Mackenzie Health
Mackenzie Richmond Hill Hospital
10 Trench Street
Richmond Hill, Ontario
L4C 4Z3

Patient Name:

Domestic Abuse and Sexual Assault Care Centre of York Region (DASA)
Patient Referral Form

Telephone: **905-883-2216** **Fax: 905-883-0772**

Forensic Nursing Care
10 Trench Street
Richmond Hill, Ontario, L4C 4Z3
Via Emergency Department

Counseling Services
955 Major Mackenzie Drive West
Vaughan, Ontario, L6A 4P9
3rd Floor Suite 362

(Print Last, First)
Patient Name:

Street: *Apt:* *City/Town* *Province* *Postal Code*
Address: #

Health Card Number: Version Code: *(dd/mm/yyyy)* Date of Birth:

Primary Number: ( ) ☐ Cell ☐ Home ☐ Work ( )

Secondary Number: ( ) ☐ Cell ☐ Home ☐ Work ( )

Did the Patient Consent to the Referral ☐ Yes ☐ No

Does the Patient Require an Interpreter? ☐ Yes ☐ No If Yes, Preferred Language:_____

Can the Hospital Leave a Voicemail? ☐ Yes ☐ No

(Print Last, First)
Emergency Contact Name: Relation: Telephone Number: ( )

Referral Source:
Please complete Physician AND/OR Agency Information

Physician Information

Referring Physician Name: *(Please Print)* _____ Referring Physician Signature: _____

Referring Billing Number: _____

Address: _____ City: _____ Postal Code: _____

Telephone Number: _____ Fax: _____

Family Physician Same as Above ☐ Yes ☐ No

If No, please provide:

Family Physician Name: _____

Address: _____ City: _____ Postal Code: _____

Telephone: ( ) _____ Fax Number: ( ) _____

Agency Information

Agency Name: _____

Contact Person Name: _____

Contact Person Number: ( ) _____

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Reason for Referral (please review all options and select all that apply):

☐ **Sexual Assault (Ages 12 & Up)**
☐ **Domestic Violence (Intimate Partner Violence by Past or Present Partner, Ages 12 & Up)**

Did the assault occur within the last **12 days**? ☐ Yes ☐ No

- **If Yes**: Please complete this referral and fax to 905-883-0772 and send the patient to our Emergency Department immediately. If you require additional information, please call 905-883-2310 to speak with the on-call DASA nurse.
- **If No:** When did the assault occur? **Date:** _____ *(dd/mm/yyyy)*
  Does the patient have **urgent safety concerns** and/or **injuries** that require immediate medical attention? ☐ Yes ☐ No
- **If Yes**: Please complete this referral and fax to 905-883-0772 and send the patient to our Emergency Department immediately. If you require additional information, please call 905-883-2310 to speak with the on-call DASA nurse.
- **If No:** Please complete this referral and fax to 905-883-0772. The patient will be contacted and scheduled for an appointment in the DASA outpatient clinic as soon as possible. If you require additional information, please call 905-883-2310 to speak with the on-call DASA nurse.

☐ **Pediatrics (Ages 11 & Under) Suspected or Known Sexual Assault or Sexual Abuse**

Did the suspected or known sexual assault occur within the last **72 Hours**? ☐ Yes ☐ No

- **If Yes**: Please complete this referral and fax to 905-883-0772 and send the patient to our Emergency Department immediately. If you require additional information, please call 905-883-2310 to speak with the on-call DASA nurse.
- **If No**: Please call 905-883-2216 for Intake and fax referral to 905-883-0772

☐ **Individual Counseling (Available for Patients Aged 13 & Up)**

- **Reason for Referral**: ☐ Sexual Assault ☐ Intimate Partner Violence
- Date of assault/ Abuse: _____ *(dd/mm/yyyy)*
- Additional Details (Type of Abuse, Safety Concerns, Diagnoses, Medications, Accessibility Needs, etc.)

_____
_____
_____
_____

☐ **Counseling Support for Family**

Print Form