Alberta Health Services

Affix patient label within this box

Early Childhood Rehabilitation Services Referral

Alberta Children's Hospital

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

The completed referral and other relevant documents/information can be Faxed to 403-955-5990

Patient Information *(Or affix patient label)*		**Referring Source** *(Physicians, Allied Health, RN, Dietitian)*		
Name (Last, First, Middle)		Name		
Address	Gender ☐ Male ☐ Female	Profession	PRACID #	
City/Prov	Postal Code	Date	Phone	Fax
Personal Health Care #	Date of Birth *(yyyy/mmm/dd)*	Family Physician/Pediatrician is aware of referral ☐ Yes ☐ No Name: ______________________		

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 primary concern or reason for this referral? ☐ Indicate if this referral is URGENT and provide reason___________________________________
If this is related to feeding, attach a growth chart and specify if you are also concerned about: ☐ N/A ☐ Poor growth ☐ Inadequate intake ☐ Mealtimes being stressful ☐ Mealtimes take longer than 30 mins ☐ Force feeding ☐ Safety of swallow ☐ Other ____
Describe the child's delays or disabilities contributing to primary concern: How do these impact participation in activities of daily living? *(eg. Child is unable to sit; Child is unable to communicate)*
What is the parents' primary concern?

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Relevant Medical Information

List confirmed or suspected diagnoses ☐ Parent is aware

Relevant medical history and physical examination findings

Birth history *(hospital, gestation, weight, issues, exposures)*

Does the child require/have any of the following
☐ Cardiac monitoring ☐ Oxygen
☐ Frequent suctioning ☐ Uncontrolled seizures

Any health risk to the child if he/she participates in group sessions? If so, explain

Specify the ACH clinics this child has been referred to/seen by ☐ N/A
(attach most recent/relevant encounter and/or consultation notes)

Medications – include alternate treatments, vitamins & herbal supplements, etc. *(attach sheet as needed)*

Allergies

Please list any imaging, lab work, tests, and/or allied health assessments recently completed *(attach all reports)*
☐ Hearing ☐ Vision ☐ Swallow Study ☐ Developmental Questionnaire
☐ Other ____

Community Support Information

Community Support/Programs involved
☐ Private therapy ☐ Preschool ☐ Daycare ☐ Other____________________

Is Family Support for Children with Disabilities (FSCD) involved?
☐ Yes ☐ No ☐ Unsure
If yes, what is being funded ☐ Developmental Aide ☐ Specialized Services ☐ Other__________
Name of FSCD worker ____________________