

Step 1

Consent for Collection and Release of Evidence and Information

Name of Health Care Facility

I, _____, freely consent to allow _____, and his/her medical and nursing associates to conduct a forensic examination, which includes the collection of evidence. This procedure has been fully explained to me and I understand that I may refuse any part of the examination. Clinical observation for physical evidence of both penetration and injury to my person will be done. Collection of other specimens and blood samples for laboratory analysis may be done per the events reported.

Patient Information: Please initial to the right to indicate agree/disagree for each statement	Agree	Disagree
<ul style="list-style-type: none"> I understand that hospitals and health care facilities must report certain crimes to law enforcement authorities in cases where a victim seeks medical care. I have been informed that Pennsylvania law provides that a victim of a sexual offense shall not be charged for the costs of a forensic rape examination. I understand that "I" do not need to talk to law enforcement authorities directly if I choose not to, however I understand that, with my consent, the health care facility will provide the evidence of the forensic rape examination to law enforcement authorities. 	<p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p>
Patient Consent: Please initial to the right to indicate agree/disagree for each statement		
<p>Examination</p> <ul style="list-style-type: none"> I understand that a forensic examination to collect evidence from the sexual assault may be conducted, with my consent, by a health care professional(s), to discover and preserve evidence of the assault. If conducted, the report of the examination and any evidence will be provided to law enforcement authorities. I understand that I may withdraw consent at any time for any portion of the examination. <p>Photographs</p> <ul style="list-style-type: none"> I understand that collection of evidence may include photographing injuries and that these photographs may include the genital area. <p>General Information</p> <ul style="list-style-type: none"> I understand that evidence including photographs may be collected from this report for health and forensic purposes and provided to health authorities and other qualified persons with a valid educational or scientific interest for demographic and/or epidemiological studies. 	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>

I fully understand the nature of the examination and the fact that medical information gathered by this means may be used as evidence in a court of law or in connection with enforcement of public health rules and law.

Print Name (patient)

Signature of Witness

Signature (patient)

Date

Time

Signature of Parent or Guardian/Relationship

Initials _____
Date

Print Name of Examiner: _____

Signature	Initials

Patient History/Initial Assessment

Pertinent Medical History: Time Recorded _____

- Vital Signs: T _____ P _____ RR _____ BP _____
- Glasgow Coma Scale: _____
- Allergies: _____
- Past Medical History: _____

- List any Medication(s) taken by the victim routinely and any medication(s) taken prior to the assault:
 1. _____
 2. _____
 3. _____
 4. _____
 5. _____
 6. _____
- Last Menstrual Period: _____
- Last Tetanus Shot: _____
- Has patient received Hepatitis B Vaccine: Yes No Unsure

Overall Appearance (Torn Clothing, Disheveled...): _____

Neurologic/Coordination:

Neurological

- Level of Consciousness
 - Alert Somnolent but arousable Unconscious
- Cognition
 - Oriented x4 Other: _____
 - No deficits noted Distracted Confused Other: _____
- Glasgow Coma Scale
 - 15 Other: _____
- Loss of Consciousness
 - No Yes (describe mechanism below)
 - If yes Physician consulted: _____
- Unable to Recall Events
 - No Yes
 - If yes Drug Facilitated Evidence Kit Collected, if not collected explain: _____

Affect/Mood: _____

Suicidal Ideations: No Yes If yes, crisis consult/referral done

Initials Date

Circumstances of the Assault/Victim's Description

Date/Time of the assault: _____ Investigating Jurisdiction: _____

Date/Time of the examination: _____

*if investigating jurisdiction is unknown, does victim have general knowledge of where assault occurred (city, street names)

