

Hospital Label

**Consent for Examination of Victims of Sexual Assault and For Release and Use of Medical and Legal Information**

I authorize the (Hospital) \_\_\_\_\_ Provider/Nurse to examine and treat me at \_\_\_\_\_ (Hospital) on \_\_\_\_\_ (date) for injuries and/or conditions incurred as a result of a sexual assault that occurred on or about \_\_\_\_\_ (date). I authorize the hospital staff to obtain any clinical samples and specimens and conduct any medical tests deemed necessary or helpful for treatment, legal evidence, and to take photographs of any injury or abnormality found.

The examination is not a routine medical exam. It is being performed in order to document, diagnose, and treat any injuries and possible conditions related to a sexual assault. The Provider/nurse will not attempt to identify, diagnose, or treat any unrelated and/or pre-existing medical problems that you may have. The exam may consist of:

- Documentation of pre- and post- assault history
- Description of the assault and assailant
- Physical examination, which may include genital and rectal exam
- Photographs and body diagrams
- Swabs from areas of the body that may contain matter such as DNA or debris related to the event
- Blood and/or urine collection for toxicology testing or pregnancy testing
- Medication options for prevention of sexually transmitted infections, HIV, and pregnancy
- Referral for treatment of injuries related to the assault

**I understand that I may decline this examination or any part of it. I understand that once the exam begins, I may decline any portion of the exam and I must notify the person conducting the exam that I wish to stop the exam. I understand that this consent authorizes a medical-forensic exam, but does not obligate me to participate in the prosecution of a crime.**

I authorize the Hospital to use samples collected, photographs taken, and information obtained during my sexual assault exam for educational purposes relating to the Hospital.

Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_

Patient       Parent       Guardian

Date: \_\_\_\_\_ Time: \_\_\_\_\_

**To be completed by Provider/Nurse:**

I have fully discussed the procedure and the information included in our sexual assault nurse examiner protocol, which includes a description of the sexual assault exam as well as a description of the patient's options regarding consent to standard release and anonymous release of the sexual assault examination kit. The patient was given the opportunity to ask questions and receive information to their satisfaction.

Staff Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

**Declination of Consent:**

Patient declined to consent to a sexual assault exam due to:

\_\_\_\_\_

Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_

Patient       Parent       Guardian

Staff Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

# SEXUAL ASSAULT EXAM REPORT

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## Conduct Sexual Assault Exam up to 120 hours following a sexual assault (or longer if indicated)

### General Information

Date of Incident:	Time of Incident:
Date of Exam:	Time of Exam:
Patient Address:	Phone:
Patient Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> Other:	
Patient Race: <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Asian <input type="checkbox"/> Other:	

### Medical History/Allergies

Chronic Illnesses: \_\_\_\_\_

Current Medications: \_\_\_\_\_


Allergies: \_\_\_\_\_

### Female GYN History

Date of first day of LMP \_\_\_\_\_ Menstruating at **time of assault**  No  Yes Menstruating at **time of exam**  No  Yes

**Does patient currently have a tampon in?** consider collecting tampon (see page 10 for packaging instructions)

Contraceptives use? \_\_\_\_\_ Pregnant?  No  Yes Hysterectomy?  Yes Tubal Ligation?  Yes

	Tell the patient that you need to know about any consensual sex in the last 2 weeks before or consensual sex after the assault, to exclude their consensual partner Date: _____ Time: _____
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Consensual Anal?  Yes  No Consensual Vaginal?  Yes  No Consensual Oral?  Yes  No

Did ejaculation occur?  Yes  No  Unsure Condom used?  Yes  No  Unsure

### Patient's General Appearance

<input type="checkbox"/> Clean/neat	<input type="checkbox"/> Dirty/stained clothing	<input type="checkbox"/> Disheveled	<input type="checkbox"/> Torn clothing	<input type="checkbox"/> Malodorous
<input type="checkbox"/> Other: _____				

### Patient's Demeanor

<input type="checkbox"/> Alert	<input type="checkbox"/> Listless	<input type="checkbox"/> Subdued	<input type="checkbox"/> Tearful	<input type="checkbox"/> Fidgeting
<input type="checkbox"/> Oriented	<input type="checkbox"/> Withdrawn	<input type="checkbox"/> Tense	<input type="checkbox"/> Trembling	<input type="checkbox"/> Restless
<input type="checkbox"/> Smiling	<input type="checkbox"/> Flat affect	<input type="checkbox"/> Irritated	<input type="checkbox"/> Wringing hands	<input type="checkbox"/> Agitated
<input type="checkbox"/> Quiet	<input type="checkbox"/> No expression	<input type="checkbox"/> Anxious	<input type="checkbox"/> Sobbing	<input type="checkbox"/> Fearful

