Saskatchewan Health Authority
Saskatoon, Saskatchewan

Mental Health and Addiction Services
Centralized Intake
Room H170, 103 Hospital Drive.
Phone: 655-7777 Fax: 655- 0186

Name: _____

HSN: _____

DOB: _____/_____/_____
(yyyy/mm/dd)

REFERRAL FORM- COMMUNITY ADULT RECOVERY (CMHN, REHAB OT, RT, SOCIAL WORK) & SENIOR'S ANXIETY & DEPRESSION - MENTAL HEALTH & ADDICTION SERVICES

Address: _____ Postal Code: _____

Telephone: Residence _____Other _____

Occupation: _____Education: _____

Male _____ Female _____ Transgender _____

Living Arrangements: _____In Hospital: RUH _____SCH: _____

Referring Consultant: _____ Family Physician: _____

Diagnosis (S): _____

_____

_____

Recovery Goals: _____

_____

_____

Current Problems and Concerns: _____

_____

_____

Signs of Relapse: _____

_____

Current Medications: _____

_____

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

_____ _____ _____
Attending Physician Signature Telephone No. Date

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