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Recommended Guidelines
Sexual Assault Medical Evaluation
Child 12 years and under

The following is a guideline for conducting the medical-legal examination and collecting forensic evidence for male and female child patients when there is a report or concern of sexual assault. These guidelines are not intended to include all the medical evaluations and tests which may be necessary for appropriate care for an individual patient. Likewise, not all the steps outlined here will be appropriate for every patient.

This outline is for pre-pubertal children, usually up to and through age 12 years. For care for adolescents, see "Recommended Guidelines for Sexual Assault Medical Exam, Adult and Adolescent"

I. GENERAL

PURPOSE OF EXAM

MEDICAL
- Identify and treat injuries
- Diagnose and treat other medical conditions
- Document history
- Document medical findings
- Assess risk of sexually transmitted diseases
- Address patient and family concerns regarding physical findings, permanent injury, and disease risk

SOCIAL/PSYCHOLOGICAL
- Respond to patient’s and family’s immediate emotional needs and concerns
- Provide crisis intervention and stabilization
- Assess safety and assist with interventions
- Explain mandatory reporting process
- Explain Crime Victims Compensation: give brochure or application (for materials call 1-800-762-3716)

LEGAL
- Collect forensic evidence when appropriate, maintain chain of custody, and transfer to law enforcement

REPORT/REFER
- Report to law enforcement and/or Child Protective Services when the medical provider has a reasonable suspicion of child abuse (see Mandatory reporting below)
- Refer for follow-up medical care
- Refer for advocacy or counseling (see appendix for Washington Community Sexual Assault Programs)

BACKGROUND

A sexual abuse medical exam is indicated when a child reports a contact sexual offense, or when a witness (including the offender) observes such an offense
- A decision to obtain a medical exam should not depend on report of “penetration”- this definition is difficult to ascertain
- Children may minimize the extent of contact
- Children may present with a combination of concerns: parent’s perception of a risky situation, non-specific physical complaints such as redness or discomfort, and child’s statements
- The child’s statements are often the most critical aspect of the medical evaluation for child sexual abuse
- However, a young child’s statements may be difficult to interpret
- Parents may bring children in for concern of sexual abuse when the child has not made a clear statement to anyone
In sexually abused children, physical findings are most often normal or non-specific

- A normal or non-specific exam does not rule out prior sexual abuse
- Physical injuries to the genital or anal regions usually heal within a few days
- The medical provider should consider differential diagnosis or alternative explanations for physical signs and symptoms
- Symptoms or signs such as redness, dysuria, vaginal discharge or bleeding may have many causes, which may or may not be associated with sexual abuse

**BACKGROUND FORENSIC EVIDENCE IN CHILDREN**

- Several recent studies concur that for pre-pubertal children body swabs are unlikely to be positive more than 48 hours after reported contact
- It may not be possible to tell from the initial history what the outcome of any case will be
- Clothing collection is critical when evidence is collected. Clothing, especially underwear, is the most likely positive site for evidentiary DNA
- **Scene investigation, including collection of linens and clothing should be done early.** Evidence from clothing and other objects is more likely to be positive than evidence from the patient’s body

**TELEPHONE TRIAGE**

Triage is often difficult over the phone: consultation with a senior social worker or medical provider should be done whenever there are questions

**URGENT OR EMERGENT EXAM IS RECOMMENDED WHEN**

- Clear report by child, or witnessed sexual contact which occurred within the previous **48 hours** (exception: child to child contact with no apparent injury)
- Active vaginal or rectal bleeding of unknown etiology and concern for abuse
- High risk situation, such as abduction
- Advise family:
  - Do not bathe child before exam
  - Bring in clothes worn at time of incident, if possible, and bring change of clothing
  - Come to office, clinic, or hospital with support person (family, friend, advocate)
- The setting for this exam will vary by community. The examiner must be capable of performing an adequate, comfortable exam, with documentation of injury and forensic evidence collection
- See forensic evidence collection guide below

**EXAMINATION WITHIN THE NEXT 1 TO 10 DAYS, DEPENDING ON CIRCUMSTANCES, IS RECOMMENDED WHEN**

- Clear report by child, or witnessed sexual contact which occurred more than 48 hours prior

**EXAMINATION BY A PRIMARY MEDICAL PROVIDER IS INDICATED WHEN**

- Child has concerning symptoms, such as pain with urination, vaginal discharge, or signs such as vulvar redness, and no clear report or witnessed abuse
- Visible vaginal or anal abnormality with no definite abuse event
- A young child has made vague statements which might have a variety of interpretations
- The primary provider may request consult with child sexual abuse specialist

**REFER TO COMMUNITY PROTOCOLS REGARDING**

- Children with sexual behavior problems
- Children exposed to sexual offenders and no specific report of abuse
ED TRIAGE

