

Children's Rehabilitation Services Referral

To make a referral to Children's Rehabilitation Services, please complete the following information and forward by mail or fax. If you have any questions, please call the nearest Intake office:

Drumheller Health Centre
351-9th Street NW
Drumheller, AB T0J 0Y1
Fax 403.823.2446
Toll Free 1.855.420.7986

Red Deer 49th Street Community Health Centre
Bay A, 4755-49th Street
Red Deer, AB T4N 1T6
Fax 403.314.5230
Toll Free 1.855.414.5272

Camrose Professional Centre
#300, 5015-50 Avenue
Camrose, AB T4V 3P7
Fax 780.608.8648
Phone 780.608.8613
Toll Free 1.866.937.7476

Child's Information					
Child's Legal Name (<i>Last Name</i>)		(First Name)		(Initial)	Personal Health Number
Date of Birth (<i>yyyy-Mon-dd</i>)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Family Physician/Pediatrician		
<input type="checkbox"/> Child is in Foster/Kinship Care. If "yes" please name Social Worker/Case Worker below.			Language spoken at home _____ <input type="checkbox"/> Interpreter needed		
Name of Case Worker (CFSA)			Phone Number (<i>Business</i>)		
			(Cell)	(Fax)	
Parent/Guardian Information					
Parent/Guardian 1:			Parent/Guardian 2:		
Phone Number (<i>Preferred</i>) _____ (<i>Alternate</i>) _____			Phone Number (<i>Preferred</i>) _____ (<i>Alternate</i>) _____		
Mailing Address			Mailing Address <input type="checkbox"/> Same as Parent 1		
City	Province	Postal Code	City	Province	Postal Code
Reason for Referral					
Referral Source					
Name			Title		
Mailing Address			Agency/Department		
Phone	Fax		Email		
<input type="checkbox"/> I confirm that the parent/guardian is aware of and agrees to this referral.					
Signature			Date (<i>yyyy-Mon-dd</i>)		
School initiated referral please complete Page 2.					

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Name of Child (<i>Last, First</i>)		School
School Contact		Teacher
Grade	Days/Time Attending	

Teacher Checklist – Please check if this child has difficulties in any of the following areas:

Physical Activity	Touch	Language
<input type="checkbox"/> Playing in the playground/gym activities <input type="checkbox"/> Walking <input type="checkbox"/> Jumping <input type="checkbox"/> Hopping/Skipping <input type="checkbox"/> Throwing and catching <input type="checkbox"/> Balance <input type="checkbox"/> Coordination	<input type="checkbox"/> Reacts strongly or adversely when touched <input type="checkbox"/> Standing in classroom lineups <input type="checkbox"/> Touches others frequently <input type="checkbox"/> Stands too close to others <input type="checkbox"/> Reluctant to touch messy or gooey things <input type="checkbox"/> Sensitive to specific clothing/texture	<input type="checkbox"/> Understanding and following instructions <input type="checkbox"/> Using correct grammar <input type="checkbox"/> Organizing and expressing thoughts <input type="checkbox"/> Asking and answering questions <input type="checkbox"/> Reading comprehension <input type="checkbox"/> Phonics
Spatial Concepts	Daily Living Skills	Hearing
<input type="checkbox"/> Concepts of under, over, first, last etc. <input type="checkbox"/> Letter/number reversals <input type="checkbox"/> Copying from the board	<input type="checkbox"/> Toilet training <input type="checkbox"/> Eating <input type="checkbox"/> Tying shoelaces/buttons/zipper/dressing. <input type="checkbox"/> Problem solving	<input type="checkbox"/> Often asks or repeats "What?" <input type="checkbox"/> Speaks very loudly <input type="checkbox"/> Following instructions in noisy situations <input type="checkbox"/> Sensitive to noise
Seated Posture	Safety	Speech
<input type="checkbox"/> Frequently out of chair <input type="checkbox"/> Frequently leans over desktop/rests on elbows <input type="checkbox"/> Falls out of chair <input type="checkbox"/> Stands/kneels on seat	<input type="checkbox"/> In bathroom <input type="checkbox"/> While eating or drinking <input type="checkbox"/> On the playground <input type="checkbox"/> Runs into objects and people <input type="checkbox"/> Falls frequently	<input type="checkbox"/> Is difficult to understand <input type="checkbox"/> Struggles to say a sound even when asked to imitate it <i>(Please indicate specific sounds: _____)</i> <input type="checkbox"/> Stuttering <input type="checkbox"/> Fast rate of speech
Fine Motor	Social Emotional	
<input type="checkbox"/> Printing/writing <input type="checkbox"/> Cutting <input type="checkbox"/> Tremors <input type="checkbox"/> Switches hands when printing/cutting	<input type="checkbox"/> Overactive <input type="checkbox"/> Easily distracted <input type="checkbox"/> Impulsive <input type="checkbox"/> Poor attention <input type="checkbox"/> Aggressive	<input type="checkbox"/> Peer relationships <input type="checkbox"/> Routines/transitions <input type="checkbox"/> Easily frustrated/upset <input type="checkbox"/> Responding to directions <input type="checkbox"/> Anxiety/worry

What are one or two questions that you are hoping to have answered through this referral?

What have you tried already to address these concerns?
