PORT Prenatal Outreach and Resource Team

Saskatoon PORT Referral Form Please Fax to 306-954-5036

Please contact the manager (306) 381-9690 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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Sanctum Care Group Inc. requires your consent to review and access your personal health and social information to determine if the Prenatal Outreach Resource Team (PORT) is the appropriate program for you.

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 providers' role.

CONSENT FOR RELEASE OF INFORMATION

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:** DD/MM/YYYY

I am aware PORT is designed to support me in meeting my goals of prenatal care engagement, harm reduction and family planning. _____ (initial)

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

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

- ☐ Ministry of Social Services
- ☐ Saskatchewan Health Authority
- ☐ Other: _____
- ☐ Saskatoon Housing Authority
- ☐ Westside Community Clinic
- ☐ YXE Women's Health

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 Sanctum Care Group Inc. I also consent to sharing my information with the above selected agencies.

_____ DD/MM/YYYY

Signature **Date**

_____ DD/MM/YYYY

Witness **Date**

https://canva.link/r5ejtcsr9pcn9tr

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