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

Referring Hospital or Agency (Check one)

- ☐ Almonte General Hospital
- ☐ Carleton Place & District Memorial Hospital
- ☐ Other ____________

Perth &Smiths Falls District Hospital

- ☐ Great War Memorial Site
- ☐ Smiths Falls Site

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. ______________________________or ☐ verbal/telephone consent
(signature of patient/client)

Referred by: (Name of RN/Physician/Other)		Date:	Fam.Phys./NP:
Reasons for referral:	☐ Sexual Assault	☐ Domestic Violence	☐ Both
Other Information:			

Office Use Only

Referral Received on (Date):	By:
Referral Form faxed to LCMH on (Date):	By:

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.

Revised July 2020