Lanark County Sexual Assault/Domestic Violence Program
Social Work/Counselling/Follow up Referral and CONSENT FORM

Referring Hospital or Agency		
☐ Almonte General Hospital ☐ OB/GYNE ☐ ED ☐ Carleton Place & District Memorial Hospital (ED)	☐ Perth &Smiths Falls District Hospital ☐ Great War Memorial Site (ED) ☐ Smiths Falls Site ☐ OB/GYNE ☐ ED	☐ Victim Services ☐ RCHS (CHC) ☐ PCP _____ ☐ Other _____

Personal Information

Name: HC:	DOB:	Gender Identity: ☐ Male ☐ Female ☐ Trans ☐ Male ☐ Female Pronoun: _____ ☐ Genderqueer/Non-Binary ☐ _____ (fill in the blank) ☐ Prefer not to disclose

Address:		
Phone #:	Okay to call ☐ Yes ☐ No	Okay to leave a message ☐ Yes ☐ No
Alternate Phone#:	Okay to call ☐ Yes ☐ No	Okay to leave a message ☐ Yes ☐ No
Email:		Preferred communication method ☐ Phone ☐ text ☐ email

I, _____, give my consent for the release of the above information for the
(printed name of patient/client)
purpose of a referral to a social worker and/or other services provided by the Lanark County SADV Program. _____or ☐ verbal/telephone consent obtained.
(signature of patient/client)

Referred by: (Name of RN/Physician/NP/Other)	Date:	Fam.Phys./NP:

Reasons for referral:
☐ Sexual Assault ☐ Domestic Violence ☐ Both ☐ Other (describe below)

Relevant Information:

Please Fax this Referral and any other documentation to the confidential fax for the SA/DV Program at 1-613-283-6986 **and** leave a voice message at 613 -283-2330 ext. 1258. Keep original document with patient/client chart.