Alberta Health Services

Affix patient label within this box

Cumulative Risk Diagnostic Clinic Referral

Alberta Children's Hospital, Child Development Services

- 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 this referral *(Pediatrician, Family, Guardian, etc)*
- Call 403-955-5999 for any referral related inquiries

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

Patient Information *(Or affix patient label)*		**Referring Source** *(Pediatrician/Pediatric Subspecialist)*	
Name (Last, First, Middle)		Name	
Address	Gender ☐ Male ☐ Female	Phone	Fax
City/Prov	Postal Code	Pracid #	Date
Personal Health Care #	Date of Birth *(yyyy/mmm/dd)*	Name of Pediatrician *(if applicable)*	

Legal Guardian Information		
Name (Last, First)	Relationship ☐ Parent ☐ Adoptive Parent ☐ CFS ☐ Private Guardianship	
Home Phone	Work Phone	Cell Phone
☐ Interpreter Required What language?_____	Is **aware of & agrees** to this referral ☐ Yes ☐ No	

Child & Family Services (CFS)		
Is CFS Involved? ☐ Yes ☐ No	Child Welfare Status? ☐ Guardianship Order ☐ Support Agreement *(Not a Legal Guardian)*	
Name of Case Worker		Phone
If Child and Family Services is the guardian, are they **aware** of the referral ☐ Yes ☐ No		

Primary Caregiver Information *(If different from Legal Guardian)*		
Name (Last, First)	Relationship ☐ Parent ☐ Foster Parent ☐ Relative	
Home Phone	Work Phone	Cell Phone
☐ Interpreter Required What language? _____	Is **aware of & agrees** to this referral ☐ Yes ☐ No	

Reason for Referral

What is your primary developmental question or reason for referral? Note: Children must be 7 years of age at time of referral to be considered for a FASD query.*(Recent/relevant encounter/consultation notes must accompany this referral)*

☐ Indicate if this referral is URGENT and provide reason_____

Which of the following services do you feel would help answer your primary developmental questions?
☐ Consultation by Telephone ☐ Direct Assessment ☐ Case Conference Only

Area of Concern

1) IDENTIFY all areas of concern on checklist below. **2) PROVIDE** documented evidence for each area of concern identified and example(s).

Documented Evidence includes but is not limited to direct physician clinic notes/reports of patient's functional deficits (checklists, rating scales, standardized tests) and/or previous assessment reports completed by other professionals such as psychologists, speech and language pathologists, occupational therapists and physiotherapists.

Development & Learning - Must present with at least ONE of the following	
☐ Cognition	The patient is functioning at least 1-2 years behind normative cognition levels. Cognitive delays are defined as impairments of general mental abilities that impact adaptive functioning and interfere with daily functioning. Provide an example:
☐ Academics	The patient is functioning at least 2 years behind grade level or has a diagnosed learning disability. Documentation may include report cards, educational testing, provincial test results or IPP. Provide an example:
☐ Communication	The patient is functioning at least 1-2 years behind normative speech and language levels in areas of articulation/speech production, language comprehension, language expression or social language which impacts their daily functioning, socialization or academics. Provide an example:
☐ Adaptive Skills	The patient has a moderate to severe impairment in their ability to perform age appropriate self-care activities (eating, dressing, toileting and grooming), follow health and safety rules, make and maintain friendships or behave appropriately in the community related to developmental delays/deficits. Provide an example:
☐ Motor Skills	The patient is functioning at least 1-2 years behind normative motor skills development which impacts activities of daily living, academic/school productivity and leisure pursuits. Manifestations of motor skill delays may include abnormalities of tone, delays in gross or fine motor skills or graphomotor skill delays. Provide an example:
Social / Emotional - Must Present with at least ONE of the following	
☐ Socialization	The patient has a moderate to severe delay in the ability to interact with others (express and comprehend feelings) in a way that is both appropriate and effective in a given situation. Appropriate interaction includes the ability to conform to social norms, values and expectations. Provide an example:
☐ Emotional/ Behavioral Regulation	The patient is exhibiting aggressive behavior towards self or others, is having severe and recurrent temper outbursts that are grossly out of proportion in intensity or duration to the situation, is hostilely defiant, has low frustration tolerance, has limited capacity to inhibit inappropriate behavior related to strong negative or positive emotion or, has limited capacity to self-soothe when physiologically aroused. Provide an example:
☐ Attachment	The patient is failing to relate socially either by exhibiting markedly inhibited behavior or indiscriminate social behavior. Attachment difficulties result when the patient's basic needs for comfort, affection and nurturing are not met and loving, caring and stable attachments with others are not established. Provide an example:

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Prenatal & Postnatal Exposures

☐ Prenatal Alcohol Exposure	Confirmed exposure reported by the birth mother or by someone who witnessed the birth mother consume alcohol during her pregnancy. **Complete and attach the Prenatal Alcohol Exposure Confirmation Letter**
☐ Other Prenatal Teratogenic Exposure	Describe
☐ Prenatal or Postnatal Toxic Stress *(at any time during the patient's life)*	Severe and prolonged stress in the absence of the buffering protection of supportive relationships. Toxic stress responses occur when a patient experiences strong, frequent, or prolonged adversity. Please indicate toxic stress: ☐ Physical/Emotional/Sexual Abuse ☐ Caregiver Substance Abuse or Mental Illness ☐ Chronic Neglect ☐ Exposure to Violence ☐ Exposure to Economic Hardship ☐ Prenatal Maternal Toxic Stress (*including intimate partner violence or severe mental illness)*

Attention Deficit Hyperactivity Disorder (ADHD) Status

ADHD management prior to CRDC Assessment may increase the validity of the testing results

Does this child have an ADHD diagnosis/ADHD symptoms? ☐ Yes ☐ No

If yes, are you activelty treating the ADHD? ☐ Yes ☐ No ☐ Legal Guardian/Caregiver Declined Treatment

Do you feel the ADHD symptoms are well managed? ☐ Yes ☐ No ☐ Treatment Resistant

Other Relevant Medical Information

Medical factors known to cause negative child outcomes

(e.g. other genetic conditions, significant familial learning or mental health difficulties, or other important chronic health condition)

Current Medications Name and Dose

1) _____ _____

2) _____ _____

3) _____ _____

4) _____ _____

Community Support Information - Current or Previous Involvement

Family Support for Children with Disabilities (FSCD) Funding?

☐ Yes ☐ No

ACCESS Mental Health

☐ Yes ☐ No

Other Counselling/Therapy

☐ Yes ☐ No