Information Provided by: Victim Law Enforcement Other

Location of assault: Inside Outside Home Workplace Vehicle

Other (details): _____

Additional Information: _____

Race of victim: African American Asian Caucasian Hispanic White

Hispanic Black Native American Other: _____

Victim's Hair Color: _____

Was the victim's clothing removed during the assault: Yes No

Did the victim lose consciousness? No Yes (explain): _____

Any drug or alcohol use by the victim in the past 24 hours: No Yes: _____

Any drug or alcohol use by the assailant: No Yes: _____

Unsure

Since the assault has the victim:	Yes	No		Yes	No
Consumed alcohol			Changed clothes		
Had something to drink/eat			Washed clothes *worn during assault		
Douched			Vomited		
Used tobacco			Defecated		
Bathed/showered			Urinated		
Brushed or flossed teeth			Used anything to wipe/clean genital area		
Used mouthwash			Used anything to wipe off any fluid		
Washed hair			Used/discarded any tampons or menstrual pads		
			Consensual intercourse prior/after assault		
			Anal (within 5 days)	___	___
			Vaginal (within 5 days)	___	___
			Oral (within 24 hours)	___	___
			If yes to above, did ejaculation occur?	___	___
			If yes to above, where did ejaculation occur: _____		
			If yes to above, was a condom used?	___	___

Initials Date

Assailant Information

Assailant Information: Known Not Known *if possible complete below

Assailant #1 Gender of assailant: Male Female Approximate age: _____ Race: _____
 Hair Color/Length: _____

Assailant #2 Gender of assailant: Male Female Approximate age: _____ Race: _____
 Hair Color/Length: _____

Assailant #3 Gender of assailant: Male Female Approximate age: _____ Race: _____
 Hair Color/Length: _____

Assailant's clothing (description): _____

Injuries to the assailant: No Yes Unsure
 (explain acts biting, scratching, recording exactly what he or she says, place quotation marks around the patient's words or phrases):

Assailant relationship to victim: _____

Coercion used:	Yes	No	If yes, please explain:
Weapon			
Hitting (punching, slapping)			
Kicking			
Pushing			
Restraining (physically, threatening)			
Strangulation (choking)			
Other (explain)			

Strangulation Assessment

Reports Strangulation Yes No

If yes, consulting physician _____

History	Yes	No
Neck pain		
Neck swelling		
Difficulty breathing		
Pain with swallowing		
Loss of Consciousness		
Petechial hemorrhages		
Redness to eyes		
Sore throat		
Voice changes (raspy, hoarse)		
Nausea/ vomiting		
Light headedness		
Incontinence		
Loss of memory		
Coughing		
Headache		

Assessment	Yes	No
Injuries to neck and throat:		
Back of neck		
Behind ears		
Eyelids		
Jaw		
Upper chin		
Scratches		
Ligature marks		
Ligature burns		
Bruising		
Patterned injury		
Other:		
Pulse oximetry		%

Method of strangulation:
<input type="checkbox"/> One arm <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Unknown <input type="checkbox"/> One hand <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Unknown <input type="checkbox"/> Fist <input type="checkbox"/> Open <input type="checkbox"/> Two hands <input type="checkbox"/> Ligature <input type="checkbox"/> Approach from front <input type="checkbox"/> Approach from behind <input type="checkbox"/> Approach, unsure <input type="checkbox"/> Other (please describe) _____

Recommended studies ordered by physician?	Yes	No
Soft Tissue xray of neck		
CAT Scan of soft tissue of neck		

Ordering physician _____

Initials Date

ACTS DESCRIBED BY PATIENT

- Any penetration of the genital or anal opening, however slight, constitutes the act of penetration. Oral copulation requires only contact. Questions about penetration of orifices need to be asked specifically.

1. Penetration of vagina by:

	NO	YES	ATTEMPTED	UNSURE	Describe
Penis					
Finger					
Object					

2. Penetration of anus by:

	NO	YES	ATTEMPTED	UNSURE	Describe
Penis					
Finger					
Object					

3. Oral copulation of genitals:

	NO	YES	ATTEMPTED	UNSURE	Describe
Of patient by assailant					
Of assailant by patient					

4. Oral copulation of anus:

	NO	YES	ATTEMPTED	UNSURE	Describe
Of patient by assailant					
Of assailant by patient					

5. Non-genital act(s):

	NO	YES	ATTEMPTED	UNSURE	Describe
Licking					
Kissing					
Suction Injury					
Biting Of patient by assailant					
Biting Of assailant/objects by patient					

6. Other act(s):

	NO	YES	ATTEMPTED	UNSURE	Describe
Other Acts					

7. Did ejaculation occur?:

	NO	YES	UNSURE	Describe
If yes, note location(s):				<input type="checkbox"/> Mouth <input type="checkbox"/> Vagina <input type="checkbox"/> Anus/Rectum <input type="checkbox"/> Other _____ <input type="checkbox"/> On Clothing <input type="checkbox"/> On Bedding <input type="checkbox"/> Body Surface

8. Contraceptive or lubricant products:

	NO	YES	ATTEMPTED	UNSURE	Describe
Lubricant used?					
Condom used?					

