Sanctum 1.5
High Risk Prenatal Care Home

Referral Form

Please fax the referral to Sanctum Care Group at (306) 954-5036
For any questions contact Program Director at (306) 491-8201

ENSURE YOU HAVE COMPLETED AND SUBMITTED THE CONSENT TO RELEASE INFORMATION WITH THIS REFERALL (PAGE 3)

Date of Referral: (mm/dd/yyyy)		
Referring Agency: **(Please indicate what agency is referring patient)**		
Name of Referring Clinician:		**Phone**
Applicant Name:		**DOB (mm/dd/yyyy)**
	Phone	
Applicant Address	**Street**	
	City **Prov.**	**Postal Code**
Is applicant homeless or inadequately housed please indicate		
Source of Income (SAP, SAID, DISABILITY etc):		
Ethnicity (e.g. Caucasian, Status Aboriginal, Non-status Aboriginal, Asian, African Canadian, etc):		

HEALTH INFORMATION

PHN	
Family Physician/ Obstetrician	
Due date for delivery:	
Is patient HIV positive? If yes please provide most recent cd4/viral load and if taking ARV's	
If not HIV positive indicate high risk factors for referral to Sanctum 1.5	
Has patient had any prenatal care? If yes please provide details :	

Sanctum 1.5
High Risk Prenatal Care Home

Referral Form

Please fax the referral to Sanctum Care Group at (306) 954-5036
For any questions contact Program Director at (306) 491-8201
ENSURE YOU HAVE COMPLETED AND SUBMITTED THE CONSENT TO RELEASE INFORMATION WITH THIS REFERALL (PAGE 3)

MENTAL HEALTH		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	
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:	

Sanctum 1.5
High Risk Prenatal Care Home

Referral Form

Please fax the referral to Sanctum Care Group at (306) 954-5036
For any questions contact Program Director at (306) 491-8201
ENSURE YOU HAVE COMPLETED AND SUBMITTED THE CONSENT TO RELEASE INFORMATION WITH THIS REFERALL (PAGE 3)
THE CONSENT TO RELEASE INFORMATION MUST ACCOMPANY THIS FORM IN ORDER TO ACCEPT A REFERAL

Name: _____ **DOB:**_____ **HSN:** _____

SANCTUM 1.5 CONSENT FOR RELEASE OF INFORMATION

I _____ agree to enter the programs and services offered at Sanctum 1.5. I am aware that Sanctum 1.5 is designed to support me in meeting my goals of having a healthy pregnancy and keeping my child in my care or 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	YXE Women's Health	Saskatchewan Health Authority
Ministry of Social Services	Broadway Obstetrics & Gynecology	Westside Community Clinic

Staff members of Sanctum 1.5 will discuss your case to determine if Sanctum 1.5 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, Child and Family Service History, programs accessed, addiction needs as well as any concerns that may impact your ability to parent such as housing, relationships, transportation and income. We require this information to determine if Sanctum 1.5 is the right program for you and your family.

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 Sanctum Care Group care team
- ❒ I give my consent to share my Information with the following member(s) Sanctum Care Group care team

❒ Sanctum Care Group	❒ Ministry of Social Services
❒ YXE women's Health	❒ Westside Community Clinic
❒ Saskatchewan Health Authority	❒ Broadway Obstetrics & Gynecology

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 1.5 and members of the Sanctum 1.5 community team.

_____ _____
Signature Date

_____ _____
Witness Date