Eye Contact, describe \_\_\_\_\_

Speech, describe \_\_\_\_\_

Responsiveness to questions \_\_\_\_\_

Other: \_\_\_\_\_





# SEXUAL ASSAULT EXAM REPORT

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<b>Assault History</b> Does patient know assailant(s)?	
<input type="checkbox"/> Yes If yes, how?      Recent acquaintance, friend, family, other? <input type="checkbox"/> No, Stranger? <input type="checkbox"/> Unknown, patient has no memory	
Number of Assailants:	
<b>Assailant: 1</b>	<b>Assailant: 2</b>
Race/Gender:	Race/Gender:
Description:	Description:
<b>Assailant: 3</b>	<b>Assailant: 4</b>
Race/Gender:	Race/Gender:
Description:	Description:
Physical surroundings of assault: (outside, home, car?)	
Ask patient to describe any verbal or physical threats:	Put it on social media? Harm patient or family? Cell phone, texts, calls made/deleted, photos?
Any patient injuries resulting in bleeding? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Yes; if yes, describe	
Did assailant bleed? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Yes; if yes, describe	
Did strangulation occur? <input type="checkbox"/> Unsure <input type="checkbox"/> No <input type="checkbox"/> Yes                                    if yes, <input type="checkbox"/> strangulation addendum completed	
Patient may describe as "choking"	
Did suffocation occur? <input type="checkbox"/> Unsure <input type="checkbox"/> No <input type="checkbox"/> Yes                                    if yes, <input type="checkbox"/> strangulation addendum completed	
<b>What has the patient done since the assault?</b>	
<input type="checkbox"/> Bathed <input type="checkbox"/> Showered <input type="checkbox"/> Cleaned genital area <input type="checkbox"/> Brushed teeth <input type="checkbox"/> Used mouthwash <input type="checkbox"/> Urinated <input type="checkbox"/> Douched <input type="checkbox"/> Had bowel movement <input type="checkbox"/> Vomited <input type="checkbox"/> Removed or inserted Tampon <input type="checkbox"/> Ate/drank <input type="checkbox"/> Washed bedding <input type="checkbox"/> Changed clothes? if yes, describe_____	
<b>Stated alcohol/drug use by patient and/or assailant</b>	
Loss of memory? <input type="checkbox"/> No <input type="checkbox"/> Yes, describe	
Indications of memory loss: Woke up in strange location? Articles of clothing missing? Period of time unaccounted for? etc.	
Loss of consciousness? <input type="checkbox"/> No <input type="checkbox"/> Yes, describe	

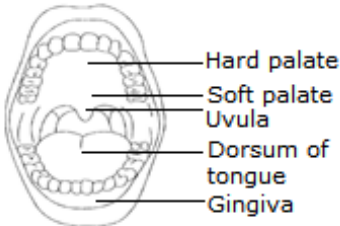
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<b>Conduct physical exam</b>		Use history to guide exam and evidence collection.				
Height	Weight	BP	HR	RR	Temp	O2 sat
<b>1 Examine head, scalp, hair, face and neck</b>	<input type="checkbox"/> No injury visible at time of exam					
<b>Did assailant(s) have oral contact with patient's neck?</b> Licking, kissing, sucking, biting						
<b>If yes,</b> Collect and document location						
Collect up to 72 hours (3 days) after assault						
Collect swabs even if patient has showered once or twice						
Use <b>2 saline moistened swabs</b> held together and gently roll on skin where oral contact occurred						
If swabbing neck, swab right and left sides with same 2 swabs and package together in envelope						
Allow swabs to air dry before placing in envelope						
Change gloves						
Record size and appearance of injuries on diagrams						
Record tenderness and pain using pain scale						
If camera available take photographs of injuries						
<b>Description of injuries</b>		Abrasion, bruise, redness, tears, petechiae, swelling, pain, tenderness				

