Saskatchewan Health Authority

West Winds Primary Health Centre

3311 Fairlight Drive

Saskatoon, SK S7M 3Y5

# FOOD FOR THOUGHT

## SASKATOON COMMUNITY / SELF REFERRAL FORM

**DATE:** _____ **DUE DATE:**_____

**NAME:**_____ **PHN:**_____ - _____ - _____
(Surname, first name, middle initial) (Provincial Health Number)

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

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

**EMAIL ADDRESS:**_____

**DATE OF BIRTH:** _____/_____ / _____**Age:**_____ **Enrolled in HMHB Program ☐ No ☐ Yes**
Day Month Year

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

**EMERGENCY CONTACT PERSON:**_____ **Relationship:**_____ **Phone #:**_____

**ALLERGIES/FOOD RESTRICTIONS IN THE HOME:** _____

**NAMES AND AGES OF CHILDREN:** _____

**CHILD-MINDING REQUIRED: ☐ No ☐ Yes** **TRANSPORTATION REQUIRED: ☐ No ☐ Yes**

**PREFERRED DAY: ☐ Monday - 12:00pm-2:00pm ☐ Tuesday - 10:00am-12:00pm ☐ unsure**

**HOW DID YOU HEAR ABOUT FOOD FOR THOUGHT:** _____

**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:**_____

**Additional Comments:** _____

_____

_____

*** PROGRAM REGISTRATION REQUIRED ***

**Once referral is received, we will contact you to register you for your preferred program.**

**Please send completed form to** foodforthought@saskhealthauthority.ca or **Fax: 306-655-4899**
**OR, you can refer by contacting us at: Text: 306-230-2482 Phone: 306-655-4824**