Saskatchewan
Health Authority

West Winds Primary Health Centre

3311 Fairlight Drive

Saskatoon, SK S7M 3Y5

FOOD FOR THOUGHT

SASKATOON COMMUNITY / SELF REFERRAL FORM

DATE: _____ **DUE DATE:**_____

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

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

PHONE #: _____ - _____ - _____ ☐ **Landline** ☐ **Cellphone** ☐ **Text Only;** **Ok to be contacted at this number?** ☐**Yes** ☐**No**

EMAIL ADDRESS:_____

DATE OF BIRTH: _____/_____ / _____ **Age:**_____ **Enrolled in HMHB Program** ☐ **No** ☐ **Yes**
Day Month Year

PRIMARY CARE PROVIDER (Physician, Nurse Practitioner, Midwife): _____

EMERGENCY CONTACT PERSON:_____ **Relationship:**_____ **Phone #:**_____

ALLERGIES/FOOD RESTRICTIONS IN THE HOME: _____

NAMES AND AGES OF CHILDREN: _____

CHILD-MINDING REQUIRED: ☐ **No** ☐ **Yes** **TRANSPORTATION REQUIRED:** ☐ **No** ☐ **Yes**

PREFERRED DAY: ☐ **Monday - 1:00pm-3:00pm** ☐ **Tuesday - 10:00am-12:00pm** ☐ **unsure**

HOW DID YOU HEAR ABOUT FOOD FOR THOUGHT: _____

REFERRED BY: ☐ **Self** ☐ **Relative/Friend** ☐ **KidsFirst** ☐ **PORT/Sanctum 1.5** ☐ **Positive Living Program**
☐ **WSCC** ☐ **Primary Care Provider:**_____ ☐ **FASD Network**
☐ **Global Gathering Place** ☐ **Open Door Society (SODS)** ☐ **Social Worker:**_____
☐ **School Guidance Counsellor:**_____ ☐ **Other:**_____

Additional Comments: _____

_____

_____

*** PROGRAM REGISTRATION REQUIRED ***

Once referral is received, we will contact you to register you for your preferred program.

Please send completed form to foodforthought@saskhealthauthority.ca or **Fax: 306-655-4899**
OR, you can refer by contacting us at: Text: 306-230-2482 Phone: 306-655-4824