Please Fax Form to: 403 – 668 – 2150

Alberta Health Services

Alberta Children's Hospital - Complex Care Program
Ambulatory & NDD Care Coordination Stream

Patient Information		**Referring Source**	Referral Date:
Name:		Name:	
Date of Birth:		Profession:	
Phone:		Phone:	
Email (if available):		Fax:	
		Email (secure):	

Is the Community Pediatrician or Family Physician aware of and supportive of this referral?	Yes ☐ No ☐
Is the Family aware of and supportive of this referral?	Yes ☐ No ☐
Is the referring source staying involved in the care of the patient?	Yes ☐ No ☐

INTAKE NOTES

What is the priority concerns to be referred to the Complex Care Coordination Stream:	**What** outcomes **do you desire to achieve through** care coordination **and your involvement in this service:**

Health Factors		**School/ Community Supports**	
Connected to a Community Pediatrician? Yes ☐ No ☐ Provider:	**Connected to an ACH specialty or clinic?** Yes ☐ No ☐	**FSCD Supports?** Yes ☐ No ☐ Concerns:	**Specialized School Support?** Yes ☐ No ☐ Grade ____ IPP in place ☐ Specialized Classroom ☐ Specialized School ☐ Not attending School ☐ Other ☐ Concerns:
Connected to a Social Worker? Yes ☐ No ☐ Provider:	**Potential Stream:** Neurodevelopmental Disorder (NDD) /Behavioural: ☐ Complex Medical (Ambulatory): ☐ Unsure: ☐		
Psychosocial Circumstances		**Community or In-Home Supports (e.g., speech, OT, etc.)?** Yes ☐ No ☐ Concerns:	**Is Children's Services Involved?** Yes ☐ No ☐ Concerns:
What impact has the family's psychosocial circumstances had on your decision to refer? No Impact ☐ Some Impact ☐ Moderate Impact ☐ High Impact ☐	**Identified Circumstances:** Parental Mental Health ☐ Cultural Isolation ☐ Low Socioeconomic Status ☐ English Language Learner ☐ Rural Living ☐ Newcomer to Canada ☐ Immigrant/ Refugee Status ☐		

Completed By:

Name:	Signature:	Designation:	Date (dd/mm/yyyy):