Concern of child sexual abuse is often a psychosocial emergency for the family, and should be triaged for urgent support and assistance

- Details of reason for concern should be obtained outside of the child’s hearing
- Depending on circumstances, the ED exam may be a limited screening exam, with or without evidence collection. The child may then be referred for a more complete evaluation by a specialist

REGISTRATION/BILLING

By law, the initial medical forensic exam for sexual abuse or assault which may have occurred in Washington State must be billed only to Washington State Crime Victim's Compensation

- A Crime Victims Compensation application does not need to be completed for this coverage to be in effect
- The diagnosis of confirmed sexual abuse or assault is not a requirement for payment. Diagnosis can be V71.5 (Observation after sexual assault)
- Specific CVC billing codes must be used. Contact Washington CVC for more information 1-800-762-3716 or web site http://www.lni.wa.gov/ClaimsIns/CrimeVictims
- If the abuse or assault occurred in another state, application will need to be made to that jurisdiction
- Treatment of injury or illness (e.g., x rays, or treatment for urinary tract infection) is billed to the patient’s insurance, with CVC as secondary insurer

CONSENT FOR CARE MINORS

Consult local hospital policy regarding care for minors

- In general, the parent or legal guardian must sign consent for care for patients under 18 years of age
- If the child’s parent or legal guardian is unavailable or unwilling to sign consent for care, and the medical providers deem that an exam for sexual abuse must be done emergently, the following steps should occur:
  - Medical provider notify police to take the child into protective custody (call 911, state “This is not an emergency” and state the reason for requesting assistance)
  - Police take the child into emergency protective custody
  - CPS authorizes medical exam (this may be done over the phone with appropriate witnesses)
  - CPS arranges placement
- Under certain circumstances reproductive health care may be rendered without consent from parents or guardians. See Adult and Adolescent Guidelines for details
MANDATED REPORTING

A report to law enforcement or CPS is mandatory if the medical providers have a reasonable suspicion of child abuse (RCW 24.44.030, see appendix)

- Non-consensual or coercive sexual acts must be reported to police and/or CPS as a crime against a child. The age of the alleged assailant is not relevant
- Police should be informed as soon as possible if forensic evidence is collected
- CPS must be informed if there is any concern for safety of patient or other children

CRIMES AGAINST MINORS

Consensual sexual activity must be reported when there is a specified age difference between the two parties. This is defined as

- When the victim is less than 12 years old, and the offender is 24 months or more older
- When the victim is 12 to 13 years old, and the offender is 36 or more months older
- When the victim is 14 to 15 years old, and the offender is 48 or more months older

Mandatory reporting applies even when a minor has signed for own care

PROFESSIONAL QUALIFICATIONS

The examiner should be familiar with normal pre-pubertal genital anatomy, basics of child development, means to maintain child's comfort, and non-intrusive methods of examination and specimen collection

- Sexual assault nurse examiners should obtain specific training in exams of children before conducting these exams
- Pediatric exams require differential diagnosis. Exams which include photo documentation should be reviewed by an independent practitioner with expertise in child sexual abuse (MD, PA-C, or ARNP)

PEER REVIEW AND EXPERT REVIEW

Peer review or formal consultation is strongly recommended when the evaluator considers an exam concerning or abnormal

- This review is best done by reviewing photographs or videos

ASSESSMENT, DIAGNOSIS AND CONCLUSIONS

- “Rape” and “molestation” are legal terms, not medical diagnoses
- Assessment should delineate history and physical findings
  - Useful terms are “report of sexual abuse” (if the child made clear report or sexual abuse was witnessed) or “concern of sexual abuse” if there is no clear statement or witness

DOCUMENTATION

- The medical chart is likely to be legal evidence
  - Use ink, print legibly or type
  - Use only standard abbreviations
- On each page of the report
  - Clearly indicate patient name and hospital number
  - Print name of staff member who completed the page
  - Sign and date
II. HISTORY

PATIENT INFORMATION

In addition to routine registration data, document
- Person who accompanied patient and relationship to patient
- Police report if filed: police department and case number if available
- CPS report if filed, and name of office

MEDICAL HISTORY OF EVENT OR CONCERN

The history is obtained from the parent or guardian and/or law enforcement.
- This information may be obtained by the health care provider or a designated member of the team
- The history may be more focused in the emergency setting, and more extensive in the clinic setting

DOCUMENT

- Who referred patient
- Source of information: document all sources of information, including telephone contacts
- Reason for concern for sexual abuse
- What information caregiver obtained from the child
- What specific questions the parent or guardian asked to elicit information
- Time (hours or days) since last probable contact
- Physical symptoms or signs noted by parent or guardian: itching, bleeding, discharge, constipation, diarrhea
- Behavioral changes such as anxiety, sleep disturbance, toileting problems
- If the patient has
  - Showered, bathed, cleaned genital-anal area, rinsed mouth, eaten, drank, urinated or defecated since the alleged abuse
  - Changed clothes, gave clothes to police at scene, or brought clothes worn at time of assault to medical setting

