Alberta Health Services

Alberta Children's Hospital

ACH Label

Developmental Psychiatry Consultation & Complex Management Clinic Visit Referral Form

Patient Information (Or affix patient label):		**Referring Source: (Pediatrician, Psychologist)**	
Name: (Last, First, Middle)		Name:	
Address:	Gender: M / F	PRACID #:	Phone:
City/Prov:	Postal Code:	Name of Family Physician/Pediatrician (if applicable):	
Personal Health Care #:	DOB:(yyyy/mmm/dd)	Is this physician 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 question for the Developmental Psychiatry Service? What do you want help with?

Description of child's presentation and/or issues that have led you to this question? (Attach most recent/relevant medical history, physical exam findings, and encounter and/or consultation notes).

Please indicate if this refferal is **URGENT**as per criteria: ☐ Yes ☐ No

Relevant Medical Information:

List confirmed diagnoses:

Please list which ACH/Richmond Road and/or Mental Health Clinics this child has been seen by/referred to: ☐ N/A

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

Developmental Psychiatry Consultation & Complex Management Clinic Visit Referral Form

Medications – include alternate treatments, vitamins & herbal supplements, etc (Attach sheet as needed):	List imaging, lab work tests and/or allied health assessments recently completed (Attach all reports):
Allergies:	

Developmental Information:

Developmental Disorder diagnosis:

1. _____ ☐ Mild ☐ Moderate ☐ Severe
2. _____ ☐ Mild ☐ Moderate ☐ Severe
3. _____ ☐ Mild ☐ Moderate ☐ Severe
4. _____ ☐ Mild ☐ Moderate ☐ Severe

Intellectual Disability (IQ): ☐ Normal range (low average to above) ☐ Borderline ☐ Mild (IQ below 70) ☐ Severe

Adaptive Skill Delay: ☐ None / Age appropriate ☐ Mild ☐ Moderate ☐ Severe
The patient has a moderate to severe impairment in their ability to perform age appropriate self-care activities (eating, dressing, toileting and grooming), motor skills or safety rules for example.

Patient's verbal ability: ☐ Nonverbal ☐ Minimal verbal ability ☐ Moderate delay ☐ No major problem

Psychiatric Information:

1) What are the main psychiatric symptoms?

☐ Mood and behavioural dysregulation ☐ Attention ☐ Anxiety ☐ Mania ☐ Obsessions
☐ Psychosis ☐ Compulsions ☐ Depression ☐ Attachment
☐ Other:_____

_____

2) In what way do these symptoms impact the child's daily functioning at home and at school?

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

Developmental Psychiatry Consultation & Complex Management Clinic Visit Referral Form

Psychosocial Information:

Family Environment:

☐ Biological ☐ Adopted ☐ Foster ☐ Residential placement ☐ Blended

Do you suspect family relationship or parenting problems? ☐ Yes ☐ No

Do you believe these are part of the patient's presentation and difficulties? ☐ Yes ☐ No

If yes, please briefly explain:

Maltreatment:

Is there a history of physical, emotional, sexual or medical maltreatment? ☐Yes ☐ No ☐ Suspected

Are there current maltreatment concerns? ☐Yes ☐ No ☐ Suspected

Please briefly elaborate:

Cultural Issues:

Please describe any cultural issues or concerns? ☐N/A

Support:

Family Financial Status: ☐ No problem ☐ Coping ☐ Struggling ☐ Poverty

Are there problems with service delivery (eg. aides, programming, etc)? ☐Yes ☐ No

If so, briefly describe:

Other:

To prevent delays or referrals being returned, please:

- ☐ Refer to inclusion/exclusion criteria for CDS clinics/services on *Alberta Referral Directory*
- ☐ Complete all fields of the referral form
- ☐ Attach any required/completed reports, notes, or assessments, 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

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

(2015-06)