

Today's Date: _____

SITE – please identify which community you are referring to below:					Central Phone Intake: 403-995-2638
<input type="checkbox"/> Canmore/Banff	<input type="checkbox"/> Claresholm	<input type="checkbox"/> Didsbury	<input type="checkbox"/> Okotoks/High River	<input type="checkbox"/> Strathmore	
Referrals can be emailed or faxed to the following: PediatricRural.AlliedHealth@ahs.ca					F: 403-995-2639

Child:			<input type="checkbox"/> M <input type="checkbox"/> F
			<input type="checkbox"/> Undefined
Last Name (legal)	First name	Date of Birth YYYY/MM/DD	
Child's Alberta Health Care Number: _____			
Parent or Legal Guardian Information:			
Name (Last, First)	Phone Number	Email (required)	Relationship to Child
Name (Last, First)	Phone Number	Email (required)	Relationship to Child
Mailing Address:			
Street	City	Postal Code	
Physician & Phone #: _____		Pediatrician & Phone #: _____	
Language(s) spoken at home: _____			
Are they eligible and receiving support through any of the following: <input type="checkbox"/> FSCD <input type="checkbox"/> AB Education Funding (i.e. PUF)			
Is the child registered in a school program? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of school: _____	
Are you the foster parent of this child? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, social worker: _____		Phone#: _____	

Reason for Referral (please briefly describe your primary concerns):
Who suggested this referral (if other than parent):

I am in agreement with (please check below):		Date: _____
<input type="checkbox"/> a referral to Rural Pediatric Allied Health	OR	Parent / legal guardian: _____ signature
<input type="checkbox"/> participating in virtual health appointments (if applicable)		Verbal consent obtained by: _____ signature
<input type="checkbox"/> receiving ZOOM meeting links via email (if applicable)		

OFFICE USE ONLY		
Date Received:	Date Parents Contacted:	<input type="checkbox"/> Attended Walk-In: OT / PT / SLP on _____ <input type="checkbox"/> Referred to OT / PT / SLP/ Feeding / Navigator <input type="checkbox"/> Referred to: _____