RISK FACTORS

Assailant risk regarding Hepatitis B, Syphilis, and HIV if known
- Multiple assailants
- Man who has had sex with men
- Recent residence in an endemic country
- Known or suspected IV drug use

MEDICAL HISTORY

- Active medical problems, significant past medical problems
- Current and recent medications, including antibiotics
- Developmental status (known speech or cognitive delays, special education)
- Patient’s history of hepatitis B vaccine or illness
- Allergies to medications
- History of past genital injury, surgery, or instrumentation especially urinary catheterization

SOCIAL HISTORY

- Home setting: family members and others in home
- School, daycare, other caregivers
- Other possible child victims or witnesses

NOTE: Caution should be exercised when documenting parent’s personal history for reasons of confidentiality
MEDICAL HISTORY FROM PATIENT

The medical history is for the purpose of medical diagnosis and treatment and psychosocial assessment, and does not substitute for a forensic interview

- Medical history may be obtained by medical provider, nurse, or social worker
- The person obtaining the history must identify self and clarify the medical role to the patient
- It is often most comfortable for the child to talk to the medical provider with the parent or other emotionally involved persons out of the room

TECHNIQUES

Obtaining the medical history does not require special training, but the professional should adhere to certain basic rules of non-leading questioning

- Help to put the child at ease by initiating neutral conversation
- Assess patient’s developmental and conversational ability, especially in speech pattern, articulation, and sense of time
- Ask non-leading questions (“why did your parent bring you here today?” or “is there a problem?” or “has someone been bothering you?”)
- Allow child to fully answer each question before asking another
- Encourage free narrative
- Avoid yes or no questions and multiple choice questions. If asked, offer another option (“or something else”)
- Do not introduce new information, such as actions (“did he do …?”) in questions. Referring to prior statements by the child is acceptable (“you told me he did …”)
- It is not necessary for the medical provider to obtain all the details of the event
- If a child is reluctant to speak, and answers only “yes” or “no” or “I don’t know” it may be best practice to discontinue efforts to obtain the history at that time

If the child is unwilling or unable to provide the medical history, do not persist

DOCUMENT HISTORY FROM CHILD

- Document persons present during conversation with child
- Near verbatim questions asked and child’s statements regarding abuse, assault, or injury
- Relevant spontaneous statements or questions by child during exam
- Child’s demeanor during conversation

DISCUSSION WITH PATIENT AND FAMILY

- Discuss medical procedures. Provide clear age appropriate explanations
- Discuss with the family the extent of the exam, the plan for photo-documentation and evidence collection, if needed
- Discuss CPS or police report, if required
- Refer to community resources for support (see attached list)
III. MEDICAL EXAMINATION

EXAM PROCESS

The exam should be done in a manner which is least disturbing to the child
Techniques to increase comfort include

- Assure the child that there are no shots given during the exam
- Offer clear age-appropriate explanations for the reasons for each procedure, offer
  patient some control over the exam process
- Offer that a person of child’s choice can be present for the entire exam. Have that
  support person positioned near the child’s head
  - Explain to parent or support person that their job is to talk to and distract the
    child, and the findings of the exam will be discussed with them after the exam is
    completed
- Use drapes to protect privacy, if the child wishes
- Use distracters: These can be:
  - The parent singing, reading a book or telling a story to the child
  - A music box or bubbles
  - A Viewmaster or visual distraction

The child should not be held down or restrained for the exam, it is not possible to
do an adequate exam under these conditions.

If it is necessary to restrain the child for a detailed exam, then either the exam
should be deferred or the child should be sedated

SEDATION

Although anxious parents or patients may request sedation for the exam,
sedation is very rarely indicated

- One clear indication for a sedated exam is active vaginal or rectal bleeding where
  the exam is needed for medical assessment

In cases where the child refuses the evidentiary exam, the following evaluation
should occur

- Is the parent’s concern increasing the child’s anxiety?
  - If so, the medical provider should take the parent aside and listen to their
    concerns. If necessary, and if the parent is in agreement, the parent should
    remain outside the room during the exam
- Is the child non-specifically distressed?
  - Offer conversation, reassurance, food, distraction
- Is the child distressed about the genital exam per se?
  - Listen to child’s concerns, emphasize privacy

Recognize that clothing and household linens may be the best source for DNA
evidence

If needed, inform police to collect evidence from scene

- If an exam is not immediately required for medical issues and if deemed appropriate
  to collect evidence, offer to trade child’s underpants for a new pair, and place
  child’s underpants in evidence
- If the child resists the genital exam, swabs from the abdomen and umbilicus may be
  a source for DNA evidence as well
### PHYSICAL EXAM