# SEXUAL ASSAULT EXAM REPORT

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Examine the oral cavity							
<b>Oral assault occur within the last 24 hours?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Attempted <input type="checkbox"/> Unsure						
Describe oral penetration, no matter how slight or brief:							
<b>Was patient orally penetrated by?</b>	<input type="checkbox"/> Penis <input type="checkbox"/> Finger <input type="checkbox"/> Object?						
Did ejaculation occur?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure						
Did assailant(s) use condom?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure						
<b>If yes,</b> <b>Collect and document</b>							
Use <b>4 dry</b> swabs held together							
<b>Gently roll</b> swabs from one side of the mouth to the other side along the upper gum line, lower gum line and under tongue							
Allow swabs to air dry before placing in envelope							
Change gloves							
Record size and appearance of injuries on diagram	<input type="checkbox"/> No injury visible at time of exam						
Record tenderness and pain using pain scale							
	<table border="1" style="width: 100%; height: 100%; border-collapse: collapse;"> <tr><td style="height: 20px;"> </td></tr> <tr><td style="height: 20px;"> </td></tr> <tr><td style="height: 20px;"> </td></tr> <tr><td style="height: 20px;"> </td></tr> <tr><td style="height: 20px;"> </td></tr> <tr><td style="height: 20px;"> </td></tr> </table>						

3

Examine Entire body	
<b>Did assailant(s) have oral contact with patient's breasts or other body area?</b> Licking, kissing, sucking, biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If yes,</b> <b>Collect and document location</b>	
Use <b>2 saline moistened</b> swabs held together and <b>gently roll</b> on skin where oral contact occurred	
If swabbing breasts, swab right and left sides separately with 2 swabs and package in separate envelopes	
If swabbing neck, swab both sides of neck (if indicated) with 2 swabs	
Allow swabs to air dry before placing in envelope	
Change gloves	
Collect up to 72 hours (3 days) after assault	
Collect swabs even if patient has showered once or twice	

# SEXUAL ASSAULT EXAM REPORT

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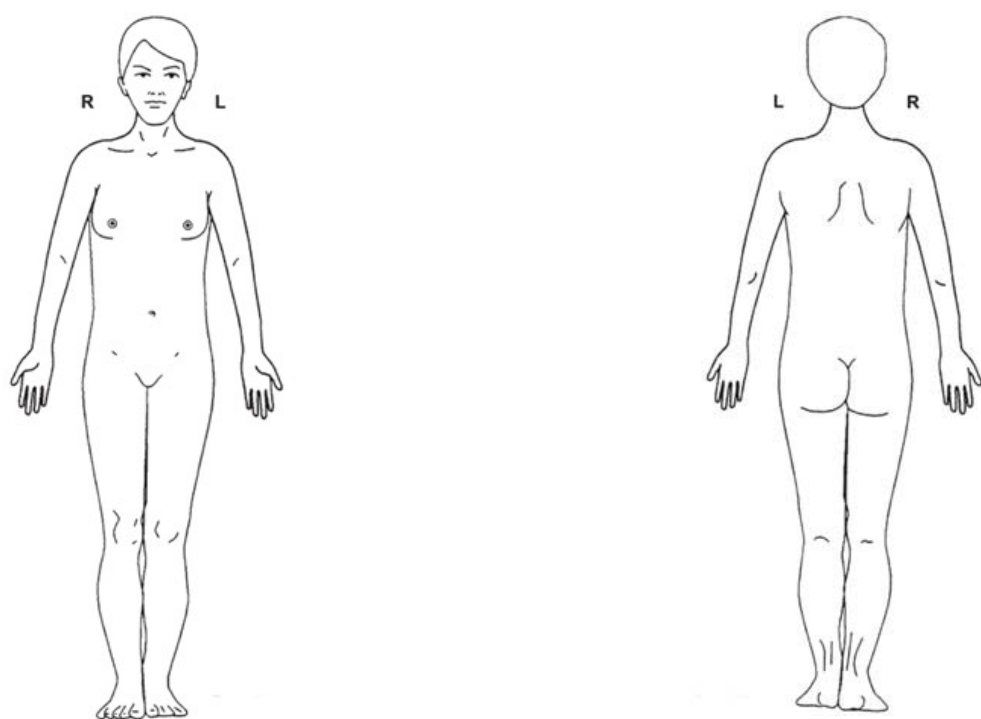
Did assailant(s) ejaculate on patient's body?  Yes  No

If yes,  Collect and document location

Use **2 saline moistened** swabs held together and **gently roll** on skin where ejaculation occurred  
 If swabbing breasts, swab right and left sides separately with 2 swabs and package in separate envelopes  
 Allow swabs to air dry before placing in envelope  
 Change gloves

