|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |

|  |  |  |
| --- | --- | --- |
| Dossier : |   |  |
| Nom, Prénom : |   |
| Date de naissance : |    | [ ]  F [ ]  M |
|  aaaa-mm-jj |
| NAM : |   |  Exp. |   |
|   |  |  | yyyy-mm |
| Nom, Prénom de la mère : |   |

 |
| **PHYSICAL DISABILITY SERVICE REQUEST****SPECIALIZED OUTPATIENT SERVICES[[1]](#endnote-1)** |  |

|  |  |
| --- | --- |
| **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](https://www.santemonteregie.qc.ca/sites/default/files/2020/06/reference_au_service_des_aides_techniques_cli-60345_2020-05.pdf) (french version only) Visit the web page [Technical aids service (TAS) - positioning and mobility](https://www.santemonteregie.qc.ca/en/services/physical-disability-physical-rehabilitation/technical-aids-service-tas-positioning-and) 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](https://www.ramq.gouv.qc.ca/SiteCollectionDocuments/professionnels/formulaires/3485.pdf), 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) [ ]  Long-term care centre (CHSLD)  [ ]  Private seniors’ residence (PSR) [ ]  Other:  |
| **Address**  **Apt.**   | **City**   | **Postal code**   |
| **Tel. no.(s):**  [ ] 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.**   |

| **SECTION 2** |
| --- |
| **CONTACT INFORMATION OF PARENTS OR REPRESENTATIVE (IF APPLICABLE)** [ ]  **Not applicable** |
| **First name, last name**  **Relationship to user**   | **First name, last name**  **Relationship to user**   |
| **Email**   | **Email**   |
| [ ]  Same address as user**Address** **Apt.**  | [ ]  Same address as user[ ]  Same address as other representative**Address** **Apt.**  |
| **City** **Postal code**   | **City**  **Postal code**   |
| **Tel. no.: Home**  **Mobile**  | **Tel. no.: Home**  **Mobile**  |
| **Tel. no. - work**   | **Tel. no. - 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? [ ]  Yes, file no. (if known)  [ ]  No [ ]  Not homologated |
| **First name and last name of respondent**  **Tel. no.**   |
| **Address**  **Apt.**   **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**   |

| **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**  **Apt.**   **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 |

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

[ ]  Yes, which one? [ ]  No

| **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.  |
| 1. **Describe the difficulties experienced on a daily basis (problem and impacts):**

[ ]  Found in the document section or page  |
| 1. **Previous interventions or follow-up (attempted solutions)?**

[ ]  Found in the document section or page  |
| 1. **Why are you submitting the request now (triggering event)?**  [ ] Not applicable for a new diagnosis

[ ]  Found in the document section or page  |
| 1. **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, if different from those expressed by the user?**  [ ]  Same needs identified[ ]  Found in the document section or page  |

| **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.caFax: 450-635-1865Mail**:** 27 rue Goodfellow, Delson, QC J5B 1V2For more information: 450-635-4779, ext. 3029 1-833-364-0944, ext. 3029 |

1. For information regarding English language services, visit the web page   [English-language services | Santé Montérégie Portal (santemonteregie.qc.ca)](https://www.santemonteregie.qc.ca/en/informations-organisationnelles/english-language-services) [↑](#endnote-ref-1)