

Children's Hospice and Palliative Care Service Referral

- Incomplete referrals will be sent back to the referral source.
- Please refer to **Alberta Referral Directory** for clarification of referral guidelines.
- Please complete all sections of this form and FAX to 403.955.5501.

Date (yyyy-Mon-dd)	Referring Physician/NP	Service		
Last Name	First Name	Personal Health Care Number		
Date of Birth (yyyy-Mon-dd)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Non-Binary/Prefer not to disclose			
Contact Person Name:	Relationship:	Phone		
Interpreter Required? <input type="checkbox"/> No <input type="checkbox"/> Yes (Specify language spoken):				
Reason for Referral				
Diagnosis				
Select all that apply <ul style="list-style-type: none"> <input type="checkbox"/> This is a serious illness with expected death in childhood <input type="checkbox"/> This is a serious illness with uncertainty in trajectory <input type="checkbox"/> Patient has shown disease progression in childhood 				
Would you be surprised if the child died in childhood? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure				
Clinical Information (check all that apply) if patients have neuromuscular disease go to next section				
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Long term oxygen therapy <input type="checkbox"/> Non-invasive ventilation in the home <input type="checkbox"/> Tracheostomy and/or 24-hour ventilation <input type="checkbox"/> Losing weight due to feeding difficulties <input type="checkbox"/> Pain/distress with feeding </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Frequent use of seizure rescue medication <input type="checkbox"/> Episodes of status epilepticus requiring intensive treatment <input type="checkbox"/> Dependent on wheelchair driven by caregiver <input type="checkbox"/> Difficulty maintaining seated position <input type="checkbox"/> Severe bulbar dysfunction </td> </tr> </table>			<input type="checkbox"/> Long term oxygen therapy <input type="checkbox"/> Non-invasive ventilation in the home <input type="checkbox"/> Tracheostomy and/or 24-hour ventilation <input type="checkbox"/> Losing weight due to feeding difficulties <input type="checkbox"/> Pain/distress with feeding	<input type="checkbox"/> Frequent use of seizure rescue medication <input type="checkbox"/> Episodes of status epilepticus requiring intensive treatment <input type="checkbox"/> Dependent on wheelchair driven by caregiver <input type="checkbox"/> Difficulty maintaining seated position <input type="checkbox"/> Severe bulbar dysfunction
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Neuromuscular Disease (only complete for neuromuscular disease)				
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