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

Hôpital Hotel Dieu Hospital

KGH Hôpital Général de Kingston General Hospital

Patient Name: _____
Date of Birth (yyyy/mm/dd): _____
Health Card: _____ - _____
Chart Number: _____
Visit Number: _____
Address: _____
_____
Telephone (Home/Mobile/Work): _____
Date of Referral (yyyy/mm/dd): _____

CHILD AND YOUTH MENTAL HEALTH PROGRAM EATING DISORDERS REFERRAL

PHONE: 613-544-3400 ext. 2508 **| FAX:** 613-544-7623

REASON FOR REFERRAL:

SERVICES ACCESSED:

COMORBIDITIES:

MEDICATIONS:

*****REQUIRED** DOCUMENTATION***

For the referral to be considered complete and eligible for triage, the following must be enclosed. Missing information will delay the triage of this consultation request. ***FAX referral and **REQUIRED** documentation below to 613-544-7623.***

IMPORTANT REMINDER: The referring Practitioner is responsible for managing the patient's care up until they are assessed by our Child and Youth Eating Disorder Team. Your patient's parents/guardian will be contacted by our clinic to schedule an intake appointment once all documentation is reviewed.

Current Height: _____ (cm) Date: _____ (yyyy/mm/dd) Current Weight: _____ (kg) Date: _____ (yyyy/mm/dd)

METHOD FOR MEASURING ORTHOSTATIC VITAL SIGNS: Have patient lay supine for 3 minutes. Take blood pressure (BP) and heart rate (HR). Immediately after, have patient stand up. Wait one minute and repeat HR and BP.

LYING: BP _____ (mmHg) Pulse _____ (bpm) **STANDING:** BP _____ (mmHg) Pulse _____ (bpm)

YOU MUST INCLUDE:

☐ Height and weight history including childhood data

☐ Electrocardiogram (ECG)

☐ Labs investigations: CBC, ALT, ALP, Na, K, Cl, glucose, urea, creatinine, magnesium, phosphate, TSH, Vitamin B12, Vitamin D-25 OH, Folate, and Ferritin

REFERRING PRACTITIONER (PRINT NAME) DESIGNATION SIGNATURE DATE (yyyy/mm/dd)