If yes, location of condom:

Initials Date

In the columns next to each body part, check *all* that apply. Please note if an alternate light source was used over the stated body part for the detection of semen/saliva.

Assessment for Injury to the Body										
	No Visual Findings at time of exam	Swelling	Bruise	Erythema	Abrasion	Laceration	Incision/Cut	Tenderness	Alternate Light Source	Other (Describe)
Head										
Eyes										
Ears										
Nose										
Mouth										
Neck										
Upper Extremities										
Chest										
Breast										
Nipples										
Abdomen										
Lower Extremities										
Back										
Buttocks										
Tanner Breast: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V Tanner Genitalia: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V										

Additional Information

Initials Date

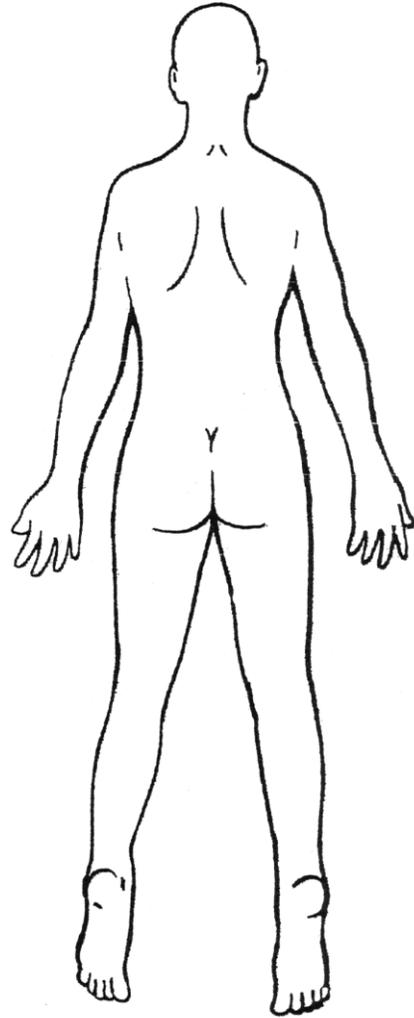
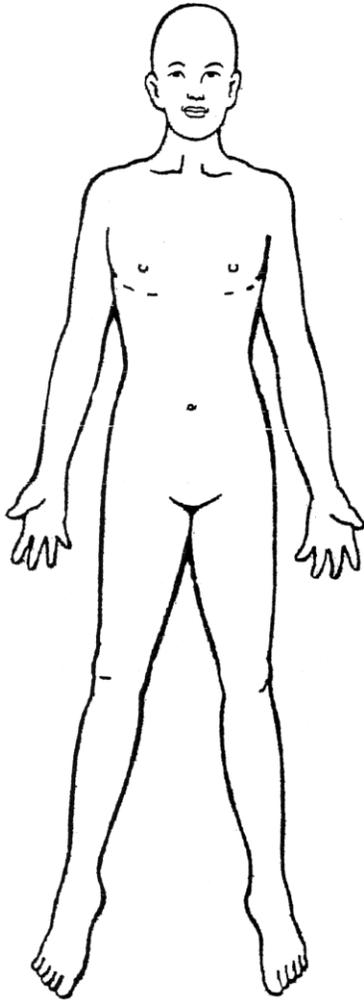
In the columns next to each area of genitalia, check *all* that apply. Note if an alternate light source was utilized for detection of semen/saliva.

Assessment for Injury to Genitalia *Note type of lubricant used, if any during speculum examination (water recommended)										
	No Visual Findings at time of exam	Swelling	Bruise	Erythema	Abrasion	Laceration	Incision/Cut	Tenderness	Alternate Light Source	Other (Describe)
Mons Pubis										
Labia Majora										
Labia Minora										
Hymen										
Posterior Fourchette										
Fossa Navicularis										
Vaginal Wall (Left)										
Vaginal Wall (Right)										
Cervix										
Perineum										
Anus										
Rectum										
Glans/Urethral Meatus										
Shaft										
Scrotum										

Additional Information

Initials Date

Draw each body injury onto the body map. Next to each injury give a brief description of the injury size, shape, color and appearance. Please number injuries to correspond to photo documentation.