Collect up to 72 hours (3 days) after assault  
 Collect swabs even if patient has showered once or twice

Record size and appearance of injuries on diagrams  
 Record tenderness and pain using pain scale  
 If camera available take photographs of injuries



**Description of injuries** Abrasion, bruise, redness, tears, petechiae, swelling, pain, tenderness

No injury visible at time of exam

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# SEXUAL ASSAULT EXAM REPORT

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**Genital Exam - Female**  NA

**Did vaginal assault occur within the last 120 hours? (5 days)**     Yes     No     Unsure     Attempted

Describe vaginal penetration, no matter how slight or brief:  
**Was patient vaginally penetrated by?**     Penis     Finger(s)     Object  
 Did ejaculation occur?     Yes     No     Unsure  
 Did assailant(s) use condom?     Yes     No     Unsure

**If yes,**  Collect and document

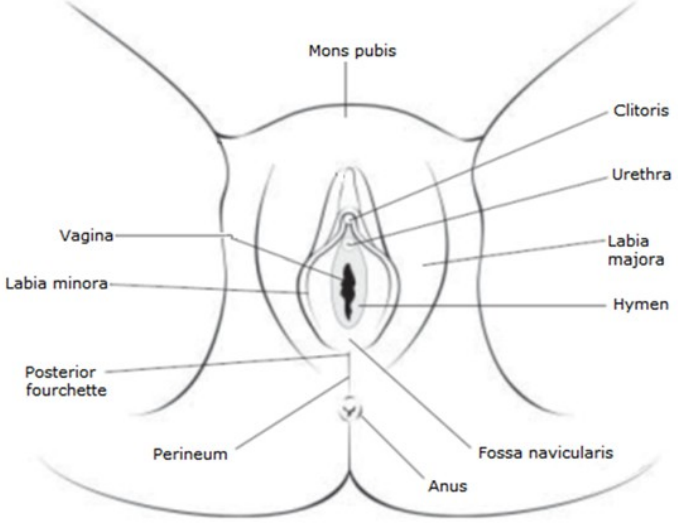
**Has patient taken a bath or shower since assault?**     Yes, then skip this step  
 No then, **Collect pubic hair combing**  
 Place paper under buttocks, use comb provided to comb pubic hair, fold comb in the paper and place back in the envelope

Allow swabs to air dry before placing in envelope  
 Change gloves

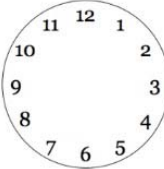
**Examine external genitalia and perineum**

**Use 4 saline moistened swabs** held together, gently roll swabs on **perineum, fossa navicularis and posterior fourchette**

Collect up to 120 hours (5 days) after assault  
 Collect swabs even if patient has showered once or twice  
 Collect even if patient is menstruating  
 Allow swabs to air dry in envelope  
 Change gloves



Record size and appearance of injuries on diagram  
 Record tenderness and pain using pain scale



Use clock to describe injury location  
 No injury visible at time of exam

Injury?	No	Yes	Describe injuries	Abrasion, bruise, redness, tears, petechiae, swelling, pain, tenderness
Mons pubis				
Clitoris				
Urethra				
Labia majora				
Labia minora				
Hymen				
Perineum				
Fossa navicularis				
Posterior fourchette				

# SEXUAL ASSAULT EXAM REPORT

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**Examine vagina and cervix** Speculum exam completed by:

If patient declines speculum exam, offer to collect by gently inserting 4 dry swabs into vagina

