

Sanctum 1.5

High Risk Prenatal Care Home

Sanctum 1.5 Referral Form Please Fax to 306-954-5036

Please contact the program director (306) 491-8201 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			
Is client HIV Positive? If yes please provide most recent CD4, Viral load and if taking ARVs			
Has client had any prenatal care? If yes please provide details:			
Indicate high risk factors for referral to Sanctum 1.5 and reason for seeking Sanctum 1.5 services:			



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 <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:		

Program Director or Care Coordinator 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 Sanctum 1.5 program is the appropriate program for you.

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. _____(Initial)

The Sanctum 1.5 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)

- | | |
|--|---|
| <input type="checkbox"/> Ministry of Social Services | <input type="checkbox"/> Westside Community Clinic |
| <input type="checkbox"/> Saskatchewan Health Authority | <input type="checkbox"/> Saskatoon Housing Authority |
| <input type="checkbox"/> YXE Women's Health | <input type="checkbox"/> Broadway Obstetrics & Gynecology |

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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