Alberta Health Services

Autism Spectrum Disorder Diagnostic Clinic Referral

Alberta Children's Hospital, Child Development Services

Affix patient label within this box

- 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** *(Physicians, Allied Health Professional)*	
Name (Last, First, Middle)		Name	
Address	Gender ☐ Male ☐ Female	Profession	PRACID #
City/Prov	Postal Code	Phone	Fax
Personal Health Care #	Date of Birth *(yyyy/mmm/dd)*	Family Physician	Pediatrician

Primary Caregiver Information *(eg. Parent, Foster Parent, Guardian, etc)*		
Name (Last, First)		Relationship
Home Phone	Work Phone	Cell Phone
☐ Interpreter Required What language? _____	Parent/guardian is **aware of and 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 ☐ Unsure

Reason For Referral

What is your specific (diagnostic) question or primary reason for referral?

☐ I am requesting a second opinion. An ASD diagnosis was ☐ confirmed ☐ ruled out at _____(age?)
Explain reason for request *(attach any current documentation, assessments, tests, etc that now supports /rules out an ASD diagnosis)*

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

☐ Indicate if this referral is **URGENT** and provide reason_____

Allied Health ONLY

Family physician/pediatrician who knows about this referral and has agreed to follow/support this child
Name _____ Phone _____

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Relevant Medical Information

List confirmed diagnoses

Relevant medical history and physical examination findings

Birth history
(eg. hospital, gestation, weight, issues, exposures)

List which ACH/Richmond Road/Mental Health Clinics this child has been seen by/referred to ☐ N/A

Allergies

Medications - include alternative treatments, vitamins & herbal supplements, etc. *(Attach sheet as needed)*

List imaging, lab work, tests, allied health assessments recently completed and referrals made to other healthcare providers *(Must attach all reports)*

Areas of Concern

A. Social, Communication and Interaction Skills *(**MUST** present with all 3)*

Social-emotional reciprocity - *(eg. Limited initiation of social interaction, Reduced sharing of emotions/affects, poor social imitations, etc)*. Provide example(s)

Non-verbal communication -*(eg. Poor use/understanding of gestures, Impaired eye contact, Poor use/understanding of affect, etc)* Provide example(s)

Development of relationships with peers of the same developmental level - *(eg. Lack of interest in peers, limited sharing of imaginary play, difficulties making friends, etc)*. Provide example(s)

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Areas of Concern - Continued

B. Restricted, Repetitive Behaviours, Interests/Activities *(Check (✓) areas of concern, **MUST** present with 2)*

☐ **Stereotyped/repetitive speech, motor movements, or use of objects** - *(eg. Echolalia, Repetitive vocalizations, finger/arm movements, abnormal posture, etc)* Provide an example(s)

☐ **Routines/rituals/resistance to change** - *(eg. Strict adherence to specific routines, Rigid thinking, Verbal or non-verbal rituals/compulsions, etc)*. Provide example(s)

☐ **Preoccupation/intense interests** - *(eg. Intense interests in certain objects/topics, Intense interest in unusual objects/topics, Strong attachment to unusual objects)* Provide example(s)

☐ **Sensory Responses** - *(eg. Hyper or hypo reactivity to sensory input, Unusual sensory interest)* Provide example(s)

C. Additional concerns noted from parents/caregivers *(Check (✓) all that apply)*

☐ Loss of skills
☐ Anxiety
☐ Self-injurious behaviours
☐ Safety concerns
☐ Hyperactivity/Impulsivity
☐ Tantrums/aggression/negative/disruptive behavior

Note: All items assessed above are only observations to assist with the diagnostic process and does not necessarily confirm a diagnosis