Initials Date

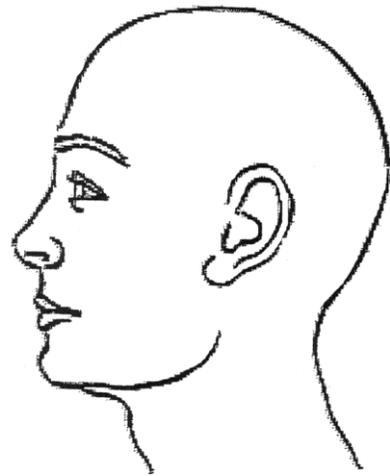
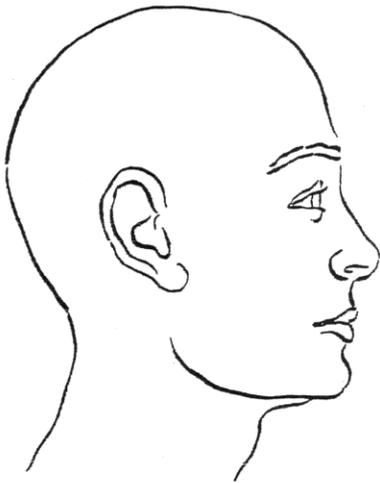
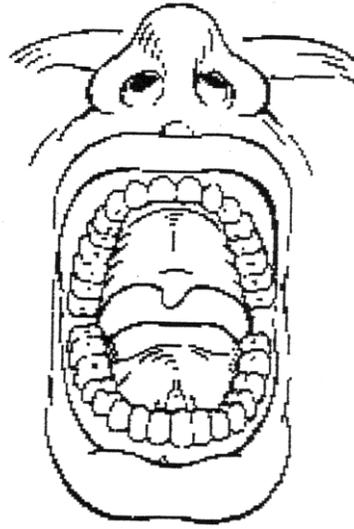
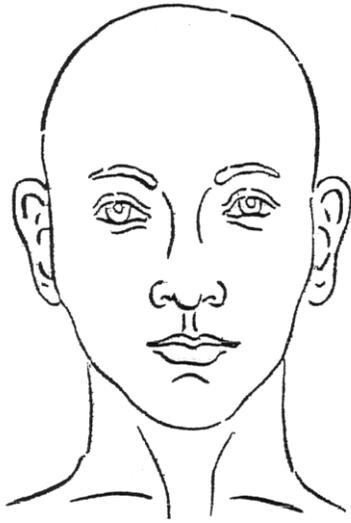
Right



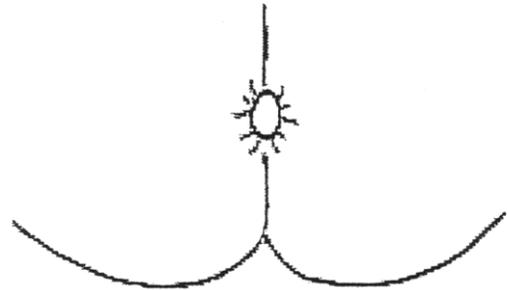
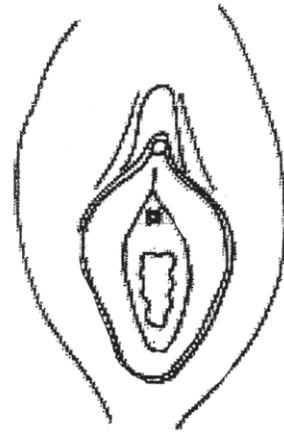
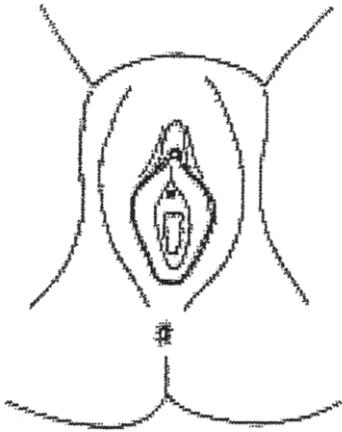
Left



