



NON-ACUTE REFERRAL

For those >13 YEARS and whose harm occurred more than 10 DAYS ago
If less than 10 days ago, call 0800 334 474 to discuss with the on call forensic examiner.

Date: _____

REFERRER DETAILS

Name:	
Agency:	
Relationship between referrer and referee:	
Contact phone:	
Contact email:	

VICTIM / PATIENT DETAILS

Name:	
Preferred name:	
Pronouns:	
Date of birth:	Must be 13 or over DD/MM/YYYY
Gender:	
Ethnicity:	
Contact phone:	
Contact email:	
Address:	

Most appropriate person to contact:

Name: _____ Contact phone: _____

Relationship: _____

DETAILS OF EVENT

Date of most recent sexual assault	MUST BE MORE THAN 10 DAYS AGO DD/MM/YYYY
Nature of most recent sexual assault (Type of contact e.g. penis in vagina; penis in mouth)	
Nature of relationship with alleged offender (e.g. Partner; family member etc.)	
Gender of alleged offender (if known)	

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OTHER RELEVANT DETAILS

Are there any safety concerns?	Y / N <i>Comment:</i>
Are there any physical or intellectual disabilities?	Y / N <i>Comment:</i>
Social concerns: Living situation, mental health, drug, or alcohol issues	Y / N <i>Comment:</i>
Communication issues (EASL)	Y / N <i>Comment:</i>
Are there any other agencies involved?	Y / N <i>Comment:</i>

IF < 16 YEARS OLD

Are there any legal guardianship/custody issues	Y / N
Has an ROC been made:	Y / N
If YES	
Date ROC made:	
By whom (Name):	
Agency:	

Please email referrals to: SAATS@msass.org.nz

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