Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

Hôpital Hotel Dieu Hospital

KGH Hôpital Général de Kingston General Hospital

EATING DISORDERS PROGRAMS CENTRALIZED REFERRAL FORM

Note: This referral form is for all Kingston Health Sciences Centre (KHSC) Eating Disorders Programs including: Adult Outpatient, Child and Youth Outpatient, and Day Treatment Program

KINGSTON HEALTH SCIENCES CENTRE'S EATING DISORDERS PROGRAMS SUMMARY
Please visit our website at https://kingstonhsc.ca/mental-health-care for additional information

Child & Youth Eating Disorders Program:	**Eating Disorders Day Treatment Program:**	**Adult Eating Disorders Program:**
An outpatient program located at the Hotel Dieu Hospital site which provides a multidisciplinary team approach. We offer family-based therapy, individualized therapy, nutritional education and support, health, and medication monitoring.	An intensive outpatient day treatment program located in the community with a multidisciplinary team approach. We offer individual counselling, medical monitoring, group therapy, family/friend support, and meal support daily for 12 weeks.	An outpatient, group therapy-based program, located at the Hotel Dieu Hospital site which provides a multidisciplinary team approach. We offer virtual cognitive behavioural therapy (CBT) as well as weekly virtual nutrition groups for approximately 12 to 18 months.
Requirements: Age: 17 years old and under	**Requirements:** Age: 16-24 years old BMI: 16 or greater	**Requirements:** Age: 18 years and older BMI: 16 or greater

Information for Referring Providers:

- A Physician or Nurse Practitioner referral is required for these services
- Please ensure your patient is aware the referral is being made
- Please submit (fax or email) all 3 pages when making a referral. To help us provide the best care possible, **include relevant documents** such as previous psychiatric consultations or discharge summaries, medication profile, psychological reports, lab and other investigations results, medical reports, and physical findings.
- **If your patient needs immediate help, please direct them to the nearest emergency department or call 911**

HOW TO SUBMIT A REFERRAL

Referrals for patients under 18 years old are faxed or emailed to:	**Referrals for patients 18 years and older are faxed or emailed to:**
Child and Youth Clinical Intake Coordinator Kingston Health Sciences Centre, Hotel Dieu Hospital Site 166 Brock St, Kingston, ON K7L 5G2 Phone: 613-544-3400 extension 2085 **Fax: 613-544-7623** **Email: CYMHIntake@kingstonhsc.ca**	Adult Outpatient and Day Treatment Program Receptionist Kingston Health Sciences Centre, Hotel Dieu Hospital Site 166 Brock St, Kingston, ON K7L 5G2 Phone: 613-544-3400 extension 2506 **Fax: 613-545-1364** **Email: AdultEDP@kingstonhsc.ca**

Legend

ECG: Electrocardiogram	#: Number
CBC & Diff: Complete Blood Count with Differential	BP: Blood pressure
ALT: Alanine transaminase	Bpm: Beats per minute
TSH: Thyroid stimulating hormone	mmHG: Millimetre of mercury
BMD: Bone mineral density	HR: Heart rate
BMI: Body mass index	CNO: College of Nurses of Ontario

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PATIENT INFORMATION	
Patient's Name:	**Date of Birth (yyyy/mm/dd):**
Gender: ☐ Female ☐ Male ☐ Trans-female ☐ Trans-male ☐ Non-binary ☐ Other:	
Primary Phone Number (Home/Mobile):	
Primary Care Provider:	
Date of Referral (yyyy/mm/dd):	**Patient is Aware of the Referral:** ☐ YES ☐ NO
CAREGIVER INFORMATION *(if applicable)*	
Parent/Caregiver Name(s): _____	Relationship to the Patient: _____
Parent/Caregiver Name(s): _____	Relationship to the Patient: _____
Primary Phone Number (Home/Mobile):	
Parent/Caregiver is Aware of the Referral: ☐ YES ☐ NO	
ADVERSE REACTIONS *(Medication/Food/Environmental):* _____	

PRESENTING CONCERN	**EATING DISORDER BEHAVIOUR** *(Check all that apply)*	**FREQUENCY** *(Episodes per week)*
	☐ Restricting Food Intake	
	☐ Binge Eating	
	☐ Vomiting	
	☐ Laxative Use	
	☐ Diuretics	
	☐ Diet Pills	
	☐ Exercise	

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CURRENT AND PREVIOUS TREATMENT *(Attach any relevant information)*

Eating Disorder Treatment? ☐ YES ☐ NO Dietitian Involvement? ☐ YES ☐ NO

Psychiatric Assessment? ☐ YES ☐ NO Other Services Accessed? ☐ YES ☐ NO

MEDICAL HISTORY *(Attach any relevant information)*

☐ Medical History Attached ☐ Medications List Attached

CURRENT PHYSICAL STATUS
(*Include in office measurements taken within the last 2 weeks)*

Height: _____ centimetres | **Weight:** _____ kilograms | **Body Mass Index:** _____

Recent Weight Loss? ☐ YES ☐ NO
Comments: (*How much? Over what timeframe?*): _____
_____
_____

FOR ALL PEDIATRIC PATIENTS:

☐ **Attach Weight and Height History from Age 2 – 18 years** (*actual values and accompanying dates*)

☐ **Complete Orthostatic Vitals:**

Have the patient lie down for 3 to 5 minutes. Measure BP and HR. Then have the patient stand immediately and measure BP and HR after 1 and 3 minutes.)

Supine BP 5 minutes: ____ (mmHg) HR: ____ (bpm)
Standing BP 1 minute: ____ (mmHg) HR: ____ (bpm)
Standing BP 3 minutes: ____ (mmHg) HR: ____ (bpm)

INVESTIGATIONS *(Attach all investigations. Bloodwork and ECG must be completed within the last 1 month)*

☐ CBC & Diff, Creatinine, Urea, Sodium, Potassium, Chloride, Bicarbonate, Calcium, Phosphate, Magnesium, ALT, Bili, TSH, Ferritin, Vitamin B12, Vitamin D-25-OH, Random Glucose, Albumin

☐ Electrocardiogram (ECG)

☐ BMD if ever amenorrheic for 6 months or greater

RISK FACTORS
(Attach any relevant information)

Diabetes	☐ YES	☐ NO
Pregnant	☐ YES	☐ NO
Amenorrhea	☐ YES	☐ NO
Substance Use	☐ YES	☐ NO
Harm to self	☐ YES	☐ NO
Harm to others	☐ YES	☐ NO

Referring Practitioner (Print Name) Designation Billing # / CNO # Signature Date (yyyy/mm/dd)