Alberta Health Services

Alberta Children's Hospital

Prior to faxing this referral, please affix a label with Physician's name and address.

HEAD SHAPE CLINIC REFERRAL

CHILD'S NAME:	
DOB:	PHN#:
PARENT(S)/LEGAL GUARDIAN(S) NAME:	
ADDRESS:	POSTAL CODE:
PHONE HOME #:	PHONE WORK #:
LANGUAGE UNDERSTOOD:	
PHYSICIAN:	

INFANT RE-POSITIONING CLASS ATTENDED: ☐ YES ☐ NO

CONCERNS ABOUT HEAD SHAPE:

- ☐ Flattening of right parietal-occipital region
- ☐ Flattening of the right parietal-occipital region, right frontal prominence, ear shift
- ☐ Flattening of the left parietal-occipital region.
- ☐ Flattening of the left parietal-occipital region, left frontal prominence, ear shift
- ☐ Flattening of the central occipital region

ADDITIONAL INFORMATION (EG. CONCURRENT DIAGNOSES, DEVELOPMENTAL DELAY, RESULTS OF DIAGNOSTIC TESTING, ETC.)

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Please sign and fax a copy of this referral to: **Attention ACH Head Shape Clinic**
Fax number: 955-7609.

Arrangements will be made for this infant to be seen in the Head Shape Clinic. If you have any questions or concerns, please contact the Head Shape Clinic at 955-5437.

Physician Signature: _____Date: _____
Practice ID# _____