A complete head to toe physical exam, with particular attention to findings of trauma or neglect, should be documented in every case

### ORAL EXAM

**Document**
- Lacerations, abrasions, petechiae, bruises
- Check mucosa, palate, frenulum, tongue
- Dental caries or infection

### SKIN EXAM

**Document**
- Visible skin injuries, bruises, abrasions, lacerations, erythema, scars
- Note bite marks and suction ecchymoses
- Ask patient (if age appropriate) if each injury is from assault or another event and document

### GENITAL EXAM: FEMALE

**Document**
- Genital lacerations, abrasions, bruises, petechiae, erythema, inflammation, vaginal discharge, scars, and hymenal transections
- Exam is usually done in supine frog leg or dorsal lithotomy position. For patient comfort, the exam position can be adapted – on parent’s lap, with legs straight in the air, even with leaving underpants on and pulling cloth to the side
- Use both labial separation and traction to examine vulva and introitus
- Prone knee chest position is usually not necessary in the acute setting, but may be a useful adjunct to assess for healed injury
- Gentle irrigation with warm water may assist with assessment of the hymenal anatomy

**For prepubertal or early adolescent girls, the vaginal speculum exam is not necessary and is contraindicated, except for exam under anesthesia**

### GENITAL EXAM: MALE

**Document**
- Penile or scrotal abrasions, bruises, lacerations, erythema, and inflammation
- Examine inner thighs, all sides of the penile shaft, corona, glans, under foreskin
- Examine scrotum, including anterior, posterior aspect

### ANAL EXAM MALE AND FEMALE

**Document**
- Perianal bruising, petechiae, abrasions, lacerations, or visible anal laxity
- Supine knee-chest (“cannonball”) position is optimal and usually comfortable for child
- Separate anal folds to visualize lacerations
- Digital exam is contraindicated, except if concern for foreign body retention
- Anoscopy may be used if there is anal bleeding or rectal pain following reported anal penetration, or if there is visible perianal injury
- Lubricant should be used for anoscopy. To avoid contamination, perform anoscopy after forensic swab collection
IV.  **FORENSIC EVIDENCE GUIDELINES**

**INDICATIONS FOR EVIDENCE COLLECTION**

| Clear report or witnessed contact offense within prior 48 hours (even if patient has bathed) when alleged assailant is 11 years of age or older OR |
| High risk situation, for example, abduction OR |
| Vaginal, anal, or perineal injury and clinician suspects abuse |
| Other circumstances may indicate forensic collection after 48 hours, this determination is done on a case by case basis |

**BACKGROUND**

| If evidence is collected, that evidence should not be limited to the areas which the patient reports contact |
| Patients may be embarrassed, or may forget aspects of the abuse/assault |
| Specimen collection is not only for possible semen, but also for DNA analysis of possible foreign saliva and hair |
| History of bathing does not rule out obtaining skin or surface swabs, as DNA may be obtained even in this circumstance |

**NOTE:** clothing collection has the highest priority in children

| Both underwear or diaper worn at the time of suspected assault and that worn to the exam should be collected |
| Forensic specimens are not processed within the hospital, but stored separately and transferred to law enforcement |
| Evidence may later be tested by the Washington State Patrol Crime Lab, but all evidence is not necessarily processed |

**EVIDENCE COLLECTION GENERAL PRINCIPLES**

**KIT**

| Use of a manufactured “Evidence Kit” is not mandatory |
| If a commercial kit is used, it should contain the necessary components to collect the evidence in the guidelines |
| TriTech USA produces a kit which conforms to the requirements of the Washington State Crime Lab, and is in compliance with these Guidelines. (Tel: 1-800-438-7884 Washington State Kit) |

**PATIENT COMFORT**

| Patient comfort should not be compromised for evidence collection |
| For example, if patient is thirsty, collect oral swabs immediately and then provide something to drink |
| If patient needs to urinate, provide specimen container immediately |

**TECHNIQUES**

| Evidence should be routinely collected from all sites |
| For example, oral and rectal swabs should be collected even if the patient reports only vaginal penetration |
| It is helpful to affix labels to the drying rack to indicate site of swabs |
| Use cotton swabs only |
| Use powder free gloves, and change frequently during exam to minimize cross-contamination |
| For skin swabs, use “wet-dry” swab technique as this increases recovery of foreign DNA |
| Moisten one swab with one drop of water and lightly swab skin area |
| Repeat with dry swab |
| Water for moistening swabs may be supplied in kit, or from sterile hospital supply |
| For orifice swabs, use 4 swabs for each orifice |
| Write on envelope any variations or modifications used in obtaining evidence |
## V. Evidence Collection Steps

