

**Saskatoon Health Region**  
Saskatoon, Saskatchewan

Name: \_\_\_\_\_

**Mental Health and Addiction Services**  
**Centralized Intake**

HSN: \_\_\_\_\_

Suite 156, 122 Third Avenue N.  
Fax: 655-4115 Phone: 655-4100

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(dd/mm/yyyy)

**REFERRAL FORM – COMMUNITY ADULT MENTAL HEALTH & ADDICTION SERVICES**

---

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: Residence \_\_\_\_\_ Other \_\_\_\_\_

Occupation: \_\_\_\_\_ Education: \_\_\_\_\_

Male \_\_\_\_\_ Female \_\_\_\_\_ Marital Status: \_\_\_\_\_ No. of Dependents \_\_\_\_\_

Living Arrangements: \_\_\_\_\_ In Hospital: RUH \_\_\_\_\_ SCH: \_\_\_\_\_

Referring Consultant: \_\_\_\_\_ Family Physician: \_\_\_\_\_

Diagnosis: Axis I \_\_\_\_\_

Axis II \_\_\_\_\_

Axis III \_\_\_\_\_

Rehabilitation Goals: \_\_\_\_\_

Current Problems and Concerns: \_\_\_\_\_

Signs of Relapse: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Does the client agree with this referral? Yes [ ] No [ ]

\_\_\_\_\_  
Attending Physician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Telephone No.

**Please enclose a copy of client's past history or admission history.**