HEALTHY MOTHER HEALTHY BABY (HMHB) PROGRAM REFERRAL FORM

CLIENT NUMBER: ____________ **DATE:** ________________

(office use only)

NAME: ____________________________________ PHN #: _____-_____-________
(Surname, first name, middle initial) (Provincial Health Number)

ADDRESS: ____________________________________ POSTAL CODE: __________
(street number, street name, apt#)

PHONE#: _____-______-_______ OK to call you here? ◻Yes ◻ No Due Date:____/______/_____
(DAY/MONTH/YEAR)

DATE OF BIRTH: ____/_____/_____ AGE: ___ ***Gestational age as of today's date_____wks***
(DAY/MONTH/YEAR)

Doctor (Family/Gyne): ________________________ **Note: Not eligible for program 30 wks or more**

Alternate Contact: __________________________ Relationship: ______________ Phone #: ___________

Needs Interpreter/Interpretation: ◻ Yes ◻ No /Interpreter Provided: ◻ Yes ◻ No / Language _____________

Interpreter Name and Contact#: ___________________________/________________________

REFERRED BY: ◻ Self ◻ Social Worker ◻ Guidance Counsellor ◻ WSCC ◻ Doctor ______________

◻ Relative/Friend ◻ Open Door Society ◻ Kids First ◻ Global Gathering ◻ Other ______________

Previously on HMHB Program: ◻ Yes ◻ No Do you have any pets in your home? ◻ Yes ◻ No

Please keep animals restrained when visited by HMHB staff ◻ Dogs __ ◻ Cats__ ◻ Reptiles __ ◻ Birds ___

SCHOOL: __________________________ PHONE#: _____________ ok to call here? ◻ Yes ◻ No

WORKPLACE: ________________________ PHONE:#: _____________ ok to call here? ◻ Yes ◻ No

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COMMENTS: ____

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For additional information contact f Healthy Mother Healthy Baby Program, Saskatchewan Health Authority, West Winds Primary Health Centre, 3311 Fairlight Drive, Saskatoon, SK S7M 3Y5: Tel: 306-655-4810
Fax #: 306-655-4899 Thank you for your interest and referral to the Program. E-mail – HMHB@saskhealthauthority.ca