Saskatchewan Health Authority

**Positive Living Program**
Royal University Hospital
103 Hospital Drive
Saskatoon, SK S7N 0W8
**Phone: 306-655-1783**
Medical Director: Dr. S. Sanche
Manager: Steven Mah 306-381-4765

**Saskatoon Community Clinic-Westside**
1528 20th Street West
Saskatoon SK S7M 0Z6
**Phone: 306-664-4310**

Medical Director: Dr. M. Markentin
Manager: Cheryl Hand 306-664-4307

# HIV Referral Form

Our clinics provide assessment, treatment, education, and support for those who have been diagnosed with Human Immunodeficiency Virus (HIV). Each clinic endeavors to notify patients of a confirmed appointment time within 3 months. **For emergency cases, call hospital switchboard at 306-655-1000 and ask them to page Infectious Disease (ID) on call.**

**Please ensure the following lab results accompany this form:** ☐ **HIV Ab** ☐ **CD4/CD8** ☐ **HIV Viral Load** ☐ **CBC** ☐ **Pregnancy Test (in all women of child-bearing age)**
**HIV Notification Form completed:** ☐ **No** ☐ **Yes (if yes, attach copy)**

**Referred by:** _____ Phone: _____ Fax: _____

**Date:** _____ Regular GP/NP: _____ **HSN:** _____

**Patient's Legal Name**: _____ **Preferred Name**: _____

**DOB:** _____dd/ _____mm/____ yyyy **Gender**: ☐ Male ☐ Female ☐ Transgender **Pronouns:** _____

**Address:** _____ or ☐ No permanent address

**City:** _____ **Province**: _____ **Postal Code**: _____

**Patient Phone**: Preferred #_____ Alternate #_____

**Email:** _____ ☐ On Reserve (specify) _____ ☐ Off Reserve

**Does the patient have any active symptoms?** Check/circle all that apply:

☐ Fever / night sweats / weight loss ☐ CNS: headache / stiff neck / focal deficits / cognitive impairment
☐ GI: thrush / anorexia / nausea / vomiting / diarrhea / difficulty swallowing
☐ Respiratory: cough / dyspnea ☐ Change in vision ☐ Other: _____
☐ Current Antiretroviral Therapy (ART) ☐ No ☐ Yes (Drug Name(s))_____

**Does the patient have other co-morbidity?** e.g. HCV ☐ No ☐ Yes _____

**Does the patient have any of the following factors?** Check/circle all that apply:

☐ Pregnant – No/Yes; Date of Last Menses:_____ ☐ Abusive Relationship
☐ Incarcerated (Fed/Prov); Release Date: _____ ☐ Physical Impairment (specify) _____
☐ Immigrant/Refugee ☐ Language Barrier/Spoken (specify) _____

**Is patient linked to Case Management or Social Work**? ☐ Unknown ☐ No ☐ Yes (who?)_____

**Is there a preferred site for this patient?** ☐ Royal University Hospital ☐ Saskatoon Community Clinic – Westside
☐ West Winds Primary Health Centre

***All patients must be advised of their diagnosis and referral prior to transmitting this form**
**_____ (initial to confirm completed)***

## FAX form to: 306-655-0614