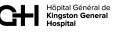


Centre des sciences de la santé de Kingston





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

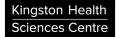
KINGSTON HEALTH SCIENCES CENTRE'S EATING DISORDERS PROGRAMS SUMMARY Please visit our website at <u>https://kingstonhsc.ca/mental-health-care</u> for additional information							
Child & Youth Eating Disorders Program:	Eating Disorders Day Treatment Program:	Adult Eating Disorders Program:					
An outpatient 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:	Requirements:	Requirements:					
Age: 8 - 17 years old	Age: 16 - 24 years old BMI: 16 or greater	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 CBC & Diff: Complete Blood Count with Differential ALT: Alanine transaminase TSH: Thyroid stimulating hormone BMD: Bone mineral density BMI: Body mass index	#: Number BP: Blood pressure Bpm: Beats per minute mmHG: Millimetre of mercury HR: Heart rate CNO: College of Nurses of Ontario			



Centre des sciences de la santé de Kingston



EATING DISORDERS PROGRAMS CENTRALIZED REFERRAL FORM

PATIENT INFORMATION								
Patient's Name: Date of Birth (yyyy/mm/dd):								
Gender:	ale 🗆 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 Refer	ral: 🗆 YES 🗆 NO						
CAREGIVER INFORMATION (if applicable)								
Parent/Caregiver Name(s):	rent/Caregiver Name(s): Relationship to the Patient:							
Parent/Caregiver Name(s):	Relationship to the Patie	Relationship to the Patient:						
Primary Phone Number (Home/Mobile):								
Parent/Caregiver is Aware of the Referral: □ YES □	NO							
ADVERSE REACTIONS (Medication/Food/Environmental):								
ADVERSE REACTIONS (Medication/Food/Environmental).		······						
ADVERSE REACTIONS (Medication/Food/Environmental)								
ADVERSE REACTIONS (Medication/Food/Environmental)	EATING DISORDER BEHAVIOUR (Check all that apply)	FREQUENCY (Episodes per week)						
	EATING DISORDER BEHAVIOUR	FREQUENCY						
	EATING DISORDER BEHAVIOUR (Check all that apply)	FREQUENCY						
	EATING DISORDER BEHAVIOUR (Check all that apply)	FREQUENCY						
	EATING DISORDER BEHAVIOUR (Check all that apply)	FREQUENCY						
	EATING DISORDER BEHAVIOUR (Check all that apply) Restricting Food Intake Binge Eating Vomiting	FREQUENCY						
	EATING DISORDER BEHAVIOUR (Check all that apply) Restricting Food Intake Binge Eating Vomiting Laxative Use	FREQUENCY						

			·					
Kingston Health Sciences Centre Centre des sciences de la santé de Kingston		RAMS	al Général de ton General tal					
CENTRALIZED REFE	ERRAL	FORM						
CURRENT AND PREVIOUS TREATMENT (Attach any relevant information)								
Eating Disorder Treatment?	□ YES	□ NO D	vietitian Involvement?	□ YES	S □ NO			
Psychiatric Assessment?	□ YES	□ NO O	ther Services Accessed	? 🗆 YES				
MEDICAL HISTORY (Attach	any releva	ant information)						
☐ Medical History Attached	□ Medi	cations List Attac	ched					
CURRENT PHYSICAL STATUS (Include in office measurements taken within the last 2 weeks)								
Height: centime	etres we	eight:	kilograms	Body Mas	ss Index:			
Recent Weight Loss?		NO peframe?):						
FOR ALL PEDIATRIC PATI	ENTS:							
□ Attach Weight and Heigl	ht History	from Age 2 – 18	3 years (actual values al	nd accompa	nying date	es)		
□ Complete Orthostatic Vi	tals:		Supine BP 5 minute	es:	(mmHg)	HR:	(bpm)	
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.)		Standing BP 1 minu		(mmHg)	HR:	,		
		Standing BP 3 minu	ites:	(mmHg)	HR:	(bpm)		
INVESTIGATIONS (Attach all investigations. Bloodwork and ECG must be completed within the last 1 month)RISK FACTORS (Attach any relevant information)								
CBC & Diff, Creatinine, Urea, Sodium, Potassium, Chloride, Bicarbonate, Calcium, Phosphate, Magnesium, ALT, Bili, TSH, Ferritin, Vitamin B12,	Diabetes	□ YES	□ NO					
	Pregnant	□ YES	□ NO					
	min D-25-OH, Random Glucose, Albumin		Amenorrhea					
□ Electrocardiogram (ECG)	fan ()		Substance Use					
□ BMD if ever amenorrheic for 6 months or greater		Harm to self Harm to others	□ YES □ YES	□ NO □ NO				
Referring Practitioner (Print I	Name)	Designation	Billing # / CNO # S	Signature	Date (yy	vy/mm/c	d)	
5 (,	5	5	5	())		,	