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

Hôpital Hotel Dieu Hospital

KGH Hôpital Général de Kingston General Hospital

ADULT MENTAL HEALTH REFERRAL (Outpatient)

ADULT MENTAL HEALTH PROGRAM (AMHP) – KHSC (HDH Site)

PHONE: 613-544-3400 ext. 3700 **| FAX:** 613-548-6032 **| EMAIL:** AdultMHIntake@KingstonHSC.ca

★All sections must be completed★

Please note that all sections of this referral must be completed, and relevant collateral information included or the referral will be considered incomplete and returned to you. Please also note that our catchment area for KHSC-AMHP Outpatient is Kingston, Frontenac, and Lennox & Addington; any referrals from outside these areas will be returned and redirected.

Date of referral: _____ (yyyy/mm/dd) **Referral source:** _____

Referred by: ☐ Family Physician ☐ Nurse Practitioner ☐ Other: _____ **Billing number:** _____

Referral stream: ☐ General / Routine ☐ Urgent (Emergency Department / Urgent Care / KHSC Inpatient only)

Family Physician: _____ **Telephone:** _____ **Fax:** _____

Name of patient: _____ **Gender:** ☐ Female ☐ Male ☐ Other: _____

Date of birth: _____ (yyyy/mm/dd) **Health Card:** _____-_____ **Language:** _____ **Interpreter?** ☐ Yes ☐ No

Telephone (Home/Mobile/Work): _____ **Telephone (Other):** _____

Address: _____

Email: _____ **Email consent provided:** ☐ Yes ☐ No

Preferred method of contact: ☐ Phone ☐ Email ☐ Mail **Can a detailed message be left?** ☐ Yes ☐ No

★ Please note that the first contact with the patient by our intake team will be by telephone ★

Health care proxy: _____ (PRINT NAME) ☐ Power of Attorney ☐ Substitute Decision Maker ☐ Trustee

Reason for referral / presenting concern (symptoms, duration, diagnostic impressions and goals)**:**

Impact on daily functioning? ☐ Mild ☐ Moderate ☐ Severe

Risk factors (If yes, please provide explanation, frequency and additional details in the area provided)**:**

Threat(s) to self:	☐ Yes	☐ No	_____
Threat(s) to others:	☐ Yes	☐ No	_____
Family violence:	☐ Yes	☐ No	_____
Legal issue(s):	☐ Yes	☐ No	_____
Substance use/abuse:	☐ Yes	☐ No	_____

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Any relevant medical or psychiatric history (developmental delay, epilepsy, dementia, head injury, etc.)**:**

Previous psychiatric diagnosis(es): _____

Current medications (please include herbal supplements, prescriptions non-prescription medication or naturopathic remedies)**:**

★ ***Please attach medication list if possible*** ★

MEDICATION	DOSE (include units)	FREQUENCY	COMMENTS

Adverse reactions: _____ **Pharmacy:** _____

Any previous or current psychiatric / community mental health involvement (please provide as much detail as possible)**:**

☐ I acknowledge that this referral has been reviewed with the patient/client and that they are aware that they will be contacted, and their needs will be assessed by the Adult Mental Health Program at KHSC-HDH for the most appropriate service.

☐ I have attached previous psychiatric reports, psychological testing or other relevant assessments.

_____

PRINTED NAME DESIGNATION SIGNATURE DATE (yyyy/mm/dd) TIME (hhmm)

Please confirm acknowledgement of the following:

☐ We are unable to provide the following services: disability follow-up appointments as part of Employment Insurance, Canada Pension Plan, Workplace Safety & Insurance Board, Ontario Disability Support Program requirements; Independent Medical Evaluations for Court and Child Welfare Assessment; Forensics or Capacity Assessments.

☐ We do not offer crisis services. If you need immediate support, are at imminent risk, or if the patient is in crisis please refer to your local crisis line or present to your local emergency department for assessment.

☐ Treatment approach and duration are at the discretion of the AMHP Clinician(s) and Psychiatrist(s), and is limited to 12-months.