PORT Prenatal Outreach and Resource Team

Regina PORT Referral Form Please Fax to 306-766-7713

Please contact the Team Lead (306) 510-6378 or portsouth@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:			

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

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MENTAL HEALTH	
Mental Health Diagnosis	**Diagnosis Date:**

Active Substance use? **YES ☐** **NO ☐**	**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
- ☐ Maternity and Wellness on Victoria
- ☐ Saskatoon Housing Authority
- ☐ Saskatchewan Health Authority

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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