Alberta Health Services

Alberta Children's Hospital

ACH Label

Cumulative Risk Diagnostic Clinic Referral Form

Patient Information (Or affix patient label):		**Referring Source:**	
Name: (Last, First, Middle)		Name:	PRACID #:
Address:	Gender: M / F	Phone:	Profession:
City/Prov:	Postal Code:	Name of Family Physician (if applicable):	
Personal Health Care #:	DOB:(yyyy/mmm/dd)	Is Family Physician aware of this referral? ☐ Yes ☐ No	

Primary Caregiver Information (eg. Parent, Foster Parent, Relative etc):		
Name (Last, First):	Relationship:	
Home Phone:	Work Phone:	Cell Phone:
Interpreter required: ☐ Yes ☐ No	If yes, for what language:	

Guardian Information (if different from Primary Caregiver):		
Name (Last, First):	Relationship:	
Home Phone:	Work Phone:	Cell Phone:
Interpreter required: ☐ Yes ☐ No	If yes, for what language:	

Does the legal guardian **agree** with this referral? ☐ Yes ☐ No

Child & Family Services (CFS):

Is CFS involved? ☐ No ☐ Yes, Worker's Name: Phone:

Child Welfare Status:
- ☐ Under Investigation
- ☐ Custody Agreement
- ☐ Family Enhancement
- ☐ Supervision Order
- ☐ Temporary Guardianship Order
- ☐ Permanent Guardianship Order
- ☐ Private Guardianship Order
- ☐ Previous Child Welfare Involvement – Now Closed

Placement Type:
- ☐ Parental Care
- ☐ Adoptive Home
- ☐ Foster Care
- ☐ Kinship Care
- ☐ Residential care
- ☐ Group Home

If *Child & Family Services* is the guardian of the child are they aware of the referral: ☐ Yes ☐ No ☐ Unsure

Reason for Referral:

What is your primary developmental question or reason for referral? (Recent/relevant encounter and/or consultation notes **must accompany** this referral.)

What level of care do you feel would answer your primary developmental question?
- ☐ Telephone Consult with Developmental Pediatrician/Child Psychiatrist
- ☐ Case Conference
- ☐ Unsure
- ☐ Developmental Pediatrician Appointment
- ☐ Multidisciplinary Assessment

Indicate any tests/assessments previously completed (attach reports):
- ☐ FASD Assessment
- ☐ Psychoeducational Assessment
- ☐ PKIC Assessment
- ☐ Genetic Testing
- ☐ Other:_____

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

(2014-09)

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

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:	
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.
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.
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.
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.
Social / Emotional / Adaptive:	
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.
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.
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.
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.
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. Please use the CRDC Prenatal Alcohol Exposure Confirmation Form attached.
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 ☐ Chronic Neglect ☐ Exposure to Economic Hardship ☐ Caregiver Substance Abuse or Mental Illness ☐ Exposure to Violence ☐ Prenatal MaternalToxic Stress (including intimate partner violence or severe mental illness)

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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):

Present Medications (attach sheet as needed):	Allergies:
Name: Dosage: 1)_____ _____ 2)_____ _____ 3)_____ _____ 4)_____ _____	

Please list any ACH or Richmond Road Diagnostic &Treatment Centre clinics this child has been referred to/seen by:

Please list any other medical or Mental Health clinics this patient has been referred to/seen by:

Community Support Information:

Family Support for Children with Disabilities (FSCD) Funding? ☐ Yes ☐ No ☐ Unsure

Please list any other Community Support/Programs involved:

Please indicate any other services this patient has been referred to/seen by:
☐ Counselling/Therapy ☐ Other:
☐ Psychiatry

Education Information:

Current preschool/school:	Has been here how long: months/years	Grade:	Alberta Learning Code:	Aide: ☐ Yes ☐ No ☐ Unsure

Other:

To prevent delays or referrals being returned, please:

☐ Indicate if this referral **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

☐ Ensure the appropriate people are aware of this referral (Family Physician, Pediatrician, Family, Guardian, etc)

☐ Fill out the CRDC Prental Alcohol Exposure Confirmation Form if this is for an FASD assessment

Fax completed referral form and documents to (403) 955 - 5990

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