

# Sexual Assault Services Referral Form

This referral contains confidential and sensitive information. Please do not read unless the information is addressed to you.

**Fax:** 250-897-0595

**Email:** [SAS@cvts.ca](mailto:SAS@cvts.ca)

**Crisis Line:** 778-225-0039

**SAS Coordinator's Cell:** 250-650-5488

Notes and date:

Phone and name of client are required. Please fill out the rest to the best of your knowledge.

EMERGENCY (Assault happened within the last 7 days)      Referral Date: \_\_\_\_\_

RECENT (Assault happened within 7 days - 2 years)

HISTORICAL/GENERAL (2+ years/unsure or for general inquiries/)

<p><b>CLIENT INFO:</b></p> <p>Name: _____</p> <p>Date of Birth: _____</p> <p>Gender/Pronouns: _____</p> <p>Cultural Background: _____</p> <p>Address: _____</p> <p>_____</p> <p>Phone: _____</p> <p>Alt Phone: _____</p> <p>Safe to leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Email address: _____</p>	<p><b>REFERRAL SOURCE INFO:</b></p> <p><input type="checkbox"/> self- referral, or</p> <p>Name of source: _____</p> <p>Relationship to client: _____</p> <p>Name of agency if applicable: _____ <input type="checkbox"/> N/A</p> <p>Contact info: _____</p> <p>Client signature indicating consent for referral: _____ <input type="checkbox"/> N/A</p> <p>Parent/Guardian's Names (If applicable): _____</p>
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<b>Report Made to Police?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Police File #:</b>	<b>Investigating Officer:</b>
<b>Alleged Offender:</b>	<b>Type of Crime:</b>	<b>Location of Crime:</b>

Referral Notes: \_\_\_\_\_

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