Children's Services
Alvin Buckwold Child Development Program
Kinsmen Children's Centre
1319 Colony Street
Saskatoon, SK S7N 2Z1
P: 306-655-1070 | F: 306-655-1449
Toll Free: 1-877-405-0042
Centralized Intake Fax: 306-655-2436

Saskatchewan Health Authority

Referral for Outpatient Service

Please fax Attention: **Intake Coordinators at (306) 655-2436**

ABCDP provides interdisciplinary assessment, diagnosis and treatment to children birth to 18 years of age who display or are at significant risk for developmental, cognitive and/or physical challenges, in 2 or more of the following areas: Cognitive; Language; Social; Adaptive; Motor Skills

PATIENT INFORMATION

CHILD'S NAME (FULL): _____ **CHILD'S BIRTH DATE:** _____

CHILD'S SK Health #:_____ **LEGAL GUARDIAN:** _____

CHILD'S ADDRESS: _____ **CITY:**_____ **PROV:**_____**POSTAL CODE:**_____

GUARDIAN'S ADDRESS (IF DIFFERENT): _____ **CITY:**_____**PROV:**_____**POSTAL CODE:**_____

PHONE HOME: (_____**)**_____-_____ **WORK: (**_____**)**_____-_____ **CELL: (**_____**)**_____-_____

What concerns do you have for this patient?

- □ Autism Spectrum Disorder
- □ Prenatal Alcohol Exposure
- □ Developmental Delay or diagnosis associated with delay
- □ Developmental delay and mental health concerns
- □ Brain Injury
- □ Spinal Cord Team
- □ Muscular Dystrophy
- □ Neuromotor Development
- □ Plagiocephaly/Torticollis
- □ Therapies (OT, PT, SLP)
- □ Feeding
- □ Augmentative/Alternative Communication
- □ Other(please explain): _____
_____

What specific questions or concerns would you like the physician/therapist to address?

Are there reasons to treat this referral with particular urgency?
Yes_____ **No** _____ **Please explain:**

Assessment history: Please list and attach relevant information from other agencies and/or specialists:

REFERRED BY(please print): _____**SIGNATURE:** _____**DATE:** _____

ADDRESS _____**CITY:**_____**PROV:**_____**POSTAL CODE:** _____

Has parent's/guardian's permission for this referral been granted? (required) **Yes** ☐ **No** ☐