Alberta Health Services

Community Outreach and Assessment Support Team Referral (Edmonton Zone)

- This form is to be completed by Caseworkers with Children's Services or Disability Services only.
- All areas of this form must be completed.
- A completed Consent to Disclose Health Information *(form 18028)*, **must** accompany this referral.
- Send completed referral to Children's Services or Disability Services Supervisor.
- For further assistance or information please **call** 780-342-5500.

Once all relevant information and reports have been received, a response that indicates if the referral is accepted will be provided within 10 days of receipt.

Demographical Information			
Client Last Name, First & Middle Name(s)			Today's Date *(yyyy-Mon-dd)*
Provincial Health Care Number ☐ Out of Province		Date of Birth *(yyyy-Mon-dd)*	Age
Client Address		Client Phone	
Primary Contact *(include relationship – parent, guardian, agency representative)*		Primary Contact Phone	
Guardian Name	Guardian Email	Guardian Phone	
Currently Resides ☐ Alone ☐ With Family ☐ Supported Housing ☐ Hospital ☐ Other _____			
Family Physician	Phone	Fax	
Pharmacy	Phone	Fax	

Referring Source, Signature and Date	
Last Name, First Name	
Email	Phone
Position, Program and Ministry	
Signature	Date *(yyyy-Mon-dd)*

Reason for Referral ***(check all that apply)***	
☐ Training/Education for Supports	☐ Mental Health and Behavioral Support
☐ Risk Mitigation and Stabilization	
Please explain reason for referral *(what are you and/or the person/family/others hoping to achieve from this referral?)*	

Relevant Reports/Investigations *(check all that apply and attach a copy of all relevant findings)*	
☐ Hospital Emergency, Admission & Discharge Summaries	☐ ISP/OP/IEP/FCAON
☐ Psychiatric Records	☐ Restrictive/Positive Procedure Plans & Tracking
☐ Outpatient Reports	
☐ Specialist Reports/Referral Information Plans	☐ OT/SLP Reports/Assessments
☐ Critical Incident Reports	☐ Psychological/Educational Assessments
☐ Probation Order or Conditions of Release	☐ Other

Communication and Mobility *(check all that apply)*			
☐ Verbal Languages spoken:		Interpreter Required ☐ Yes ☐ No	
☐ Non-Verbal ☐ Gesture ☐ Sign ☐ Communication Aid			
Ability to Read ☐ Yes ☐ No		Ability to Write ☐ Yes ☐ No	
Hearing:		Vision:	
Mobility Issues ☐ No ☐ Wheelchair ☐ Unable to Attend Clinic ☐ Other			

Background Information

Medical History *(complete medical history including operations, illnesses, drug allergies, epilepsy, head injury)*

Developmental History & Mental Health - *Is there a history of delay in major developmental milestones (e.g. walking, talking, toilet training) or current concerns regarding the person's mental health (e.g. mood problems, anxiety, hallucinations, self-harm, or suicidal ideations)? If so, please describe.*

Personal Strengths, Interests and Current Relationships *(please explain in detail)*

Current and Past Funded Supports *(out of home supports, day program, school specialized services)*

Medications *(complete list of psychiatric & physical medications, over-the-counter, vitamins and supplements if known)*	

Education History

Please explain in detail. If the client attended a special education program, please provide the level of support and scholastic achievement.

Quality of Life

Indicate the degree to which the presenting issue *(reason for referral)* is impacting the person's quality of life and which areas are affected.

Risk

What are the main risks to the person, professionals, or others? How are they currently being managed? *(include any history of harm to self and others, substance misuses, isolation, self-neglect)*

Legal History

Does the person have any relevant legal history *(e.g. probation orders or cautions)*? If so, please describe:

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Key Stakeholders - ***Provide detail for all services currently accessed by the person and whether they are aware of this referral. (e.g. Psychiatry, Family Physician, Support Staff, Guardian, Agencies, Social Worker, Probation Officer, ISD Worker)***

Name	Name
Role	Role
Phone	Phone
☐ Involved ☐ Aware	☐ Involved ☐ Aware
Name	Name
Role	Role
Phone	Phone
☐ Involved ☐ Aware	☐ Involved ☐ Aware
Name	Name
Role	Role
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☐ Involved ☐ Aware	☐ Involved ☐ Aware
Name	Name
Role	Role
Phone	Phone
☐ Involved ☐ Aware	☐ Involved ☐ Aware

Consent, Support & Decision Making ***(check all that apply and ensure the AHS consent form is completed)***

☐ **Guardianship Order** *(provide a copy and indicate primary contact information below)*

Name	Phone

Consent signed by

Last Name, First Name	
Relationship to referred party	
Signature	Date *(yyyy-Mon-dd)*

Referral form completed by

Last Name, First Name	
Signature	Date *(yyyy-Mon-dd)*