<table>
<thead>
<tr>
<th>Site</th>
<th>Patient Selection Rationale</th>
<th>Technique</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forensic tox.</td>
<td>If patient reports blackout, clinical signs of intoxication or concern of drug facilitated sexual assault</td>
<td>For medical care, obtain stat blood alcohol and urine toxicology screen&lt;br&gt;For forensics:&lt;br&gt;• if &lt; 24 hours, 2 grey top blood tubes + 30 ml urine&lt;br&gt;• if &gt; 24 hours, 20 ml. urine only&lt;br&gt;• Collect urine in standard specimen cup, then transfer urine to state toxicology leak-proof plastic cup or 2 red top tubes. Place in biohazard bag&lt;br&gt;• Maintain at room temperature, refrigerate or freeze until transfer&lt;br&gt;• Do NOT freeze glass tubes.&lt;br&gt;<em>Do NOT package in kit. Transfer separately to law enforcement</em></td>
</tr>
<tr>
<td>Oral swabs</td>
<td>All&lt;br&gt;Even if ate /drank /rinsed mouth after assault</td>
<td>Use 4 cotton swabs total. Do not moisten&lt;br&gt;Using 1swab at a time, swab around gingival border, at margins of teeth, buccal and lingual surfaces&lt;br&gt;Repeat with remaining 3 swabs</td>
</tr>
<tr>
<td>Trace debris</td>
<td>If abuse occurred out of home or outdoors, and patient has not changed clothes</td>
<td>Place clean bed sheet (or paper sheet) on floor&lt;br&gt;• Place clean paper sheet (at least 2’ x 2’) on top&lt;br&gt;• Have patient undress while standing on paper&lt;br&gt;• Fold paper to retain debris&lt;br&gt;• Place in envelope, seal, sign and date over tape</td>
</tr>
<tr>
<td>Outer clothing</td>
<td>If wearing (or brought in) clothing worn at time of abuse&lt;br&gt;If event occurred out of doors or clothing was stained or damaged collection is particularly important</td>
<td>Place each item of clothing in a separate brown paper grocery-type bag&lt;br&gt;• Place patient label on each bag&lt;br&gt;• Write contents on outside of each bag, e.g. “jeans”&lt;br&gt;• Tape each bag closed with clear packing tape, and sign over tape&lt;br&gt;• Place smaller clothing bags in one large brown paper grocery bag&lt;br&gt;• Tape this bag closed with clear packing tape. Label with patient ID, and with permanent marker sign and date over tape&lt;br&gt;• Maintain chain of evidence. Lock in secured area when not directly observed&lt;br&gt;<em>Do not cut through any existing holes, rips, or stains. Do not shake out patient’s clothing or trace evidence may be lost</em>&lt;br&gt;<strong>Wet items</strong> – place in double paper bag, place in open plastic container or in open plastic bag.&lt;br&gt;Label “WET” and transfer to law enforcement within 3 hrs</td>
</tr>
<tr>
<td>Underpants Diaper</td>
<td>All, even if changed after event (exception: if police have collected at scene)</td>
<td>If dry, package in a small paper bag (supplied in kit)&lt;br&gt;• Seal, label, and place in the Evidence Kit&lt;br&gt;If wet or damp&lt;br&gt;• Do not attempt to dry wet underpants or diapers. Either transfer to law enforcement within 3 hours, or place in double paper bag, seal, place in open plastic container (basin) or open plastic bag.&lt;br&gt;Label “WET” and refrigerate or freeze until transfer</td>
</tr>
<tr>
<td>Reference hair</td>
<td>All&lt;br&gt;May be needed to compare with hair pulled out at scene</td>
<td>Pluck 10 hairs from scalp&lt;br&gt;Place on clean paper (alt., place on sticky side of clean Post-it note)&lt;br&gt;Fold in paper and place in envelope</td>
</tr>
<tr>
<td><strong>Fingertip swabs</strong></td>
<td><strong>All</strong></td>
<td>Use 4 swabs total - 2 swabs for each hand</td>
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<tr>
<td></td>
<td></td>
<td>• With 1 moistened swab, swab all 5 fingertips on one hand, concentrating on area under nails</td>
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<td></td>
<td></td>
<td>• Repeat with 1 dry swab on same hand</td>
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<td></td>
<td></td>
<td>• Repeat process on other hand</td>
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<tr>
<td></td>
<td></td>
<td>• If other areas of hand are swabbed, package in “Skin swabs” envelope</td>
</tr>
<tr>
<td><strong>Reference blood</strong></td>
<td><strong>Not required for children</strong></td>
<td>May be obtained at a later date. If blood is obtained for another reason</td>
</tr>
<tr>
<td></td>
<td><strong>To obtain patient’s DNA</strong></td>
<td>• Using blood from syringe, place drops on designated FTA paper in kit. Fill each circle completely, fill all 4 circles</td>
</tr>
<tr>
<td><strong>Debris on skin</strong></td>
<td><strong>If debris visible and especially when alleged assault was out of home (e.g., threads, dirt)</strong></td>
<td>Use 1 swab, moisten with 1 drop water</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Lift off debris, place in clean paper</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Fold and place in envelope</td>
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<tr>
<td></td>
<td></td>
<td>• Write on envelope site of collection</td>
</tr>
<tr>
<td><strong>Skin swabs</strong></td>
<td><strong>All</strong></td>
<td>Swab all suspect areas, as well as visible bite marks or suction bruises, and dried secretions on skin.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Use 2 swabs total for each site</td>
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<td></td>
<td></td>
<td>• Moisten 1 swab with 1 drop of water</td>
