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*

Parent/ Guardian Information (please ensure info is up to date)	*Name:* **Language Line Needed: Yes / No** **Home Language**:	*Home Phone:* *Work Phone:*
	Address: *Email Address:*	

NEW AHS ELIGIBILITY CRITERIA: **AHS provides services for any developmental need, birth to school entry (OT, PT, SLP, Audiology)** (If the child is in a PUF or FSCD program, the eligibility for AHS service eligibility will be reviewed)

Children and youth enrolled in school: Children and youth enrolled in school programs are eligible for AHS clinic, home or zoom/virtual support (even with PUF or FSCD support in place) for specific AHS services such as:

- Movement, Mobility, Motor Skills & Positioning Equipment, Seating, Self-Care Productivity and Leisure, Incontinence Supplies, Splinting, Orthosis, Serial Casting, Torticollis, Head Shape
- Speech Sounds, Hearing Loss, Fluency, Voice, Resonance, Augmentative/Alternative Communication, Eating, Feeding, Swallowing

Specific episodes of care for a **new functional need** are provided by AHS staff for **eligible services** when children/ youth experience **significant changes** (a substantial improvement or decline)

1. CHILDREN'S ALLIED HEALTH -THERAPY SERVICES (Parents & healthcare professionals & physicians & pediatricians please check the boxes that apply to the child's needs):

☐ **Child Development** (CHILDREN'S ALLIED HEALTH will determine which disciplines are involved, i.e., Home Based Development, Occupational Therapy, Physical Therapy, Dietitian, Speech Language Pathology, Social Work)
☐ **Premature infant developmental follow ups**
☐ **Child Behaviour** (Birth to age 7 for anxiety, anger, parent divorce, sleep strategies, referral, parent support)
☐ **Children's Audiology** (Hearing assessment)
☐ **Infant + Child feeding, swallowing, lactation consultant**

Reason for Referral if the child meets eligibility criteria above:

Diagnosis (if available):

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

☐ ***2. SOUTHEAST ALBERTA – DEVELOPMENTAL & BEHAVIOURAL DIAGNOSTIC CLINIC*** ***(This section must come from a physician or pediatrician only)*** **Collaborative Diagnostic Review with Pediatrician, AHS & Education**

Please Circle All That Apply: Loss of skills Feeding / nutrition concerns Safety / self-harm Tantrums / aggression
Additional Concerns:

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