Alberta Health Services

Affix patient label within this box

Consultative Diagnostic Clinics Referral

Alberta Children's Hospital, Child Development Services

- Refer to inclusion/exclusion criteria on the Alberta Referral Directory
- Complete all fields of the referral form
- Attach any required/completed reports, notes, or assessments, etc
- Ensure the appropriate people are aware of referral *(Family Physician, Pediatrician, Family, Guardian, etc)*
- Call 403-955-5999 for referral related inquiries

Once completed Fax referral and any other relevant documents/information to 403-955-5990

Patient Information *(Or affix patient label)*		**Referring Source** *(Pediatricians, Pediatric Subspecialists, Family Physicians)*	
Name (Last, First, Middle)		Name	
Address	Gender ☐ Male ☐ Female	Phone	Fax
City/Prov	Postal Code	PRACID #	Date *(yyyy/mmm/dd)*
Personal Health Care #	Date of Birth *(yyyy/mmm/dd)*	Pediatrician's Name	Family Physician's Name

Primary Caregiver Information *(e.g. Parent, Foster Parent, Guardian, etc)*

Name (Last, First)		Relationship
Home Phone	Work Phone	Cell Phone
☐ Interpreter Required What language?		Parent/Guardian is **aware of & agrees** to this referral ☐ Yes ☐ No

Child & Family Services (CFS)

Is CFS Involved? ☐ Yes ☐ No	Name of Worker	Phone
If Child and Family Services is the guardian, are they **aware** of the referral ☐ Yes ☐ No		

Reason for Referral

Select clinic/service child is being referred to
- ☐ Developmental Neurology Clinic
- ☐ Youth Health Program
- ☐ Consultative Clinic in Developmental Pediatrics

What is your specific diagnostic/developmental question or primary reason for referral?

☐ Indicate if this referral is URGENT and provide reason _____

Description of child's presentation and/or issues that have led you to this question
(Most recent/relevant encounter and/or consultation notes must be attached)

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Relevant Medical Information
List confirmed diagnoses
Relevant medical history and physical examination findings
Birth history *(e.g. hospital, gestation, weight, issues, exposures)*
Allergies
List which ACH/Richmond Road and/or Mental Health Clinics this child has been seen by or referred to ☐ N/A
Medications - include alternative treatments, vitamins & herbal supplements, etc. *(Attach sheet as needed)*:
List imaging, lab work, allied health assessments recently completed. *(Attach all reports)*