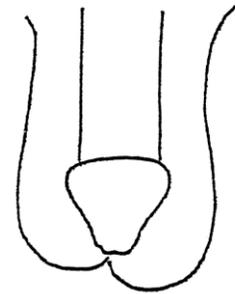
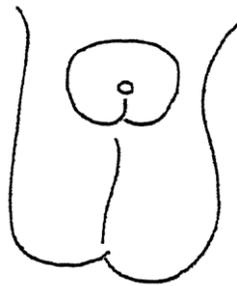
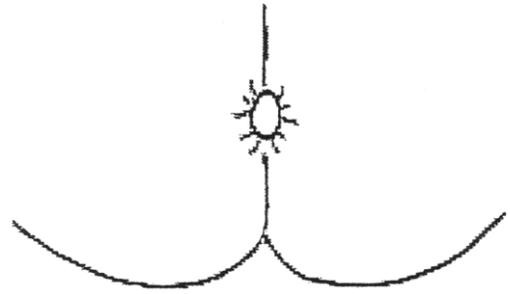
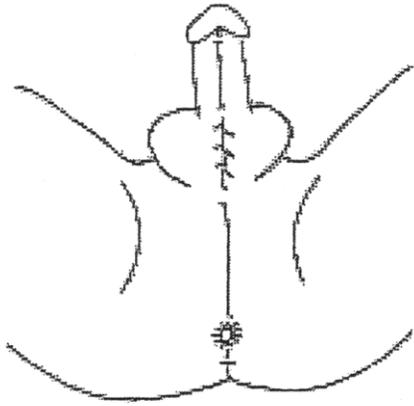
Initials Date



Initials Date



Initials _____
Date



Initials _____
Date

Photo Documentation (Optional)

Photograph each injury:

1. Take a picture of the injury including at least two anatomical sites (for identification of the location of the injury)
2. Take two pictures of the injury close up-(one with and one without a scale)
3. Note what type of camera or if picture was taken with a colposcope
4. If a scale is not available use items of standard sizes, ex.: quarter etc.
5. List photograph distribution

Photographs

- No Photographs taken. If not why: _____
- Photographs taken, complete the itemized listing below as appropriate:

Photo Injury #	Digital	35 mm	Colposcope/ Magnification	Anatomical Site	Additional Notes
Examiner Identification			/		
Patient Identification			/		
Full body photo of patient			/		
			/	<input type="checkbox"/> see diagram	
			/	<input type="checkbox"/> see diagram	
			/	<input type="checkbox"/> see diagram	
			/	<input type="checkbox"/> see diagram	
			/	<input type="checkbox"/> see diagram	
			/	<input type="checkbox"/> see diagram	
			/	<input type="checkbox"/> see diagram	
			/	<input type="checkbox"/> see diagram	
			/	<input type="checkbox"/> see diagram	
			/	<input type="checkbox"/> see diagram	
			/	<input type="checkbox"/> see diagram	
			/	<input type="checkbox"/> see diagram	

Photograph Distribution

- Hand Held Camera: _____
- Colposcope
- Photos given to law enforcement
- Photos locked in secure area
- Photos placed in medical file

Initials Date

Step 11

Transfer of Evidence/Chain of Custody Form

On _____ at _____ (am or pm) the
(Date) (Time)

following items were given to _____
(Police Officer)

of the _____
(Police Department)

Evidence Received

Check YES or NO for all items (if no, explain)

Photographs: CD YES NO _____
Other YES NO _____

Clothing (list): Shirt/Blouse YES NO _____
Pants/Slacks YES NO _____
Bra YES NO _____
Underpants YES NO _____
Jacket/Coat YES NO _____
Other YES NO _____

Sexual Assault Evidence Collection Kit: YES NO _____
Tampon/Sanitary napkin included: YES NO _____

Drug Facilitated Sexual Assault Kit: YES NO _____
Copy of Forensic Medical Record: YES* NO _____
*If yes copy included for State Crime Lab YES NO _____

