Saskatchewan Health Authority
Saskatoon, Saskatchewan

Name: ______________________________

HSN: ______________________________

Mental Health and Addiction Services
Centralized Intake
4th Floor, 715 Queen Street Saskatoon SK S7K 4X4
Phone: 655-8877 Fax: 655- 8875

DOB: __________/___________/_____________
(yyyy/mm/dd)

REFERRAL FORM- GENERAL COUNSELLING SERVICES, MENTAL HEALTH & ADDICTION SERVICES

Address: ____ Postal Code: ______________________

Telephone: Residence ___________________________________Other ________________________________

Male ______________ Female ______________Transgender ______________

Referring Consultant: __________________________________ Family Physician: ___________________________

Diagnosis (S): ____

____

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Current Problems and Concerns: ____

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____

Current Medications: ____

____

Is the client aware of this referral? Yes [ ] No [ ]

____ ______________________________

Attending Physician Signature Telephone No. Date