**Use 4 dry swabs** held together to collect from the vaginal vault  NA

Collect swabs even if patient is menstruating

Allow swabs to air dry before placing in envelope

Change gloves

**Use 2 dry swabs (one at a time)** to collect from **cervix**  NA

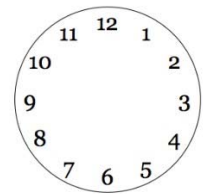
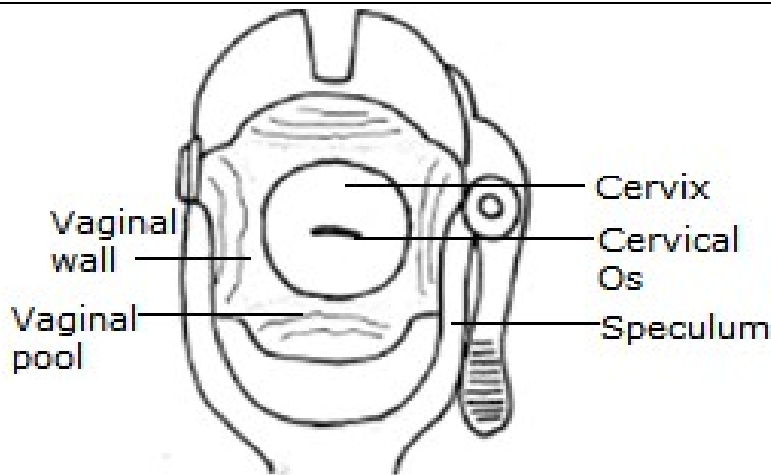
Collect swabs even if patient is menstruating

Allow swabs to air dry before placing in envelope

Change gloves

Record size and appearance of injuries on diagram  No injury visible at time of exam

Record tenderness and pain using pain scale



Use clock to describe injury location

Injury?	No	Yes	Describe injuries
			Abrasion, bruise, redness, tears, petechiae, swelling, pain, tenderness
Vagina			
Cervix			

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**Examine buttocks and anus**

**Did Anal assault occur within the last 48 hours?**    Yes    No    Attempted    Unsure

Describe anal penetration, no matter how slight or brief:

**Was patient anally penetrated by?**    Penis    Finger    Object?

Did ejaculation occur?    Yes    No    Unsure

Did assailant(s) use condom?    Yes    No    Unsure

**If yes,**      **Collect and document**

**Collect 4 saline moistened swabs from Anal canal**

Insert swabs into anus 2 cm, rotate gently.

Collect two swabs then two more (total)

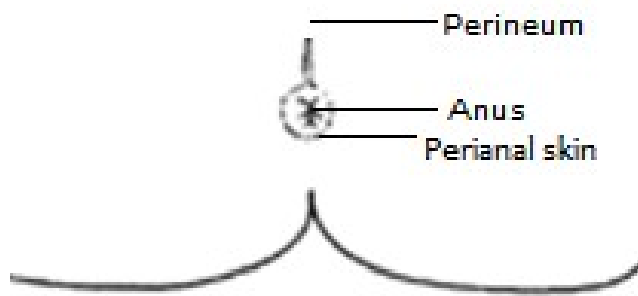
Allow swabs to air dry before placing in envelope

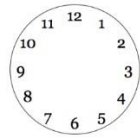
Collect up to 48 hours after assault

Change gloves

Record size and appearance of injuries

Record tenderness and pain using pain scale  No injury visible at time of exam





Use clock to describe injury location

Injury?	No	Yes	Describe injuries:      Bruise, redness, tears, petechiae, swelling , pain, tenderness
Buttocks			
Anus			
Perianal skin			

# SEXUAL ASSAULT EXAM REPORT

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**Genital Exam - Male**

**Has patient taken a bath or shower since assault?**  Yes, then skip this step  
 No then, **Collect pubic hair combing**  
 Place paper under buttocks, use comb provided to comb pubic hair, fold comb in the paper and place back in the envelope

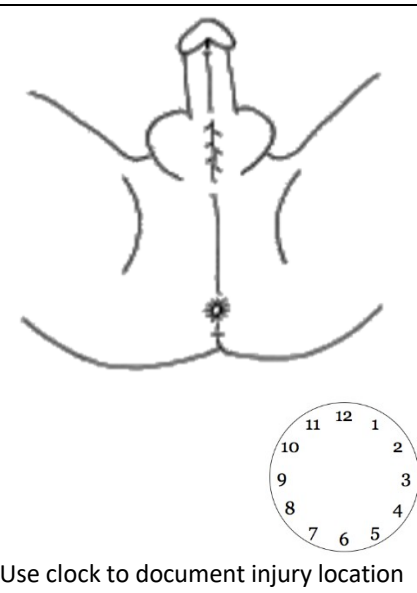
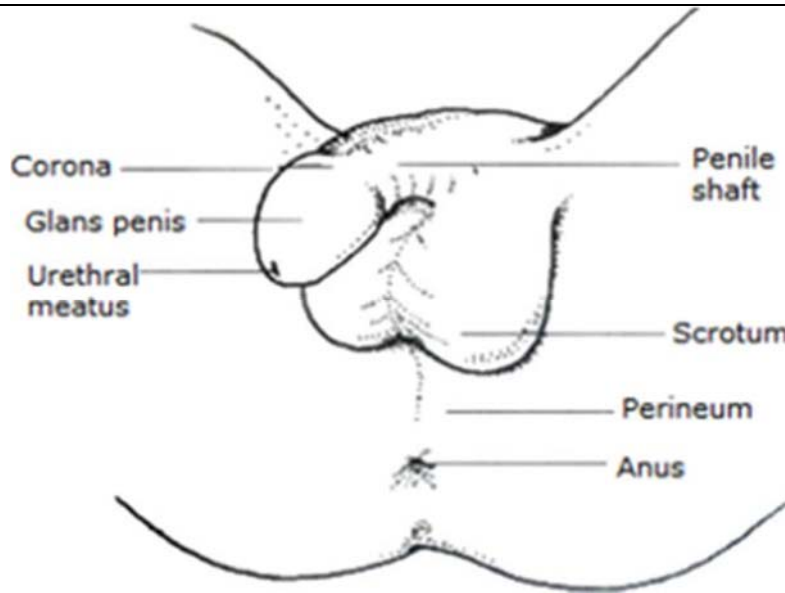
**Use 2 saline moistened swabs** held together and **gently roll** the swabs on **penis** (if indicated by history)  NA