Other evidence: YES NO
If YES, describe: _____

From: _____
Date: _____ Time: _____ am/pm

To: _____
Date: _____ Time: _____ am/pm

From: _____
Date: _____ Time: _____ am/pm

To: _____
Date: _____ Time: _____ am/pm

Initials Date

TIME	<p><i>The following medication orders are guidelines based on the 2010 CDC recommendations for treatment of sexual assault</i></p> <p style="text-align: center;">ORDER</p>	TIME NOTIFIED	NURSING SERVICE SIGNATURE									
	<p>Allergies:</p> <p><input type="checkbox"/> NKDA <input type="checkbox"/> Allergies:</p> <p>Height _____ in / cm Weight _____ lb / kg</p> <p>Pregnancy Test Result (+ or -) : Urine _____ Serum _____</p> <p style="text-align: center;"><i>Treatment Protocol for Patients</i></p> <p style="text-align: center;"><i>This suggestion is for non-pregnant patients with no known allergies.</i></p> <p><input type="checkbox"/> Ceftriaxone (Rocephin®) (3rd generation cephalosporin) 250 mg IM in a single dose for treatment of possible exposure to gonorrhea <u>AND</u></p> <p><input type="checkbox"/> *Metronidazole (Flagyl®) 2 grams orally in a single dose for treatment of possible bacterial vaginosis and trichomoniasis post assault (<i>Send home with patient if alcohol ingestion in previous 24 hours</i>) <u>AND</u></p> <p><input type="checkbox"/> Azithromycin (Zithromax®) (macrolide) 1 gram orally in a single dose for treatment of possible exposure to chlamydia <u>AND</u></p> <p><input type="checkbox"/> Emergency Contraception (consider: Plan B®, Plan B one-step®, ella ®) <u>AND</u></p> <p><input type="checkbox"/> Antiemetic of choice: _____</p> <p><input type="checkbox"/> Hepatitis B vaccine for adults, per dosing guidelines below (<i>if patient has not already received Hep B vaccine</i>):</p> <table style="margin-left: auto; margin-right: auto;"> <tr> <td></td> <td style="text-align: center;"><u>Recombivax HB ®</u></td> <td style="text-align: center;"><u>Engerix B®</u></td> </tr> <tr> <td>Adolescents 11-19 yrs</td> <td style="text-align: center;">5 micrograms</td> <td style="text-align: center;">10 micrograms</td> </tr> <tr> <td>Adults > 19 yrs</td> <td style="text-align: center;">10 micrograms</td> <td style="text-align: center;">20 mcg micrograms</td> </tr> </table> <p>*Metronidazole may be given 1 gram orally at the time of exam and 1 gram orally to be taken in 12 hours if patient reports gastric sensitivity to antibiotics.</p>		<u>Recombivax HB ®</u>	<u>Engerix B®</u>	Adolescents 11-19 yrs	5 micrograms	10 micrograms	Adults > 19 yrs	10 micrograms	20 mcg micrograms		
	<u>Recombivax HB ®</u>	<u>Engerix B®</u>										
Adolescents 11-19 yrs	5 micrograms	10 micrograms										
Adults > 19 yrs	10 micrograms	20 mcg micrograms										
Physician's Signature:		Nurse's Signature:										

DATE	TIME	ORDER	TIME NOTIFIED	NURSING SERVICE SIGNATURE
		Treatment Protocol for Patients with Potential / Known Allergies		
		Chlamydia:		
		<input type="checkbox"/> Doxycycline (Vibramycin®) 100 mg orally twice a day for 7 days OR		
		<input type="checkbox"/> Levofloxacin (Levaquin®) (quinolone) 500 mg orally once a day for 7 days		
		Gonorrhea:		
		<input type="checkbox"/> Azithromycin (Zithromax®) 2 grams orally in a single dose.		
		Bacterial Vaginosis:		
		<input type="checkbox"/> Clindamycin (Cleocin®) 300 mg orally twice a day for 7 days		
		Trichomoniasis:		
		<input type="checkbox"/> Metronidazole (Flagyl®) 500 mg orally twice a day for 7 days (no other FDA approved medication available for treatment)		
		Alternative Treatment Protocol for Pregnant Patients		
		Chlamydia:		
		<input type="checkbox"/> Azithromycin (Zithromax®) 1 gram orally in a single dose OR		
		<input type="checkbox"/> Erythromycin 500 mg orally 4 times a day for 7 days OR		
		<input type="checkbox"/> Amoxicillin 500 mg orally 3 times a day for 7 days		
		*Doxycycline and levofloxacin are contraindicated in pregnant women		
		Gonorrhea:		
		<input type="checkbox"/> Ceftriaxone (Rocephin®) 250 mg IM in a single dose		
		* Pregnant women should not be treated with quinolones or tetracyclines		
		Bacterial Vaginosis:		
		<input type="checkbox"/> Clindamycin (Cleocin®) 300 mg orally 2 times a day for 7 days		
		Trichomoniasis:		
		<input type="checkbox"/> Recommend follow-up with OB/GYN physician to determine treatment		
Physician's Signature:		Nurse's Signature:		

