

Referral for Pediatric Medical and Forensic Examination Regional Sexual Assault and Domestic Violence Treatment Centre St. Joseph's Health Care, London

Patier	nt's name:	_ Contact #:		
Do we	e have permission to contact the pat	tient?	☐ Yes	☐ No
Refer	ring Physician (Print):	Signatu	ıre	
Contact #:Referring		ng Facility:		
Date:		Time: _		
	ce: degional Sexual Assault and Domes ing services for children with known Forensic evidence collection (time Forensic documentation of injuries Forensic photo-documentation Medical examination, prophylaxis, Follow-up medical care Counseling for the patient and/or to Safety planning	or suspected sexes sensitive) and treatment if i	rual abuse:	provide the
All cri	iteria must be met: Patient is 11 years of age or und process for patients over 11 years		referral. (Please	see the adult referra
	Sexual assault reported to have o	ccurred in the pre	vious year.	
	Urgent medical concerns assessed and treated before transfer to the RSADVTC. The on-call nurse may request that the patient is medically cleared before being seen by the sexual assault team.			
	Referral made to Children's Aid So on Name of person contacted at CAS	ociety by at S	hours	
	e indicate other service providers	s who have been		
1	Contact the on-call nurse at 519-6	346-6100 #0 (Swit	tchhoard). The o	n-call nurse will

- Contact the on-call nurse at 519-646-6100, #0 (Switchboard). The on-call nurse will coordinate an appointment time based on the needs of the patient.
- 2. Upon acceptance of this referral by the on-call nurse, please fax this consultation/referral form and face sheet of the medical record to RSADVTC at 519-646-6243.

Children's Aid Society London & Middlesex, Oxford, and Elgin

London and Middlesex Children's Aid Society (519) 455-9000

After hours (519) 432-5987

Oxford County Children's Aid Society (519) 539-6177

Elgin County Children's Aid Society (519) 631-1492