Alberta Health Services

Alberta Children's Hospital

ACH Label

Developmental Psychiatry Consultation & Complex Management Clinic
Telephone Consultation Referral Form

Patient Information (Or affix patient label):		Referring Source (Physicians):	
Name: (Last, First, Middle)		Name:	
Address:	Gender: M / F	PRACID #:	
City/Prov:	Postal Code:	Fax:	Phone:
Personal Health Care #:	DOB:(yyyy/mmm/dd)	Are the patient's parent(s)/guardian aware of this consult? ☐ Yes ☐ No	
RHRN/ACH#:			

Problem List:

Please briefly list the patient's conditions/difficulties:

Psychosocial Issues:

Are there any relevant psychosocial issues? If so, please describe:

Medical Concerns:

Are there any significant/active general medical concerns? If so please describe:

Current Medications:

Telephone Consult:

Estimated time needed for the consult: ☐ under 15 mins ☐ 15-30 mins What would you like to discuss in this phone consult?

Fax completed consult form and any other relevant documents/information to (403) 955-5990

cc: ACH Health Records

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