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

Heads Up! Early Psychosis Intervention Program
Hotel Dieu Hospital site
Serving Frontenac, Lennox & Addington, Hastings, Prince Edward, Lanark, Leeds & Grenville Counties
Please fax referral to: 613-545-1364

Client Information	**Referral Agent Information**
Name: Address: Date of Birth (dd/mm/yy): __ / __ / __ Telephone (home): Telephone (work): Alternate contact person (name): Alternate contact person (phone #): Health Card #: Health Card Version code: May we contact the client directly? ☐ Yes ■ No Can a detailed message be left? ☐ Yes ■ No Any Communication barrier? ☐ Yes ☐ No Please specify:	Date of Referral: Referring Physician/Nurse Practitioner **ONLY & Billing No.**: Telephone: Fax: Family Physician / Psychiatrist: (if different from above) Name: Telephone: _____ Legal Status: _____ Substitute Decision Maker: _____ Address: _____ Telephone Number:

Reason for the Referral:

CURRENT SITUATION	**PSYCHIATRIC HISTORY**
Current working psychiatric diagnosis	Previous diagnoses ☐ None
Current mental health / psychiatric contacts / community supports (please describe) ☐ None	Previous **out-patient** mental health and/or addiction treatment (please describe) ☐ None
Current medical conditions (please describe) ☐ None Current medications (please describe) ☐ None	Previous **in-patient** psychiatric admissions ☐ Yes ☐ No (please describe)

Signature: (of Referring Doctor/NP **ONLY**) **Date:** **BILLING NO:**

Note: 1) Signature acknowledges that this referral will be assessed by one of the Heads Up or FLA Access Coordinators
2) Referrals will **ONLY** be accepted if signed by a referring Physician or NP with a valid Billing Number
3) **Please append/forward any relevant consultation reports/discharge summaries**.