Sanctum HIV Hospice and Transitional Care Home

SANCTUM REFERRAL FORM

Please fax referral form and consent for release of information to 306-244-1224. Contact the registered nurse at 306-244-1240 or email RN@sanctumcaregroup.com if you have any questions.

Referral information					
Referring agency	☐ SPH ☐ SCH ☐ RUH			**Date**	12/3/26
Name of person referring client			**Phone**	( ) -	
Unit location of client			**Location phone**	( ) -	

Client contact information			
Name of client		**Date of birth**	
Health card #		**Treaty #**	☐ N/A
Family physician	☐ N/A		
Client's address	☐ Inadequately housed ☐ Homeless		
City		**Province**	

Client health information					
Hospital admission diagnosis					
Ready for discharge?	☐ Yes ☐ No	**Client is aware of referral?**	☐ Yes ☐ No		
Known allergies	☐ N/A				
HIV diagnosis date (If known)		**CD4 count (CD4/CD3 Abs)**		**CD4 labs date (if known)**	
HIV viral load		**Viral load labs date (if known)**			
Is patient taking HIV medication?	☐ Yes ☐ No	**If yes, which ones?**			
Is client using substances?	☐ Yes ☐ No	**If yes, list substances and route of use (if known):**			

Additional health conditions

- ☐ **Asthma**
- ☐ **Chronic obstructive pulmonary disease**
- ☐ **Diabetes**
- ☐ **Heart disease**
  Details: _____
- ☐ **Hepatitis C**
  Viral load (if known): _____
- ☐ **Hypertension**
- ☐ **Kidney disease**
- ☐ **Liver disease**
- ☐ **Mental health**
  Details: _____
- ☐ **Other** _____

Additional comments	_____

Transitional health care

Mobility	☐ Independant ☐ Walker ☐ Wheel chair ☐ Other: _____		
Does the client have their own mobility equipment?	☐ Yes ☐ No		
Is client receiving wound care?	☐ Yes ☐ No	**Location and frequency of dressing changes**	
Does client require IV antibiotic?	☐ Yes ☐ No	**Name and frequency of antibiotic**	
Anticipated end date of antibiotic therapy			
Does the client hava a peripherally inserted central catheter (PICC)?	☐ Yes ☐ No	**If no, planned insertion date?**	
Source of income	☐ Saskatchewan Assured Income for Disability (SAID) ☐ Old Age Security (OAS) ☐ No source of income	☐ Saskatchewan Income Support (SIS) ☐ Other: _____	

Please attach the following documents with the referral:

- ☐ Sanctum's Consent for Release of Information
- ☐ Medication Administration Record (MAR)

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Contact the registered nurse at 306-244-1240 or by email at RN@sanctumcaregroup.com if you have any questions.

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

The Sanctum 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 providers' role.

CONSENT FOR RELEASE OF INFORMATION

Once in the Sanctum program, your data might be used for research. SCG follows strict privacy standards, which protect your privacy by making sure no one can determine who you are from our data. Your name and any identifying details are removed from your data and results are combined into large groups so that personal confidentiality is assured.

This consent remains in effect for one year from date of signature. You can change your mind at any time regarding who you allow to access and share your information by notifying your Case Manager. If you change your mind, the information previously shared is not affected.

Name: _____ **HSN:** _____ **Date of Birth:**

I am aware that Sanctum is designed to support me in meeting my goals of living with and managing my HIV care. _____ (initial)

The information shared will assist me in reaching my health and social goals. I therefore give my consent for Sanctum Care Group to share information about my physical and mental health, substance use, community supports, housing and income on a minimum-necessary, need-to-know basis. _____ (initial)

I give my consent to SCG to access my information and share it with the following selected agency(s) that I have identified will be part of my support team. Please check all that apply:

- ☐ eHealth
- ☐ Government of Saskatchewan
- ☐ Saskatchewan Health Authority
- ☐ Other: _____
- ☐ Saskatoon Tribal Council
- ☐ U of S College of Medicine Infectious Disease
- ☐ Westside Community Clinic

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. _____ (initial)

I, _____ (printed name), hereby provide authorization for the collection, use and disclosure of information about myself to SCG. I also consent to sharing my information with the above selected agencies.

_____ _____
Signature **Date**

_____ _____
Witness **Date**

https://canva.link/vr8ptjtjashjppt

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