Alberta Health Services

Alberta Children's Hospital

ACH Label

Consultative Diagnostic Clinics Referral Form

(Developmental Neurology Clinic, Consultative Clinic in Developmental Pediatrics, Youth Health Program)

Patient Information (Or affix patient label)		**Referring Source:**	
Name: (Last, First, Middle)		Name:	
Address:	Gender: M / F	Phone:	Fax:
City/Prov:	Postal Code:	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:	
Name of Worker:	Phone:
If *Child and Family Services* is the guardian of the child, are they aware of the referral: ☐Yes ☐ No ☐Unsure	

Reason for Referral:

Important – see *Alberta Referral Directory* for descriptions and inclusion/exclusion criteria for <u>all</u> CDS clinics/services.
Please select clinic/service child is being referred to:

☐ Developmental Neurology Clinic ☐ Youth Health Program ☐ Consultative Clinic in Developmental Pediatrics

What is your specific (diagnostic/developmental) 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 <u>must</u> be attached):

Alberta Children's Hospital - Child Development Services
c/o 2888 Shaganappi Trail NW, Calgary, AB T3B 6A8
Phone (403) 955-5900 Fax (403) 955-5990

Alberta Health Services

Alberta Children's Hospital

ACH Label

Consultative Diagnostic Clinics Referral Form

(Developmental Neurology Clinic, Consultative Clinic in Developmental Pediatrics, Youth Health Program)

Relevant Medical Information:	
List confirmed diagnoses:	
Relevant medical history and physical examination findings:	Birth history (eg. hospital, gestation, weight, issues, exposures):
Allergies:	
Please list which ACH/Richmond Road and/or Mental Health Clinics this child has been seen by or referred to: ☐ N/A	
Medications - include alternative treatments, vitamins & herbal supplements, etc. (Attach sheet as needed):	List imaging, lab work, allied health assessments recently completed. (Attach all reports):
Other:	

To prevent delays or referral being returned, please:

- ☐ Indicate if this referral is **URGENT** and provide reason_____
- ☐ Refer to inclusion/exclusion criteria for CDS clinics/services on *Alberta Referral Directory* to select appropriate clinic
- ☐ Complete all fields of the referral form
- ☐ Attach any required/completed reports, notes, or assessments, etc.
- ☐ Ensure the appropriate people are aware of referral (Family Physician, Pediatrician, Family, Guardian, etc)

Fax completed referral form to (403) 955 – 5990

Alberta Children's Hospital - Child Development Services
c/o 2888 Shaganappi Trail NW, Calgary, AB T3B 6A8
Phone (403) 955-5900 Fax (403) 955-5990