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

Hôpital Hotel Dieu Hospital

KGH Hôpital Général de Kingston General Hospital

CHILD AND YOUTH MENTAL HEALTH PROGRAM
URGENT CONSULT CLINIC REFERRAL

PHONE: 613-544-3400 ext. 2518 **| FAX:** 613-544-4643

NOTE: Youth must be at imminent risk for suicidal/ homicidal behaviour. All referrals are triaged by the team to determine appropriateness and acuity. If the referral does not meet criteria they may be referred to the closest Children's Mental Health Service; if the youth is in immediate crisis please refer them to the closest emergency department.

Date of Referral: _____

Family Health Team/Agency (if applicable):_____

Name of child/youth (print): _____ **Date of Birth:** _____ (yyyy/mm/dd)

OHIP: _____-_____ **Contact # for patient/caregiver/guardian:** _____

Address:_____

Caregiver/Parent: _____ **Relationship:** _____

Is the parent or youth aware that this referral has been made? ☐ Yes ☐ No **Chart Number:**_____

Referring physician (staff doctor) please complete:

_____

Printed Name **Designation** **Signature** **Date (yyyy/mm/dd)** **Time (hhmm)**

Presenting Concer/Reason for Referral (provide as much detail as possible):

Relevant Medical or Psychiatric History:

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

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

☐ **I have attached previous psychiatric reports, psychoeducational testing, treatment summaries or other reports.**

We strive to see patients within 48 hours of receipt of their information. Weekends, Holidays or lack of access to a Psychiatrist may delay scheduling your appointment.