Saskatchewan Health Authority

Positive Living Program
Royal University Hospital
103 Hospital Drive
Saskatoon, SK S7N 0W8
Phone: 306-655-1783
Fax: 306-655-0614
Medical Director: Dr. S. Sanche

Saskatoon Community Clinic-Westside
1528 20th Street West
Saskatoon, SK S7M 0Z6
Phone: 306-664-4310
Medical Director: Dr. L. Kiesman

HIV Referral Form

Our clinics provide assessment, treatment, education, and support for those who have been diagnosed with Human Immunodeficiency Virus (HIV). Each clinic endeavors to notify patients of a confirmed appointment time within 3 months. **For emergency cases, call hospital switchboard at 306-655-1000 and ask them to page Infectious Disease (ID) on call.**

Please ensure the following lab results accompany this form: ☐ **HIV Ab** ☐ **CD4/CD8** ☐ **HIV Viral Load** ☐ **CBC** ☐ **Pregnancy Test (in all women of child-bearing age)**
HIV Notification Form completed: ☐ **No** ☐ **Yes (if yes, attach copy)**

Referred by: _____ Phone: _____ Fax: _____

Date: _____ Regular GP/NP: _____ **HSN:** _____

Patient's Legal Name: _____ **Preferred Name**: _____

DOB: _____dd/ _____mm/____ yyyy **Gender**: ☐ Male ☐ Female ☐ Transgender **Pronouns:** _____

Address: _____ or ☐ No permanent address

City: _____ **Province**: _____ **Postal Code**: _____

Patient Phone: Preferred #_____ Alternate #_____

Email: _____ ☐ On Reserve (specify) _____ ☐ Off Reserve

Does the patient have any active symptoms? Check/circle all that apply:

☐ Fever / night sweats / weight loss ☐ CNS: headache / stiff neck / focal deficits / cognitive impairment
☐ GI: thrush / anorexia / nausea / vomiting / diarrhea / difficulty swallowing
☐ Respiratory: cough / dyspnea ☐ Change in vision ☐ Other: _____
☐ Current Antiretroviral Therapy (ART) ☐ No ☐ Yes (Drug Name(s))_____

Does the patient have other co-morbidity? E.g. HCV ☐ No ☐ Yes _____

Does the patient have any of the following factors? Check/circle all that apply:

☐ Pregnant – No/Yes; Date of Last Menses:_____ ☐ Abusive Relationship
☐ Incarcerated (Fed/Prov); Release Date: _____ ☐ Physical Impairment (specify) _____
☐ Immigrant/Refugee ☐ Language Barrier/Spoken (specify) _____

Is patient linked to Case Management or Social Work? ☐ Unknown ☐ No ☐ Yes (who?)_____

Is there a preferred site for this patient? ☐ Royal University Hospital ☐ Saskatoon Community Clinic – Westside

***All patients must be advised of their diagnosis and referral prior to transmitting this form**
_____ (initial to confirm completed)*

FAX form to: 306-655-0614