Affix patient label within this box

Central Zone
Children's Rehabilitation Services Referral

To make a referral to Children's Rehabilitation Services in Central Alberta, please complete the following information and forward by mail, email or fax to Coordinated Intake at one of the locations below. If you have any questions, please call our toll-free number. *Click on email address below to automatically generate email to our intake team.*

Toll Free	1-855-414-5272	Email	childrens.rehabilitationreferrals@ahs.ca

Mail	Camrose Professional Centre #300, 5015 – 50 Avenue Camrose, AB, T4V 3P7	Red Deer 49th Street Community Health Centre Bay A, 4755 – 49 Street Red Deer, AB, T4N 1T6
Fax	(780) 608-6848	(403) 314-5230

Child's Information					
Child's Legal Name (Last)	(First Name)		(Initial)	Date of Birth (dd-mon-yyyy)	
Personal Health Number	Language Spoken	Is Interpreter required? No Yes		Family Physician/Pediatrician	

Parent/Guardian Information					
Parent/Legal Guardian 1 (Print)			Parent/Legal Guardian 2 (Print)		
Phone (preferred)			Phone (preferred)		
Phone (alternate)			Phone (alternate)		
Mailing Address			Mailing Address ☐Same as Parent/Guardian 1		
City	Province	Postal Code	City	Province	Postal Code
Email Address			Email Address		

Child is in Foster/Kinship Care (If yes, please name Case Worker below)			
Name of Case Worker	Phone Number(Business)	Cell	Email

Requested Children's Rehabilitation Service(s):
(Check all that apply. If available, please provide documents with referral and any concerns documented by parents)

Service Category	Reason for Referral (Please specify)
☐ Speech & Language	
☐ Audiology	
☐ Occupational Therapy	
☐ Physiotherapy	
☐ Early Childhood Intervention Program	

Referral Source (if affix stamp must be legible and include name, address, Practice ID., office phone and fax)			
Referred By (print name)			☐ Family Physician ☐ Pediatrician ☐ Nurse Practitioner
Contact Information	Phone Fax	Address	
☐ I have reviewed and discussed the details of this referral with the child's family.			Date (yyyy-Mon-dd)
Physician/Nurse Practitioner Signature			Practice ID

*** ***Referral to Pediatric Specialty Clinic (see page 2)***

Alberta Health Services

Central Zone (Camrose & Red Deer)
Pediatric Specialty Clinic (PSC) Referral

Reason for Pediatric Specialty Referral	☐ Camrose Pediatric Specialty Clinic	☐ Red Deer Pediatric Specialty Clinic
	☐ Autism Spectrum Disorder (ASD) ☐ Developmental Coordination Disorder (DCD) ☐ Fetal Alcohol Spectrum Disorder (FASD)* *(*only available for Camrose and area')*	☐ Autism Spectrum Disorder (ASD) ☐ Developmental Coordination Disorder (DCD)

Referral Criteria for Pediatric Specialty Clinic:

- Child must be over 24 months of age and be under 18 years of age.
- Prior to referral, the child must have previously received services from a community or school-based occupational therapist, speech-language pathologist, psychologist, or psychiatrist.
  - ➢ Please include any supporting documentation—formal or informal—from the involved providers that clearly outlines evidence of complex developmental concerns. A consultation letter containing these details is acceptable.
- Child must display evidence or concerns in 2 or more complex developmental concerns that require multidisciplinary approach:

Autism Spectrum Disorder	Developmental Coordination Disorder	Fetal Alcohol Spectrum Disorder (requires confirmed prenatal alcohol exposure)
☐ Communication/Language ☐ Restricted/repetitive behaviors ☐ Social skills ☐ Emotional regulation ☐ Sensory processing ☐ Other (Specify)	☐ Fine motor skills ☐ Gross motor skills ☐ Executive functioning ☐ Other (Specify)	☐ Academics ☐ Behavior ☐ Motor skills ☐ Language ☐ Attention ☐ Other (Specify)

- Most recent pediatrician consult letter included with the referral (if pediatrician involved).
- Physician consult letters or other relevant documents for referral are attached.
- For FASD (Fetal Alcohol Spectrum Disorder), a psychoeducational assessment must be completed prior to referral.

The Pediatric Specialty Clinics work in a consult model with community providers and do not "take over" care.
The primary care Physician or Nurse Practitioner must be involved to assist the family with continued health maintenance, routine developmental surveillance, and monitoring of ongoing and emerging medical concerns.

Physician/Nurse Practitioner Referral Details		
Does child meet criteria above	☐Yes ☐No (if no provide reason for referral)	
Date of last physical exam (dd-mon-yyyy)	Date of last vision exam (dd-mon-yyyy)	Date of last hearing exam or referral to Audiology (dd-mon-yyyy)
List of existing diagnoses		
Describe your concerns for this patient in detail (use additional pages as required)		
Parent's/Guardian's concerns, as described to you (use additional pages as required)		

By submitting this Pediatric Specialty Clinic referral, you are agreeing to participate in shared care of this child

Physician/Nurse Practitioner Signature		Date (dd-mon-yyyy)