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: 8 - 17 years old	**Requirements:** Age: 16 years and older 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 Child & Youth Eating Disorders Program are faxed or emailed to:	**Referrals for Eating Disorders Day Treatment Program & Adult Eating Disorders Program 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 22085 **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 22506 **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

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

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):	
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	

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

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)