Alberta Health Services

☐ Bassano ☐ Bow Island ☐ Brooks
☐ Medicine Hat ☐ Oyen

Affix Client Label Here or Complete Required Information
CHILD'S NAME:

Physician:
Alberta Health Care #:
Date of Birth:

CHILDREN'S ALLIED HEALTH, SLP, Audiology *referral form*

Parents or Guardians Name:	*Home Phone:* *Work Phone:*

Address:

Email Address:

THERAPY SERVICES:

☐ **Child Development** (Including OT, PT & SLP supports, birth to age 18: **Intake to determine eligibility**)
☐ **Child Behavior** (Supports to age 7 for anxiety, anger, parental divorce, sleep strategies & parental support)
☐ **Children's Audiology** (Hearing assessment)
☐ **Infant + Child Feeding, Swallowing, Lactation consultant**

Description of Concerns:

I have made the parent(s) aware that I am supporting this referral & the parents agrees to refer ☐ Yes ☐ No

SOUTHEAST ALBERTA – DEVELOPMENTAL & BEHAVIOURAL DIAGNOSTIC CLINIC **Must be referred by a Physician or Pediatrician only**

Concerns:

☐ Loss of skills ☐ Tantrums / aggression ☐ Other (Please Comment)
☐ Feeding / nutrition concerns ☐ Safety / self-harm

I have made the parent aware I am querying Autism Spectrum Disorder ☐ Yes

Health Professional Referral Source Information	*Person:*	*Agency/Department:*
	Phone:	*Referral Date:*

FAX OR MAIL THIS FORM TO: CHILDREN'S ALLIED HEALTH
Medicine Hat Regional Hospital, 666 5th Street SW, Medicine Hat, Alberta T1A 4H6
Children's Allied Health Fax: 403 529-8859 Phone: 403 529-8966