OVERDOSE OUTREACH TEAM (OOT) REFERRAL FORM

PHONE: 306-510-3445
EMAIL: OOTRegina@saskhealthauthority.ca

DEMOGRAPHIC INFORMATION:

NAME OF CLIENT:	HEALTH SERVICES NUMBER: (If available)	DATE OF BIRTH: (If available) YYYY MM DD
CLIENT'S ADDRESS:		POSTAL CODE:
☐ NO FIXED ADDRESS	☐ VERBAL CONSENT	

TELEPHONE (HOME):	TELEPHONE (WORK):	TELEPHONE (CELL):	CAN A PHONE MESSAGE BE LEFT? ☐ YES ☐ NO

Referral Source:

- ☐ EMS
- ☐ Family/Friend
- ☐ Regina Fire and Protective Services
- ☐ Regina Police Services
- ☐ Community Organization (specify) _____
- ☐ SHA – Community _____
- ☐ Self
- ☐ SHA – Hospital _____
  - ☐ Physician/Nurse
  - ☐ EDAC
  - ☐ Social Work
- ☐ Other _____

DATE OF REFERRAL:	YYYY MM DD	**ADDRESS OF OVERDOSE:**	
DATE OF OVERDOSE:	YYYY MM DD		

Other information that may assist with locating and/or supporting this individual: _____ _____	Name and contact information of person referring: _____ _____