Collect even if patient has showered once or twice  
 Allow swabs to air dry before placing in envelope  
 Change gloves

**Use 2 saline moistened swabs** held together and **gently roll** the swabs on **scrotum** (if indicated by history)  NA

Collect swabs even if patient has showered one or two times  
 Allow swabs to air dry before placing in envelope  
 Change gloves

**Examine external genitalia and perineum**  No injury visible at time of exam  
 Circumcised:  No  Yes  
 Record size and appearance of injuries on diagram  
 Record tenderness and pain using pain scale



Injury?	No	Yes	Describe injuries
			Abrasion, bruise, redness, tears, petechiae, swelling, pain, tenderness
Inner thighs			
Perineum			
Foreskin			
Glans penis			
Penile shaft			
Urethral meatus			
Scrotum			

# SEXUAL ASSAULT EXAM REPORT

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<b>Evidence collected</b>		
Clothing obtained as evidence	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> declined	
<b>Collect clothing:</b> underwear worn after the assault and outer clothing if indicated		
Place clothing in a paper bag (may all clothing in one bag)		
Label bag with patient's name, MRN, date/time of exam		
Case number (if reported) and Jurisdiction		
Moist or damp clothing needs to dry before packaging		
Description of clothing collected:		
<b>Forensic specimens collected</b>		
Blood (Patient's DNA) <input type="checkbox"/> No <input type="checkbox"/> Yes	4-6 Drops of blood on filter paper provided in envelope (may use lancet if not drawing blood)  Describe location: _____	
Pubic hair combing <input type="checkbox"/> No <input type="checkbox"/> Yes		
Swabs:		
1. Oral <input type="checkbox"/> No <input type="checkbox"/> Yes		
2. Fingernail <input type="checkbox"/> No <input type="checkbox"/> Yes		
3. Skin <input type="checkbox"/> No <input type="checkbox"/> Yes		
4. Perineum <input type="checkbox"/> No <input type="checkbox"/> Yes		
5. Vaginal <input type="checkbox"/> No <input type="checkbox"/> Yes		
6. Cervix <input type="checkbox"/> No <input type="checkbox"/> Yes		
7. Penile <input type="checkbox"/> No <input type="checkbox"/> Yes		
8. Scrotum <input type="checkbox"/> No <input type="checkbox"/> Yes		
9. Rectal <input type="checkbox"/> No <input type="checkbox"/> Yes		
10. Other: specify		
<b>Other evidence collected</b>		
<b>Foreign hair(s)</b> or other biological evidence from assailant		
Place in Foreign Matter envelope		
<b>Condoms or Tampons:</b>		
Package in sterile urine cup with holes punched in the cover for ventilation		
Label cup and place in paper bag		
Seal paper bag, label bag with patient's name, MRN, date/time of exam		
Case number (if reported) and Jurisdiction		
Place in refrigerator		
<b>Toxicology    Use Legal Urine and Legal Blood draw kits</b>		
Blood for alcohol/toxicology      Collect up to 48 hours post assault	<input type="checkbox"/> No <input type="checkbox"/> Yes   Time: <input type="checkbox"/> patient declined	
Urine toxicology      Collect up to 120 hours post assault	<input type="checkbox"/> No <input type="checkbox"/> Yes   Time: <input type="checkbox"/> patient declined	
Label blood and urine kits and place in refrigerator		
Photographs taken		
<input type="checkbox"/> No <input type="checkbox"/> Yes   If yes, describe:		
Advocate Present? <input type="checkbox"/> No <input type="checkbox"/> Yes      First name(s)		
Others present?      During interview? <input type="checkbox"/> No <input type="checkbox"/> Yes      During exam? <input type="checkbox"/> No <input type="checkbox"/> Yes      Name(s)		
Mandated report?		
Child Protection notified? <input type="checkbox"/> No, not applicable <input type="checkbox"/> Yes, by		
Adult Protection notified? <input type="checkbox"/> No, not applicable <input type="checkbox"/> Yes, by		

