

## Telephone Consultation Referral for Developmental Psychiatry Consultation & Complex Management Clinic

The completed referral form and other relevant documents/information can be Faxed to 403-955-5990  
Alberta Children's Hospital, Child Development Services, Phone 403-955-5999

Patient Information <i>(Or affix patient label)</i>		Referring Source <i>(Community Pediatricians)</i>	
Name (Last, First, Middle)		Name	
Address	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	PRACID #	
City/Prov	Postal Code	Phone	Fax
Personal Health Care #	Date of Birth <i>(yyyy/mm/dd)</i>	Are the patient's <b>parent(s)/guardian aware</b> of this consult? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Problem(s) List			
Please briefly list the patient's conditions/difficulties			
Psychosocial Issues			
Are there any relevant psychosocial issues? If so, please describe			
Medical Concerns			
Are there any significant/active general medical concerns? If so please describe			
Current Medications			
Telephone Consult			
Estimated time needed for the consult? <input type="checkbox"/> under 15 minutes <input type="checkbox"/> 15-30 minutes What would you like to discuss in this phone consult?			