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<td></td>
<td></td>
<td>• Swab area of suspected foreign secretions</td>
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<td></td>
<td></td>
<td>• Repeat with 2nd, dry swab</td>
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<tr>
<td></td>
<td></td>
<td>• Repeat 2 swab wet/dry technique for each suspect area</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Indicate on envelope if saliva or semen is suspected by patient report</td>
</tr>
<tr>
<td><strong>Pubic hair combing</strong></td>
<td><strong>Only if pubic hair visible</strong></td>
<td>With patient in dorsal lithotomy, place clean paper under buttocks</td>
</tr>
<tr>
<td></td>
<td><strong>Omit if shaved or absent pubic hair</strong></td>
<td>• Using supplied comb, comb downward to collect loose hairs</td>
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<tr>
<td></td>
<td></td>
<td>• Fold paper to retain hairs, and place in envelope</td>
</tr>
<tr>
<td><strong>Pubic hair plucking</strong></td>
<td><strong>Omit if shaved or absent pubic hair</strong></td>
<td>Pull 5 – 10 hairs from different areas of pubis</td>
</tr>
<tr>
<td></td>
<td><strong>To compare with foreign hair</strong></td>
<td>• Place on clean paper (alt., place on sticky side of clean Post-it note)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Fold in paper and place in envelope</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If patient declines, may obtain at a later date</td>
</tr>
<tr>
<td><strong>Vulvar/perineal swabs</strong></td>
<td><strong>All females</strong></td>
<td>Use 4 cotton swabs total</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Moisten 2 swabs with 1 drop of water on each</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Swab external genital folds and perineum</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Repeat with 2 dry swabs</td>
</tr>
<tr>
<td><strong>Inner labia swabs</strong></td>
<td><strong>All pre-pubertal girls</strong></td>
<td>Use 4 cotton swabs total</td>
</tr>
<tr>
<td></td>
<td><strong>NOTE: method of collection differs from Adult/Adolescent Guidelines</strong></td>
<td>• Moisten 2 swabs with 1 drop of water on each</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Gently swab or roll swab over inner labia bilaterally</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Repeat with 2 dry swabs</td>
</tr>
<tr>
<td><strong>Package in “Vaginal/endo cervical” envelope</strong></td>
<td><strong>Note: because of the extreme sensitivity of this area in prepubertal girls, intravaginal swabs are NOT recommended in this age group</strong></td>
<td></td>
</tr>
<tr>
<td><strong>For post menarchal patients, if patient tolerates:</strong></td>
<td><strong>Intravaginal swabs (4) may be obtained</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Use 4 cotton swabs total</strong></td>
<td>Use 4 swabs total</td>
</tr>
<tr>
<td></td>
<td><strong>Use 2 swabs for vaginal pool specimens</strong></td>
<td>• Use 2 swabs for vaginal pool specimens</td>
</tr>
<tr>
<td></td>
<td><strong>Using one swab at a time, insert in posterior direction approx 4”, and swab posterior vaginal pool</strong></td>
<td>• Using one swab at a time, insert in posterior direction approx 4”, and swab posterior vaginal pool</td>
</tr>
<tr>
<td></td>
<td><strong>Repeat with next 3 swabs</strong></td>
<td>• Repeat with next 3 swabs</td>
</tr>
<tr>
<td></td>
<td><strong>Speculum exam is not indicated except under anesthesia or deep sedation</strong></td>
<td>Speculum exam is not indicated except under anesthesia or deep sedation</td>
</tr>
<tr>
<td>Male genital swabs</td>
<td>All boys</td>
<td>Penile swabs</td>
</tr>
<tr>
<td>--------------------</td>
<td>----------</td>
<td>--------------</td>
</tr>
<tr>
<td></td>
<td>May be tested for foreign debris or saliva</td>
<td>Use 4 cotton swabs. Moisten 2 with 1 drop of water on each</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Swab penis: anterior, lateral, posterior and glans penis and under foreskin with moistened swabs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Repeat with 2 dry swabs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>After drying, package in “vaginal endocervical” envelope. Write site of collection on envelope</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Perineal swabs</th>
<th>Use 4 cotton swabs total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Moisten 2 swabs with 1 drop of water on each</td>
</tr>
<tr>
<td></td>
<td>Swab perineum and scrotum</td>
</tr>
<tr>
<td></td>
<td>Repeat with 2 dry swabs</td>
</tr>
<tr>
<td></td>
<td>After drying, package in “Vulvar-perineal” envelope</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Anal swabs</th>
<th>All even if anal assault not reported.</th>
<th>Perianal: Use 2 swabs total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Moisten 1 swab with 1 drop water</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Swab peri-anal folds. Repeat with dry swab</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Anal: Use 2 swabs total</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Moisten each with 1 drop of water</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Insert 1 swab 1-2 cm into anus</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Repeat with second moistened swab</td>
</tr>
</tbody>
</table>
VI. Forensic Evidence Processing and Storage

