

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**

Cortellucci Vaughan Hospital  
 3200 Major Mackenzie Drive West  
 Vaughan, Ontario, L6A 4Z3  
 Via Emergency Department

**Counseling Services**

Mackenzie Richmond Hill Hospital  
 10 Trench Street  
 Richmond Hill, Ontario, L4C 4Z3  
 (Please go to Registration, C Wing, Main Floor)

<i>(Print Last, First)</i>				
<b>Patient Name:</b>				
<i>Street:</i>	<i>Apt:</i>	<i>City/Town</i>	<i>Province</i>	<i>Postal Code</i>
Address: #				
Health Card Number:		Version Code:	Date of Birth: <i>(dd/mm/yyyy)</i>	
Primary Number: (    )		<input type="checkbox"/> Cell	<input type="checkbox"/> Home	<input type="checkbox"/> Work (    )
Secondary Number: (    )		<input type="checkbox"/> Cell	<input type="checkbox"/> Home	<input type="checkbox"/> Work (    )
Did the Patient Consent to the Referral?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Does the Patient Require an Interpreter?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, Preferred Language: _____
Can the Hospital Leave a Voicemail?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<i>(Print Last, First)</i>				
Emergency Contact Name:		Relation:	Telephone Number: (    )	
<b>Referral Source:</b>				
<b>Please complete Physician AND/OR Agency Information</b>				
<b>Physician Information</b>				
Referring Physician Name: <i>(Please Print)</i> _____			Referring Physician Signature: _____	
Referring Billing Number: _____				
Address: _____		City: _____	Postal Code: _____	
Telephone Number: _____		Fax: _____		
Family Physician Same as Above <input type="checkbox"/> Yes <input type="checkbox"/> No				
If No, please provide:				
Family Physician Name: _____				
Address: _____		City: _____	Postal Code: _____	
Telephone: (    ) _____		Fax Number: (    ) _____		
<b>Agency Information</b>				
Agency Name: _____				
Contact Person Name: _____				
Contact Person Number: (    ) _____				



Patient Name:

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

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- Counseling Support for Family**