Alberta Health Services

Pediatric Specialty Clinic Physician Referral Form

Client Demographics		
Name:	**D.O.B.** (d/m/y):	**PHN:** _ _ _ _ _ - _ _ _ _
Address:	**City:**	**Postal Code:**
Parent/Guardian:	**Contact Phone Number:**	

Referral Information

What are the main areas of concern?

- ☐ Fetal Alcohol Spectrum Disorder
- ☐ Autism Spectrum Disorder
- ☐ Attention Deficit/Hyperactivity
- ☐ Behavioral
- ☐ Developmental Coordination Disorder
- ☐ Developmental Delay
- ☐ Emotional
- ☐ Language
- ☐ Learning Disability
- ☐ Motor Skills
- ☐ Physical Disability
  Please specify: _____
- ☐ Psychiatric
- ☐ Speech
- ☐ Other _____

What are your reasons for wanting this child assessed by the Pediatric Specialty Clinic?

_____
_____
_____
_____
_____
_____
_____
_____

Relevant medical history (include hospital of birth):

_____
_____
_____
_____
_____

Are there reasons to treat this referral with particular urgency? Yes ☐ No ☐
Please explain:

_____
_____

Current medication(s) (type and dosage):

_____
_____
_____
_____

Name, phone number and address of physician:

Physician Signature: _____ **Date:** _____

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