Alberta Health Services

Affix patient label within this box

Pediatric Outpatient Physical and Occupational Therapy Services Referral

This referral is to be completed to make Pediatric Outpatient referrals to the Stollery Children's Hospital.

Please **note** that this service does not provide Feeding or Swallowing Services.

Send completed form by **fax** to 780.407.7534 or by **mail** to 8440 - 112 Street, Walter Mackenzie Center, Room 1F1 Rehabilitation Services. For other enquiries **call** 780.407.6002 or 780.407.6203.

Incomplete or illegible forms will be returned, thus may delay service

Patient Information

Date *(yyyy-Mon-dd)*	Name *(Last,First)*		Date of Birth *(yyyy-Mon-dd)*
Gender ☐ Female ☐ Male	Personal Health Number	Name of Parent(s) or Guardian *(Last,First)*	
Address	City/Town	Province	Postal Code
Home Phone Number	Work Phone Number	Cell Phone Number	
Name of Family Physician/Pediatrician	Practice ID	Phone Number	Fax Number

Birth History
☐ No Complications ☐ Preemie ☐ Neonatal ICU ☐ Other, *specify* _____

Diagnosis

Past Medical History

Is the patient currently receiving Physical or Occupational therapy services?
☐ No
☐ Yes, *specify* _____

Is an interpreter required?
☐ No
☐ Yes, *specify language* _____

Type of Service Requested

☐ Physical Therapy ☐ Occupational Therapy

Reason for Referral

☐ Developmental Delay ☐ Torticollis/Head Tilt ☐ Persistent Toe Walking
☐ Gait & Balance ☐ Coordination ☐ Pain, *location* _____
☐ Musculoskeletal, *location* _____
☐ Other _____ ☐ Functional Issues/Activity of Daily Living (ADLS)

Consultations

☐ Physiatry ☐ Psychiatry/Psychology ☐ Orthopaedics
☐ Neurology/Neurosurgery ☐ Surgeon *specify* _____ ☐ Other, *specify* _____

Other Programs Referral Made

☐ Homecare
☐ Learning and Development Clinics
☐ Edmonton Regional Collaborative Service
☐ Neonatal Clinic
☐ Other *specify* _____
☐ Preschool Rehab Services OT/PT
☐ Program Unit Funding (PUF)
☐ Glenrose Rehabilitation Hospital
☐ Family Support for Children with Disabilities (FSCD)

Referring Healthcare Professional

Name	Signature		Date	Phone Number
Mailing Address	City/Town	Province	Postal Code	Fax Number