**Processing Forensic Specimens**
- Forensic specimens are not processed within the hospital, but stored separately and transferred to law enforcement
- Evidence may later be tested by the Washington State Patrol Crime Lab
- All evidence is not necessarily processed

**Chain of Custody for Forensic Specimens**
- One staff member must be responsible for maintaining chain of evidence.
- That staff member at all times:
  - Maintains continuous physical possession of specimens and items of evidence, OR
  - Designates another staff member to maintain possession of evidence, OR
  - Locks specimens in closed area (room, cabinet, refrigerator or freezer)

**Drying Evidence**
- Thorough drying is the most critical step in evidence preservation
  - All evidence must be thoroughly dried before packaging
  - If items cannot be dried (e.g., tampons or clothing) package in paper bag and transfer immediately, or place in plastic bag, seal, and freeze until transfer. Mark the outside of these packages “WET”

**Drying Swabs**
- Maintain chain of custody while drying
  - Swabs may be locked in room, cabinet or drying box to dry
  - Do not use heat to dry swabs
  - If drying box is used, place swabs from only one patient at a time in drying box
  - Use plastic “Crash cart” lock to close box
  - When drying is complete, place used plastic lock into evidence kit to demonstrate chain of custody of evidence
  - Clean drying box with 20% bleach or hospital approved disinfectant

**Time for Drying**
- A swab moistened with 3 drops of water will take 1 hour to dry in a standard drying box. Swabs left in a locked cabinet will take a similar time to dry

**Evidence Storage**
- Temperature
  - Dry or dried evidence may be kept at room temperature or frozen.
  - Damp or wet evidence or specimens must be kept at cool temperature (refrigerated or frozen) until transfer OR transfer within 3 hours
- Evidence Kit
  - All evidence placed in the Evidence Kit must be dry or dried before packaging
  - Store sealed Evidence Kit in locked cabinet, refrigerator, or freezer until transfer to law enforcement
- Clothing
  - Store clothing in locked room or cabinet until transfer to law enforcement
  - *Wet clothing* must be transferred within 3 hours to law enforcement or frozen pending transfer
- Do not thaw and refreeze
TOXICOLOGY SPECIMENS

Urine and Blood

Do not place in the Evidence Kit

- Urine for toxicology may be collected in a standard medical specimen cup
- Transfer 20-50 ml into a leak proof container supplied by the State Toxicology lab
- Urine may be left at room temperature, refrigerated, or frozen in plastic until transfer
- Blood tubes for toxicology (grey tops) may be left at room temperature or refrigerated until transfer

Do not freeze as glass tubes may break

LABELING AND PACKAGING SWABS

- Swabs must be labeled with site of collection – this label may be on the swab itself or on the cardboard box for the swab
- Write on a label the site of specimen, e.g., “Skin - right upper leg,” “oral,” “endocervical,” “vulvar,” “rectal”
- Using a cardboard box from the manufactured Evidence Kit
- Place 2 swabs from same site in one box
  - Affix label to cardboard box
- Alternatively, if not using a cardboard box
  - Affix label to wooden shaft of swabs, one label to 2 swabs from same site
- Place dried swabs (in cardboard box) in envelope. Place swabs from only one site in each envelope (oral, vaginal/endocervical, rectal, skin)
- Place patient label on envelope. Write contents on outside of envelope
- Seal envelopes using tape, adhesive seal, or patient ID label. Never lick envelope to seal.
- Sign over seal, and place in Evidence Kit

FOREIGN OBJECTS

Items which may contain forensic evidence, such as sanitary pads, condom, or tampon

