Soldiers' MEMORIAL HOSPITAL Orillia

Patient Label

Sexual Assault & Domestic Violence Treatment Centre
Social Work Referral Form

The Orillia Soldiers' Memorial Hospital Sexual Assault & Domestic Violence Treatment Centre (SADVTC) provides case management and counselling services to individuals who have experienced sexual assault or intimate partner violence (IPV).

For counselling support, clients must be 16 years of age or older and the primary focus must relate to the assault and / or violence experienced. If the client's primary concern is unrelated to the assault and / or violence, the SADVTC Social Worker will assist in facilitating referral to a more appropriate service.

Please review the eligibility criteria below prior to submitting a referral:

1. Client consents to a referral to the OSMH SADVTC Social Worker
2. Client is 16 years of age or older
3. The primary reason for referral is related to sexual assault or IPV
4. Client is not currently engaged in counselling services elsewhere
5. Sexual Assault - Client received care from an SADV treatment center within the past 6 months
6. IPV - The most recent incident of violence occurred within the past 6 months

* Mandatory Field

REFERRAL INFORMATION	
Date of Referral*	
Referring Person & Agency*	
Contact Information*	
Person Completing Form*	

CLIENT INFORMATION			
Client's Name*		Preferred Name	
Date of Birth (DD/MM/YYYY)*		Age*	
Gender Identity*		MRN	
Current Address*			

Soldiers' MEMORIAL HOSPITAL Orillia

Patient Label

CLIENT INFORMATION CONTINUED					
Telephone Number*		Consent to Text? (Y/N)		Consent to Leave Voicemail? (Y/N)	
OHIP Number		Primary Care Provider			
Does the client identify as First Nation, Indigenous or Metis? (Y/N)		Language(s) Spoken			
Seen by SADV? (Y/N)		Date Seen			

NATURE OF VIOLENCE	
Overview of the Offence* 1. Nature 2. Duration / Frequency 3. Force / Violence 4. Coercion / Threats 5. Relevant Injuries 6. Photography / Internet	
Offender Name & Relation	
Police Charges	

PRESENTING CONCERNS			
Mental Health History			
Suicide Screen	Completed? O Yes O No If completed, results: O Low Risk O Moderate Risk O High Risk		
Primary Reason(s) for Referral*	Anxiety Emotional Dysregulation O Depression / Low Mood O Sleep Difficulties Flashbacks / Nightmares O Shame / Guilt Panic Attacks Social Withdrawal	O Difficulty with ADLs O Substance Use O Self-Harm O Relationship Difficulties O Service Navigation O Safety Planning O Housing Support O Legal / Court Support	O Other:
Relevant Clinical Information	Please include any relevant clinical information required to support the referral.		

Please fax referral to the attention of the OSMH SADVTC Social Worker at 705-327-9182