



PORT

Prenatal
Outreach and
Resource Team

The Battlefords PORT Referral Form Please Fax to 306-445-7678

Please contact the manager (306) 441-8546 or portnorth@sanctumcaregroup.com 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:			
Name of Referring Agent:		Phone	

Client Name:			Phone			
Facebook Messenger name:			DOB (mm/dd/yyyy)			
Is client homeless or inadequately housed?						
Client address or best to place locate them.	Street					
	City		Prov		Postal Code	
Pharmacy:						
Source of Income (SIS, SAID, NO SOURCE etc):						
Ethnicity (e.g. Caucasian, Status Aboriginal, Non-status Aboriginal, Asian, African Canadian, etc):				Treaty #		

HEALTH INFORMATION

PHN		Due date for delivery: (mm/dd/yyyy)	
Family Physician/ Obstetrician			
Has client had any prenatal care? If yes please provide details:			
Indicate high risk factors for referral to PORT and reason for seeking PORT's services:			



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MENTAL HEALTH		
Mental Health Diagnosis	Diagnosis Date:	
Active Substance use? YES <input type="checkbox"/> NO <input type="checkbox"/>	What substances are currently used?	
Current Client Supports: Please list current supports working with client		
Support Name	Support Agency	Contact information
Family Information		
Does client 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 agent if client referral has been accepted.



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CONSENT FOR RELEASE OF INFORMATION

Name: _____ HSN: _____ Date of Birth: _____

Sanctum Care Group (SCG) requires your consent to review and access your personal health information to determine if the Prenatal Outreach Resource Team (PORT) is the appropriate program for you.

I am aware that PORT is designed to support clients with attaining goals related to prenatal care engagement, harm reduction, and family planning. _____ (Initial)

The PORT program works collaboratively with physicians, nurses, case managers, social workers, and other support services involved in your care. Information will only be shared on a minimum-necessary, need-to-know basis, depending on each provider’s role.

The information shared may include relevant details about your physical and mental health, substance use, community support, relationships, housing, parenting and income. _____ (initial)

I give my consent to SCG to access my Information and share it with the following selected agency(s). (Please check all that apply)

- Ministry of Social Services
- Saskatchewan Health Authority
- Battle River Treaty Six Health Inc.
- BATC – Battleford Agency Tribal Chiefs

I understand that my access to 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 to access and share my information. I understand that if I change my mind, the information previously shared is not affected.

I, _____ (Printed Name), hereby provide authorization for the collection, use and disclosure of information about myself to Sanctum Care Group Inc. I also consent to sharing my information with above listed agencies.

Signature

Date

Witness

Date



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