PORT Prenatal Outreach and Resource Team

Saskatoon PORT Referral Form Please Fax to 306-954-5036

Please contact Brie (306) 381-9690 if you have questions.

PLEASE ENSURE YOU HAVE COMPLETED AND SUBMITTED WITH THIS REFERRAL THE CONSENT TO RELEASE INFORMATION

Date of Referral: (mm/dd/yyyy)		
Referring Agency: **(Please indicate what agency is referring patient)**		
Name of Referring Agent:		**Phone**
Applicant Name:		**DOB (mm/dd/yyyy)**
	Phone	**Facebook Messenger name:**
Applicant Address or best to place locate them.	**Street**	
	City: **Prov. SK**	**Postal Code**
Is applicant homeless or inadequately housed please indicate.		
Pharmacy:		
Source of Income (SIS, SAID, NO SOURCE etc):		
Ethnicity (e.g. Caucasian, Status Aboriginal, Non-status Aboriginal, Asian, African Canadian, etc):		
HEALTH INFORMATION		
PHN		
Family Physician/ Obstetrician		
Due date for delivery:		
Indicate high risk factors for referral to PORT.		

SCG
134 Avenue O South, Saskatoon, SK S7M 2R5
(306) 244-1200 | info@sanctumcaregroup.com | sanctumcaregroup.com

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Reason for seeking PORT's services:	
Has patient had any prenatal care? If yes please provide details:	

MENTAL HEALTH		**CLIENTS SUPPORTS**
Mental Health Diagnosis:	**Diagnosis Date:**	**Please list current supports working with patient (including name / agency and contact info)**
1.		1.
2.		2.
3.		3.
4.		4.
Active Substance use:	**YES/NO**	5.
Substances Currently used:		**Comments:**

Family Information

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Does patient have other children? If so please list and indicate who has custody of child (foster care, family etc)	
Does patient have a partner? If yes, include name and contact info:	

PORT Manager or Team lead will notify referring source if client has been accepted to the Prenatal Outreach Resource Team.

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Prenatal Outreach Resource Team
CONSENT FOR RELEASE OF INFORMATION

I _____ agree to enter the programs and services offered through Sanctum Care Group: Prenatal Outreach Resource Team. I am aware that PORT is designed to support me in meeting my goals of having a healthy pregnancy and establishing a plan for my child once born. This program works collaboratively between programs, physicians, nurses, case managers, social workers, and other support services.

In order to assist you in receiving effective care, we would like your permission to collect, use and disclose your personal health information or personal information between the referring organization, Social Services and members of your support team. The team consists of professionals representing the following agencies:

Sanctum Care Group	Ministry of Social Services
Westside Community Clinic	Saskatchewan Health Authority
Saskatoon Housing Authority	YXE Women's Health

Staff members of Sanctum will discuss your case to determine if PORT is the appropriate program for you. In order to determine if this program is right for you, Sanctum will collaborate on issues related to your various care needs. Specific information discussed may include your physical and mental health, substance use, supports in the community, relationships, housing, and income. We require this information to determine if PORT is the right program for you.

I agree to release my Information as follows (please check one of the following options):

- ❒ I give my consent to share my Information with all the members of the Prenatal Outreach Resource Team
- ❒ I give my consent to share my Information with the following member(s) of Prenatal Rounds.
  - ❒ Ministry of Social Services
  - ❒ Sanctum Care Group
  - ❒ Westside Community Clinic
  - ❒ Saskatchewan Health Authority
  - ❒ Saskatoon Housing Authority
  - ❒ YXE Women's Health

I understand that my access to care from these specific programs will not be affected by my decision to allow my Information to be shared or not.

This consent remains in effect for one year from date of signature; I understand that I can change my mind at any time, regarding who I allow my information to be shared with. I understand that if I change my mind, the information previously shared is not affected.

I, _____ (Printed Name), hereby provide authorization to the collection, use and disclosure of information about myself to Sanctum and members of the Prenatal Outreach Resource Team.

_____ _____

Signature Date

_____ _____

Witness Date

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