Alberta Health Services

Alberta Children's Hospital

ACH Label

ASD Diagnostic Clinic Referral Form

Patient Information (Or affix patient label):		**Referring Source (Physician, Allied Health Professional):**	
Name: (Last, First, Middle)		Name:	
Address:	Gender: M / F	Profession:	Phone:
City/Prov:	Postal Code:	Fax:	PRACID #:
Personal Health Care #:	DOB:(yyyy/mmm/dd)	Family Physician/Pediatrician (if applicable):	

Primary Caregiver Information (eg. Parent, Foster Parent, Guardian, etc):		
Name (Last, First):		Relationship:
Home Phone:	Work Phone:	Cell Phone:
Interpreter required: ☐Yes ☐ No	If yes, for what language:	
The parent/guardian is aware of and **agrees** to this referral: ☐Yes ☐ No		

If Child & Family Services is involved (if known):	
Name of Worker (if known):	Phone:
If *Child and Family Services* is the guardian of the child, are they aware of the referral: ☐Yes ☐ No ☐ Unsure	

Reason for Referral:
What is your specific (diagnostic) question or primary reason for referral?
Description of child's presentation and/or issues that have led you to this question (Most recent/relevant encounter and/or consultation notes must be attached):

Relevant Medical Information:	
List confirmed diagnoses:	
Relevant medical history and physical examination findings:	Birth history (hospital, gestation, weight, issues, exposures):

Child Development Services
c/o 2888 Shaganappi Trail NW, Calgary, AB T3B 6A8
Phone (403) 955-5999 Fax (403) 955-5990

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Please list which ACH/Richmond Road/Mental Health Clinics this child has been seen by/referred to: ☐ N/A

Allergies:

Medications - include alternative treatments, vitamins & herbal supplements, etc. (attach sheet as needed):	List imaging, lab work, tests and/or allied health assessments recently completed (all reports must be attached):

Allied Health ONLY: Family physician/pediatrician who knows about this referral and has agreed to follow/support this child:
Name: Phone:

Assessment of Social, Communication and Interaction Skills - For sections A and B below, please:
1. **CHECK** (✓) all areas of concern and **2. PROVIDE** examples/descriptions of child's behavior for each area of concern selected:

A. Social, Communication and Interaction Skills: (Must present with all 3)

☐ **Social-emotional reciprocity** (eg. Limited initiation of social interaction, Reduced sharing of emotions/affects, poor social imitations, etc). Provide example(s):

☐ **Non-verbal communication** (eg. Poor use/understanding of gestures, Impaired eye contact, Poor use/understanding of affect, etc). Provide example(s):

☐ **Development of relationships with peers of the same developmental level** (eg. Lack of interest in peers, limited sharing of imaginary play, difficulties making friends, etc). Provide example(s):

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B. Restricted, Repetitive Behaviours, Interests or Activities: (Must present with 2)

☐ **Stereotyped/repetitive speech, motor movements, or use of objects** (eg. Echolalia, Repetitive vocalizations, finger/arm movements, abnormal posture, etc). Provide example(s):

☐ **Routines/rituals/resistance to change** (eg. Strict adherence to specific routines, Rigid thinking, Verbal or non-verbal rituals/compulsions, etc). Provide example(s):

☐ **Preoccupation/intense interests** (eg. Intense interests in certain objects/topics, Intense interest in unusual objects/topics, Strong attachment to unusual objects). Provide example(s):

☐ **Sensory Responses** (eg. Hyper or hypo reactivity to sensory input, Unusual sensory interest). Provide example(s):

C. Additional concerns noted from parents/caregivers:

☐ Loss of skills ☐ Safety Concerns ☐ Anxiety
☐ Hyperactivity/Impulsivity ☐ Self Injurious behaviours ☐ Tantrums/aggression/negative/disruptive behavior

Note: All items assessed above are only observations to assist with the diagnostic process and does not necessarily confirm a diagnosis.

Other:

To prevent delays or referral being returned, please:

☐ Indicate if this referral is **URGENT** and provide a reason_____
☐ Refer to inclusion/exclusion criteria for CDS clinics/services on *Alberta Referral Directory* to select clinic and referral form
☐ 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 (Family Physician, Pediatrician, Family, Guardian, etc)

Fax completed referral form to (403) 955-5990

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