HEALTHY MOTHER HEALTHY BABY

SASKATOON REFERRAL FORM

Saskatchewan Health Authority

CLIENT NUMBER (Office Use Only**):** _____ **DATE:** _____

NAME: _____ **PHN:** ____ - ____ - ____
(Surname, first name, middle initial)

ADDRESS: _____ **POSTAL CODE:** _____
(Street number, street name, apt #)

PHONE #: _____ - _____ - _____ ☐ **Landline** ☐ **Cellphone** ☐**Text Only;** **Ok to be contacted at this number?** ☐ **Yes** ☐ **No**

WhatsApp Contact #: _____ **; Email Address:** _____

Date of Birth: _____/_____ / _____ **Age:** _____ **Previously On HMHB Program** ☐**No** ☐**Yes**
Day Month Year

DUE DATE: _____**; GESTATIONAL AGE as of today's date:** _____**(# wks)**

PRIMARY CARE PROVIDER (Physician, Nurse Practitioner, Midwife): _____

Alternate Contact Person: _____**; Relationship:** _____**; Phone #:** _____

NEEDS INTERPRETER/INTERPRETATION: ☐ **No** ☐ **Yes; Language:** _____
Interpreter Provided: ☐ **Yes** ☐**No**
Interpreter Name & Contact #: _____

REFERRED BY: ☐**Self** ☐**Relative/Friend** ☐**KidsFirst** ☐**PORT/Sanctum 1.5** ☐**Positive Living Program**
☐**WSCC** ☐**Primary Care Provider:** _____ ☐**FASD Network**
☐**Global Gathering Place** ☐**Open Door Society (SODS)** ☐**Social Worker:** _____
☐**School Guidance Counsellor:** _____ ☐**Other:** _____

SCHOOL: _____**; WORK PLACE:** _____

DO YOU HAVE ANY PETS IN YOUR HOME? ☐ **No** ☐**Yes; Dogs** _____ **Cats** _____ **Other** _____
*All animals must be restrained when visited by HMHB staff

Safety Concerns staff need to know for home visiting at address provided: _____
_____

Additional Comments: _____
_____
_____

For additional information contact:
Healthy Mother Healthy Baby Program, Saskatchewan Health Authority
West Winds Primary Health Centre, 3311 Fairlight Drive, Saskatoon, SK S7M 3Y5
Telephone: 306-655-4810 Fax: 1-855-947-2840
Email: HMHB@saskhealthauthority.ca
Thank you for your interest in and referral to the program.