

Pediatric Outpatient Physical and Occupational Therapy Services Referral

This referral is to be completed to make Pediatric Outpatient referrals to the Stollery Children's Hospital. Please **note** that this service does not provide Feeding or Swallowing Services. Incomplete/illegible forms will result in a delay in service.

Send completed form by **fax** to 780.407.7534 or by **mail** to 8440 - 112 Street, Walter Mackenzie Center, Room 1F1 Rehabilitation Services. For other enquiries **call** 780.407.6002 or 780.407.6203.

Patient Information				
Date (yyyy-Mon-dd)	Name (Last,First)		Date of Birth (yyyy-Mon-dd)	
Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Personal Health Number		Name of Parent(s) or Guardian (Last,First)	
Address		City/Town	Province	Postal Code
Home Phone Number	Work Phone Number		Cell Phone Number	
Name of Family Physician/Pediatrician		Practice ID	Phone Number	Fax Number
Birth History <input type="checkbox"/> No Complications <input type="checkbox"/> Premie <input type="checkbox"/> Neonatal ICU <input type="checkbox"/> Other, <i>specify</i> _____				
Diagnosis				
Past Medical History				
Is the patient currently receiving Physical or Occupational therapy services? <input type="checkbox"/> No <input type="checkbox"/> Yes, <i>specify</i> _____			Is an interpreter required? <input type="checkbox"/> No <input type="checkbox"/> Yes, <i>specify language</i> _____	
Type of Service Requested				
<input type="checkbox"/> Physical Therapy		<input type="checkbox"/> Occupational Therapy		<input type="checkbox"/> Both
Reason for Referral				
<input type="checkbox"/> Fine Motor Delay		<input type="checkbox"/> Torticollis/Head Tilt		<input type="checkbox"/> Gross Motor Delay
<input type="checkbox"/> Persistent Toe Walking		<input type="checkbox"/> Gait & Balance		<input type="checkbox"/> Coordination
<input type="checkbox"/> Pain, <i>location</i> _____		<input type="checkbox"/> Musculoskeletal, <i>location</i> _____		
<input type="checkbox"/> Other _____		<input type="checkbox"/> Functional Issues/Activity of Daily Living (ADLS)		
Consultations				
<input type="checkbox"/> Psychiatry		<input type="checkbox"/> Psychiatry/Psychology		<input type="checkbox"/> Orthopaedics
<input type="checkbox"/> Neurology/Neurosurgery		<input type="checkbox"/> Surgeon <i>specify</i> _____		<input type="checkbox"/> Other, <i>specify</i> _____
Other Programs Referral Made				
<input type="checkbox"/> Homecare		<input type="checkbox"/> Preschool Team		<input type="checkbox"/> Learning and Development Clinics
<input type="checkbox"/> Program Unit Funding (PUF)		<input type="checkbox"/> Edmonton Student Health Integrated Partnership (ESHIP)		
<input type="checkbox"/> Glenrose Rehabilitation Hospital		<input type="checkbox"/> Intensive Learning Services (ILS)		
<input type="checkbox"/> Neonatal Clinic		<input type="checkbox"/> Family Support for Children with Disabilities (FSCD)		
<input type="checkbox"/> Other <i>specify</i> _____				
Referring Healthcare Professional				
Name	Signature		Date	Phone Number
Mailing Address	City/Town	Province	Postal Code	Fax Number