Saskatchewan Health Authority

Bridge Clinic Referral

Temporary medical clinic for people who **do not** have a primary care provider

PATIENT INFORMATION				
LAST NAME:	FIRST NAME:		PREFERRED NAME:	
PHN:	BIRTHDATE: (DD/MMM/YYYY)		SEX ASSIGNED AT BIRTH:	
ADDRESS:			GENDER:	PRONOUNS:
CITY:	PROVINCE:		POSTAL CODE:	
PRIMARY PHONE:		SECONDARY PHONE:		
CONTACT INFORMATION CONFIRMED W/PATIENT □ **YES** □ **NO**				
REQUIRES INTERPRETER: □ YES □ NO	LANGUAGE:		EMAIL ADDRESS:	
ALTERNATE CONTACT:	NAME:	PHONE:		RELATION:

Please verify that patient meets eligibility criteria for Bridge Clinic intake (must answer YES):

Has the patient provided verbal consent for this referral and release/ disclosure of information to Bridge Clinic? □ YES □ NO

Is patient without a family physician? □ YES □ NO

Note: Patients attached to a primary care provider are NOT eligible for referral to Bridge Clinic

PERTINENT MEDICAL HISTORY

Reason for Referral: □ Discharge Summary Attached (*if applicable*)

Pertinent Medical History *(please attach relevant consultations, investigations, discharge summaries):*

Medications

□ Current Medications up-to-date on EHR Viewer □ Current Medication List Attached

□ Discharge Medication List Attached

IN-HOSPITAL REFERRALS

Patient Location: □ RUH □ SPH □ SCH □ SCH Inpatient Rehab □ Irene and Leslie Dube Centre □ Other_____

Planned hospital discharge date, *if known*:

PREVIOUS INVESTIGATIONS *(please attach)*

	Complete	Pending		
ECHO	□	□	Diagnostic Imaging	□_____
ECG	□	□	Specialist/Consult	□_____
Holter	□	□	Other	□_____

REFERRING HEALTHCARE PROFESSIONAL	**BRIDGE CLINIC WILL CONTACT PATIENTS WITHIN 4-6 WEEKS**	
NAME:	□ Time-Sensitive Follow-Up Appointment Required	
PHONE:	*Please indicate time frame required for follow-up and SPECIFIC reason:*	
FAX:		
REFERRING SERVICE:	SIGNATURE:	DATE: (DD/MMM/YYYY)

FAX COMPLETED REFERRAL FORM TO 1-888-675-9852