Alberta Health Services

Alberta Children's Hospital

ACH Label

Early Childhood Rehabilitation Referral Form

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

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:	
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:

What is your primary concern or reason for this referral?

If this is related to feeding, attach a growth chart and specify if you are also concerned about: ☐ N/A

☐ Poor growth ☐ Inadequate intake ☐ Mealtimes being stressful ☐ Duration of mealtimes (>30 mins)
☐ Safety of swallow ☐ Force feeding ☐ Other _____

1) Describe the child's delays or disabilities contributing to primary concern:

2) How do these impact participation in activities of daily living? (eg. Child is unable to sit; Child is unable to communicate)

What is the parents' primary concern?

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

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Relevant Medical Information:

List confirmed or suspected diagnoses: ☐ Parent is aware

Relevant medical history and physical examination findings:

Birth history (hospital, gestation, weight, issues, exposures):

Does the child require/have any of the following:

☐ Cardiac monitoring ☐ Oxygen
☐ Frequent suctioning ☐ Uncontrolled seizures

Any health risk to the child if he/she participates in group sessions? If so, please explain:

Specify the ACH clinics this child has been referred to/seen by (attach most recent/relevant encounter and/or consultation notes):
☐ N/A

Medications – include alternate treatments, vitamins & herbal supplements, etc. (attach sheet as needed):

Allergies:

Please list any imaging, lab work, tests, and/or allied health assessments recently completed (attach all reports):

☐ Hearing ☐ Vision ☐ Swallow Study ☐ Developmental Questionnaire
☐ Other:_____

Community Support Information:

1) Community Support/Programs involved: ☐ Private therapy ☐ Preschool ☐ Other_____
2) Family Support for Children with Disabilities (FSCD) Funding? ☐ Yes ☐ No ☐ Unsure
If yes, what is being funded: ☐ Developmental Aide ☐ Specialized Services

Other:

To prevent delays or referrals 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, growth chart, etc.
☐ Ensure the appropriate people are aware of this referral (Family Physician, Pediatrician, Family, Guardian, etc)

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

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