ☐ **Not applicable**	
☐ SAAQ ☐ CNESST ☐ IVAC ☐ Other :	
File no :	**Agent/Advisor :**
Email :	**Tel. no :**
If applicable, date of accident/event :	

Last name, First name: File:

SECTION 5

IDENTIFICATION OF REFERRING PERSON/PERSON WHO FILLED OUT THE REQUEST, IF OTHER THAN USER		
Last name :	**First name :**	
Professional title and license no. OR relationship :		
Name of program and institution :		
Address :	**City :**	**Postal code :**
Email :	**Tel. no :**	**Fax :**

SECTION 6

MEDICAL INFORMATION/DIAGNOSIS(ES)

Professional diagnosis or conclusion related to this request :

Other diagnosis(es) or associated condition(s) :

Do you have a family doctor/pediatrician? ☐ Yes, first name and last name Tel. no :

☐ No, first name and last name of attending physician, if applicable Tel. no :

PREVIOUS OR ONGOING ASSESSMENT(S)/FOLLOW-UP(S) ☐ Not applicable

Assessment(s)	Date	First name and last name of professional/specialist and name of institution (CISSS/CIUSSS)	Results/ diagnosis (if applicable)	Follow-ups after the assessment?	Reports available
☐ Pending ☐ Ongoing ☐ Previous				☐ Yes ☐ No ☐ Pending	☐ Yes ☐ No
☐ Pending ☐ Ongoing ☐ Previous				☐ Yes ☐ No ☐ Pending	☐ Yes ☐ No
☐ Pending ☐ Ongoing ☐ Previous				☐ Yes ☐ No ☐ Pending	☐ Yes ☐ No
☐ Pending ☐ Ongoing ☐ Previous				☐ Yes ☐ No ☐ Pending	☐ Yes ☐ No

Referral(s) to an organization or institution (CISSS/CIUSSS) other than the CISSS de la Montérégie-Ouest?

☐ No ☐ Yes, which one? :

Last name, First name: File:

SECTION 7 (READ THE DIFFERENT OPTIONS CAREFULLY)

INFORMATION NEEDED ABOUT THE SITUATION RELATED TO THIS REQUEST

For a request regarding the Clinique de spasticité (Botox)*, go to Section 8.

**Note that a referral from a general practitioner or a specialist is mandatory if the user is not a patient of a specialist at a medical clinic at the Centre de réadaptation en déficience physique (CRDP-CISSS de la Montérégie-Ouest)*

For a request related to rehabilitation services for one of the following reasons, You do not need to fill out Section 7, **but you must** fill out the relevant additional information form.

☐ Language impairment - user 6 years and under in a multilingual environment ☐ Stutter

☐ Auditory processing disorder (APD*)* ☐ Developmental coordination disorder (DCD)

☐ Assistive Technology/Communication ☐ Driving evaluation or vehicle adaptation ☐ Regional chronic pain program

For requests related to a reason other than those mentioned above, including an accommodation request, you must fill out Section 7. **HOWEVER**, if the answers to the questions are contained in a document attached to this request, indicate below where the information can be found.

A) Describe the difficulties experienced on a daily basis (problem and impacts):

☐ Found in the document ____ section or page _________

B) Previous interventions or follow-up (attempted solutions)?

☐ Found in the document ____ section or page _________

C) Why are you submitting the request now (triggering event)?

☐ Found in the document ____________________ section or page _______ ☐ Not applicable for a new diagnosis

D) Regarding the difficulties mentioned in the first question, what are the needs (expectations) expressed by :

- The user and their family (loved ones)? :

- The referring person, <u>if different</u> from those expressed by the user?

☐ Found in the document ____________________ section or page _______ ☐ Same needs identified

Last name, First name: File:

SECTION 8

CONSENT

I, (user 14 years and over or person with parental authority or representative),

☐ Confirm having been informed of this referral and, as needed, will cooperate with the analysis of the request.

☐ Understand that it is my responsibility to communicate any change in my contact information.

☐ Consent to the referring person sending the relevant information and reports related to this service request.

☐ Authorize the CISSS de la Montérégie-Ouest to obtain a copy of the relevant reports related to this service request, as identified in the **Medical information/diagnosis(es)** section, if they concern institutions of the CISSS de la Montérégie-Ouest.

IMPORTANT

The user and the referring person will receive a letter **by email** informing them whether or not the request is admissible. The referring person will receive the letter only if their full contact information appears in the service request form.

Please check if applicable ☐ User wants to receive a paper copy ☐ The referring person wants to receive a paper copy

______________________________________ _________________________

Signature of user or their representative ☐ or verbal consent Date (YYYY-MM-DD)

______________________________________ _________________________

Signature of person who obtained the verbal consent Date (YYYY-MM-DD)

Before submitting your documentation to the ID-ASD-PD access desk, make sure to:

☐ Fill out all sections of this request, if applicable;

☐ Fill out the complementary information sheets, if applicable;

☐ Attach all relevant documents - See checklist for referring persons for the list of required documents.

Note that incomplete requests will be return to the referring person.

ACCESS DESK CONTACT INFORMATION

Use email preferably	**Email:** guichet-acces.di-tsa-dp.cisssmo16@ssss.gouv.qc.ca Fax: 450-635-1865 Mail**:** 27 rue Goodfellow, Delson, QC J5B 1V2 For more information: 450-635-4779, ext. 3029 1-833-364-0944, ext. 3029

[i] For information regarding English language services, visit the web page English-language services | Santé Montérégie Portal (santemonteregie.qc.ca)