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 ☐ Smiths Falls Site ☐ OB/GYNE ☐ ED	☐ Victim Services ☐ RCHS (CHC) ☐ PCP _____ ☐ Other _____

Personal Information

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

Address:

Emails/texts between you and our program staff are not encrypted; therefore, we cannot guarantee your confidentiality in an email/text. We will never communicate personal health information by email/text. Messages may be forged, forwarded, or seen by others using the internet. Email/text communication is used only with your permission and at your own risk.

Phone #:	Consent to call ☐ Yes ☐ No	Consent to leave a message ☐ Yes ☐ No
Alternate Phone#:	Consent to call ☐ Yes ☐ No	Consent to leave a message ☐ Yes ☐ No
Email:		Consent for communication by: ☐ Phone ☐ text ☐ email

I, _____, give my consent for the release of the information in this referral for
(printed name of patient/client)
the 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.