# SEXUAL ASSAULT EXAM REPORT

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<b>Medication recommendations for medical provider:</b>		
<b>Pregnancy Prevention</b> (give up to 120 hours post-assault)		
UPT result:		
<input type="checkbox"/> Patient declined Emergency Contraception      Patient signature if declined:		
<input type="checkbox"/> Levonorgestrel (Plan B) 1.5 mg orally, one dose (if two 0.75 mg tablets dispensed, take both at once)		
<input type="checkbox"/> Emergency Contraception information given to patient		
<b>Immunizations</b>		
<input type="checkbox"/> Up-to-date		
<input type="checkbox"/> Follow-up with PCP		
Last Tetanus Booster:		Immunized for Hepatitis B? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unsure
<b>Antibiotics</b> (for prevention of Sexually Transmitted Infections)		<b><a href="http://cdc.gov/std/treatment/2010/sexual-assault">cdc.gov/std/treatment/2010/sexual-assault</a></b>
<input type="checkbox"/> Patient declined antibiotic for STI		Patient initials:
<input type="checkbox"/> <b>Trichomonas:</b> Metronidazole 2 g orally in one dose (Do not take with alcohol at least 48 hours before and 48 hours after)		
<input type="checkbox"/> Written prescription given to patient		
<input type="checkbox"/> <b>Chlamydia:</b> Azithromycin 1 g orally in one dose		
<input type="checkbox"/> <b>Gonorrhea:</b> Ceftriaxone sodium 500 mg IM now		
<b>HIV Post-Exposure Prophylaxis (PEP)</b>		<b>National Clinician's Post-Exposure Prophylaxis Hotline: 1-888-448-4911</b>
Assault > 72 hours	<input type="checkbox"/> Patient not eligible for PEP, informed PEP not effective when started after 72 hours	
No or low HIV risk to patient	<input type="checkbox"/> Patient prefers to be started on HIV PEP despite low risk	
Increased HIV risk to patient due to: (check all that apply)	<input type="checkbox"/> multiple assailants <input type="checkbox"/> Anal penetration <input type="checkbox"/> Assailant has genital lesions or bleeding <input type="checkbox"/> Patient has genital lesions or bleeding <input type="checkbox"/> Assailant is known IV drug user <input type="checkbox"/> Assailant is bisexual or gay <input type="checkbox"/> Assailant is from area of high endemic HIV	
HIV PEP Started	<input type="checkbox"/> <b>Truvada</b> (Emtricitabine 200 mg +Tenofovir 300 mg) PO once daily for 28 days <b>Plus</b> <input type="checkbox"/> <b>Dolutegravir</b> (Tivicay) 50 mg PO once daily for 28 days <input type="checkbox"/> or - Raltegravir (Isentress) 400 mg PO twice daily for 28 days <input type="checkbox"/> Baseline HIV test done <input type="checkbox"/> Discussed side effects of medications with patient <input type="checkbox"/> Discussed follow-up with patient <input type="checkbox"/> Patient given HIV PEP instructions <input type="checkbox"/> Patient given prescriptions for medications	
HIV PEP indicated, patient <b>declined</b>	<input type="checkbox"/> Discussed <b>with patient</b>	Patient signature :
<input type="checkbox"/> Discharge information reviewed and given to patient		
Disposition:	Time:	Accompanied by:
<b>Patient Signature:</b>		
I have received and reviewed discharge information, including information about each medication and the sexual assault exam.		
<b>Examiner Signature:</b>	<b>Print:</b>	<b>Date:</b>
<b>Physician Signature:</b>	<b>Print:</b>	<b>Date:</b>