



Religious Hospitallers  
of Saint Joseph  
of the Hotel Dieu of Kingston  
HOTEL DIEU HOSPITAL

**FORWARD REFERRAL FORM TO:**  
**Hotel Dieu Hospital PASTORAL CARE**  
**FAX: 613-544-2208**  
**TELEPHONE 613-544-3400 EXT 2231**

**PASTORAL CARE REFERRAL FORM**

<b>PATIENT INFORMATION</b>	<b>REFERRAL INFORMATION</b>
<p><u>OR</u> attach Patient Information Label</p> <p>Last Name: _____</p> <p>First Name: _____</p> <p>Address: _____</p> <p>Home Telephone #: _____</p> <p>Work #: _____</p> <p>Date of Birth Y-M-D: _____</p> <p>Health Card # _____</p> <p>Version Code: _____</p> <p>May we contact client directly? YES / NO</p> <p>Can a message be left? YES / NO</p> <p>Any communication barrier?</p>	<p>Date of Referral:</p> <p>URGENT? YES / NO</p> <p>REASON FOR REFERRAL:</p> <p><input type="checkbox"/> Spiritual / Religious Issues</p> <p><input type="checkbox"/> Emotional Distress (denial, guilt, shame, hopelessness, fear, etc)</p> <p><input type="checkbox"/> Grief &amp; Loss Issues</p> <p><input type="checkbox"/> Supportive Counseling</p> <p><input type="checkbox"/> End of Life Issues</p> <p><input type="checkbox"/> Other – specify: _____</p> <p>_____</p>

***Health Services Referral:***

HDH Out-patient Mental Health     KGH- Inpatient Mental Health     Providence Care

Referring Physician: \_\_\_\_\_ Signature: \_\_\_\_\_  
PLEASE PRINT PHYSICIAN'S FULL NAME

If you are willing to remain as the physician on record, please initial here: \_\_\_\_\_

***Hotel Dieu Hospital Clinic Referral:***

Referral made by: \_\_\_\_\_ Signature: \_\_\_\_\_  
PLEASE PRINT PHYSICIAN'S / HEALTH PROFESSIONAL'S FULL NAME

Clinic: \_\_\_\_\_

WHAT IS BEING REQUESTED? \_\_\_\_\_

NOTES / PERTINENT MEDICAL & PSYCHIATRIC HISTORY AND / OR MEDICATIONS:

\_\_\_\_\_  
\_\_\_\_\_