Alberta Health Services

Prior to faxing this referral, please affix a label with physician/clinic/health center name & address

Head Shape Clinic Referral

Please fax a completed copy to:

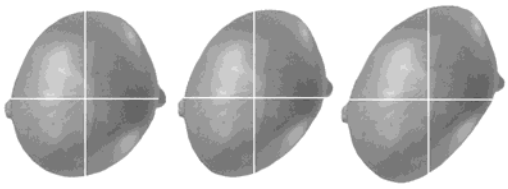
☐ Alberta Children's Hospital
2888 Shaganappi Trail NW Calgary Alberta
Fax: 403.476.7756
Phone 403.955.7918

☐ Stollery Children's Hospital
Clinical Sciences Building (CSB) 1-170
8440 112 Street, Edmonton Alberta
Fax: 780.407.6284
Phone 780.407.1980

Child's Information Label Include current home address		Parent/Guardian *(last name, first name)* Phone Number Interpreter Required? ☐ No ☐ Yes *(specify language)* _____
Current Age	Adjusted Age	Infant Re-Positioning Class Attended (ACH only)? ☐ No ☐ Yes
Suspected side of flatness ☐ Right ☐ Left	Suspected Torticollis? ☐ No ☐ Yes	Attending Physiotherapy? ☐ No ☐ Yes *(specify location)* _____
Accessing other treatment options? ☐ No ☐ Yes *(describe)* _____		

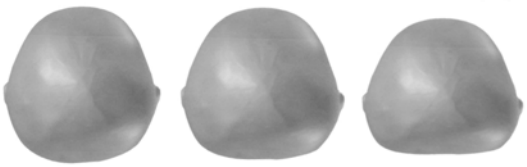
Please circle all areas of the head shape that match areas of concern and severity

Plagiocephaly



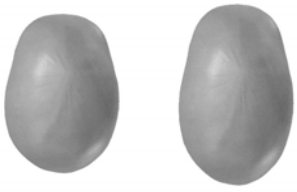
Mild Moderate Severe

Brachycephaly



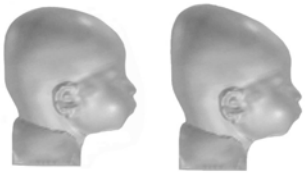
Mild Moderate Severe

Scaphocephaly



Mild Severe

Sagittal view



Mild Severe

Additional information and further explanation of head shape *(eg. concurrent diagnoses, developmental delay)*

Referring Provider *(print name)*	Signature	Prac ID	Date *(yyyy-Mon-dd)*