

# REFERRAL FORM

Mail or Fax to:  
MENTAL HEALTH AND ADDICTION SERVICES  
CENTRALIZED INTAKE  
2<sup>nd</sup> Floor - 715 Queen Street  
Saskatoon SK S7K 4X4  
Phone: 655-7950 Fax: 655-7811  
ADULT COMMUNITY MENTAL HEALTH SERVICES

NAME: \_\_\_\_\_ D.O.B: \_\_\_\_\_ SEX: M \_\_\_\_\_ F \_\_\_\_\_

ADDRESS: \_\_\_\_\_ POSTAL CODE: \_\_\_\_\_

SHSP # \_\_\_\_\_ PHONE: Home - \_\_\_\_\_ Work - \_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_ LIVING ARRANGEMENTS: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EDUCATION: \_\_\_\_\_

MEDICATIONS IF ANY \_\_\_\_\_

CURRENT PROBLEMS or CONCERNS: \_\_\_\_\_

GOALS OF THERAPY :: \_\_\_\_\_

SERVICE / PROGRAM REQUESTED

REFERRED BY: \_\_\_\_\_ TELEPHONE #: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_