DATE	TIME	ORDER	TIME NOTIFIED	NURSING SERVICE SIGNATURE
		<i>Additional Treatment Considerations</i>		
		<ul style="list-style-type: none"> ❖ Consider treatment for pain management 		
		<ul style="list-style-type: none"> ❖ Consider treatment for integument injury <ul style="list-style-type: none"> ➤ Consider tetanus vaccine 		
		<ul style="list-style-type: none"> ❖ Consider treatment for HIV exposure <div style="border: 1px solid black; padding: 10px; margin: 10px auto; width: 80%;"> <p>The preferred PEP regimen for sexual assault is the same as that for other types of non-occupational exposures and occupational exposures:</p> <p style="text-align: center;">Tenofovir 300 mg PO qd + Emtricitabine 200 mg PO qd</p> <p style="text-align: center;">Plus</p> <p style="text-align: center;">Raltegravir 400 mg PO bid</p> <p>See <i>HIV Prophylaxis Following Non-Occupational Exposure</i> for regimen considerations when the source is known to be HIV-infected, dose adjustments for patients with renal insufficiency, drug-drug interactions, and recommended alternative regimens.</p> <p>For additional information:</p> <p>http://www.hivguidelines.org/clinical-guidelines/post-exposure-prophylaxis/hiv-prophylaxis-for-victims-of-sexual-assault/#I. INTRODUCTION</p> </div>		
Physician's Signature:		Nurse's Signature:		

Realizing that no one is able to remember all the information provided during an examination, you are receiving a list of medications that have been administered to you during this examination and /or prescribed for you to take after discharge. Information regarding your follow-up is also included. The professionals who cared for you understand that it took great courage and strength to come in for an examination. Once you leave, you may experience a wide range of emotions as a result of the assault. Please use this information to assist you in your recovery.

Medications:

- No medications were given today. Please follow up with your healthcare provider within two weeks.
- You have been given the following medications:
 1. Chlamydia prevention
 - Azithromycin 1 gram orally Doxycycline as prescribed Other: _____
 2. Gonorrhea prevention
 - Ceftriaxone 250 mg injection Azithromycin 2 grams orally Other: _____
 3. Trichomoniasis and Bacterial Vaginosis prevention
 - Flagyl 2 grams orally Other: _____

Note: If you are on birth control, you should use an additional method of birth control while taking antibiotics. Oral contraceptives may not work properly while you are taking antibiotics, please use additional method of birth control through the current month or “pack of pills”.

 4. Hepatitis B Vaccine
 - 1st dose today, 2nd dose in two months, 3rd dose within four months (see family doctor for 2nd & 3rd dose)
 - Patient reports having vaccine in past
 - Patient will inform healthcare provider at the follow-up exam with current status
 5. Emergency Contraception Provided: Type: _____ Dose: _____
 6. Diphtheria/ Tetanus
 - Immunization initiated, follow-up with healthcare provider
 - Patient reports being up-to-date
 - Patient will inform healthcare provider at the follow-up exam with current status
 - Booster given
 7. Antiemetic: Type: _____ Dose _____
 8. Additional medications: (Please Specify) _____ Dose: _____

 9. Prescription(s) Given: (Place copies of Prescriptions on Medical Record)

Follow-Up Instructions

- Your pregnancy test was positive negative today. You should have a follow-up evaluation for pregnancy by your healthcare provider.
- No treatment for HIV was provided today. Please refer to your community’s resource list(s) for testing and counseling options.
 - No sexually transmitted infection testing was done today. Please discuss any concerns with your healthcare provider during your follow-up visit.
 - You did not receive a pap smear during the visit. Please discuss any concerns with your healthcare provider during your follow up visit.

