Saskatchewan Health Authority

HEALTHY MOTHER HEALTHY BABY (HMHB) PROGRAM - SASKATOON
REFERRAL FORM

CLIENT NUMBER: _____ (office use only) **DATE:** _____

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

ADDRESS: _____ (Street number, street name, apt #) **POSTAL CODE:** _____

PHONE #: _____ - _____ - _____ **Ok to call you here?** ☐ **Yes** ☐ **No**

DATE OF BIRTH: _____ / _____ / _____ (Day / Month / Year) **AGE:** _____ **DUE DATE:** _____ / _____ / _____ (Day / Month / Year)

GESTATIONAL AGE AS OF TODAY'S DATE: _____ **wks**
Note: May not be eligible for program 30 wks or more

DOCTOR (Family/Gyne): _____

ALTERNATE CONTACT: _____ **RELATIONSHIP:** _____ **PHONE #:** _____

NEEDS INTERPRETER/INTERPRETATION: ☐ **Yes** ☐ **No**
Interpreter Provided: ☐ **Yes** ☐ **No / Language** _____
Interpreter Name & Contact # _____

REFERRED BY: ☐ **Self** ☐ **Doctor/NP** _____ ☐ **Social Worker**
☐ **Guidance Counsellor** ☐ **WSCC** ☐ **Relative/Friend** ☐ **Open Door Society**
☐ **KidsFirst** ☐ **Global Gathering** ☐ **Other** _____

PREVIOUSLY ON HMHB PROGRAM: ☐ **Yes** ☐ **No**

DO YOU HAVE ANY PETS IN YOUR HOME? ☐ **Yes** ☐ **No**
☐ **Dogs**___ ☐ **Cats**___ ☐ **Reptiles**___ ☐ **Birds**___ Please keep animals restrained when visited by HMHB staff

SCHOOL: _____ **Phone #:** _____ **Ok to call here:** ☐ **Yes** ☐ **No**

WORKPLACE: _____ **Phone #:** _____ **Ok to call here:** ☐ **Yes** ☐ **No**

COMMENTS:
_____
_____
_____

For additional information contact:
Healthy Mother Healthy Baby Program, Saskatchewan Health Authority
West Winds Primary Health Centre, 3311 Fairlight Drive, Saskatoon, SK S7M 3Y5
Telephone: 306-655-4810 Fax: 1-855-947-2840
Email: HMHB@saskatoonhealthregion.ca
Thank you for your interest in and referral to the program.