- Place item in plastic biohazard bag or sterile urine cup and seal
- Place patient label over seal, sign over seal
- If item is wet or damp, transfer to law enforcement within 3 hours, or store in locked refrigerator or freezer until transfer
- **DO NOT** place these items inside the Evidence Kit
VII. MEDICAL PHOTOGRAPHY

GENERAL

Injuries which are judged concerning for abuse should be documented as thoroughly as possible, including careful drawings and photodocumentation
- Photodocumentation may be by digital, 35 mm, or video camera
- Each camera type has advantages and limitations
  - Polaroid photos generally have poor color and preservation
  - Video should have no sound recording unless all parties are aware of and consent (RCW 9.73.030)
- Careful documentation with drawing are recommended even when photographs are obtained, since technical challenges may be encountered
- Each institution should take appropriate steps to maintain the privacy and dignity of the patient in photos

Always document name of photographer and date of photos
- This may be done by documentation in the chart, in a photo log, or by writing the photographer name and date on the patient identification label which is then photographed

TECHNIQUE

- Staff must be trained in specific camera and photography techniques
- If date function is used, verify that date is correct
- Check flash function: photos may be better either with or without flash
- First photo is of patient identification label
- One photo should include patient face

Photograph each injury site 3 times
- First, from at least 3 feet away, to demonstrate the injury in context
- Second, close up
- Third, close up with a measuring device (ruler, coin, or ABFO rule)

BODY PHOTOS

Photos of body injury are as significant as genital injury in sexual assault cases
- Drape patient appropriately, photos may be shown in open court
- Hospital personnel may either take the photos or assist law enforcement in obtaining photos

BITE MARKS

- Bite marks should be photographed and police should be notified for police photographer to obtain technically optimal photos
- Use of a measuring device and good technique (camera perpendicular to plane of skin) is particularly important

COLPOSCOPY

- Magnified photographs (colposcopy) are recommended for documentation of acute injury, healed injury and other findings, and has definite value for comparing one examination with a later exam, second opinion and peer review, as well as evidentiary value
- Photocolposcopy can be with digital camera, video, macro 35 mm, or a colposcope with attached photographic device
- Use of a photocolposcope requires special training, equipment and technical expertise and may not always be available in the emergency setting
- Measuring device is not needed in these photos
- If blood or debris is present, photograph first, then clean area and photograph again
- Toluidine blue is not recommended for child exam

**PHOTO STORAGE AND RELEASE**

- Photos are part of the medical record
- Photos may be stored outside of the medical records department (just as x-ray films are stored in the radiology department)

*Provide formal tracking of copies, release dates, and person responsible for releasing and receiving photos*

- Follow HIPPA compliance policies for release of all records, including photos
- Photos may be released to law enforcement with proper consents
- Follow medical records retention rules regarding disposal of photographs
- Because of the extremely confidential nature of colposcopy photos, these photos are not released along with other portions of the medical record

**Colposcopy photos are released only in response to a subpoena and then are released directly to the medical expert who will review the photos**
# VIII. Pregnancy, STD, and Toxicology Testing

## Pregnancy Test
- Should be done on girls 11 years and older, and on any girl who has either had any menstrual periods, or who has breast development or pubic hair (Tanner stage 3 or above)
- Urine test is as sensitive and accurate as blood test, and easier for patient

## STD Tests
- Positive STDs are highly significant in evaluation of child abuse
- However, the positive predictive value of a positive test in a low prevalence population is low
- Therefore, all positive non-culture tests should be confirmed with culture or another test, e.g., confirm nuclear amplification test with another test which targets another section of DNA/RNA, or with culture
- Tests are unlikely to be positive in the hours or first few days after a single episode of abuse: in these cases may be best to defer testing to a follow-up visit

## Indications for STD Testing
- Routine testing for all STDs in children has a very low yield
- Testing is recommended when:
  - Clear report of genital to genital or genital to anal contact with a teen or adult or
  - Signs of disease, specifically vaginal or urethral discharge, or genital ulcers or
  - Positive diagnosis of another sexually transmitted disease
- Follow-up for lab results must be arranged

## Gonorrhea
- In prepubertal girls, GC is a vaginal, not cervical infection. Cervical specimens DO NOT need to be obtained in children
- Infection is very unlikely in the absence of vaginal discharge in girls
- Swab of the vaginal discharge, or in boys of the meatal discharge, suffices for culture. Intravaginal swabs rarely need to be obtained
- Urine for nuclear amplification test (NAAT) may be used as a first test
- If an initial non-culture test is positive, culture is preferred as confirmatory test.
- Anal GC: anal infection is very rare in the absence of vaginal infection in girls. However, for boys or girls who report anal penetration, anal culture is recommended (rapid tests are not approved for this site)
- Pharyngeal GC: obtain culture if report of penile-oral contact within previous 3 months (rapid tests are not approved for this site)

## Chlamydia
- Vertical infection (perinatal) infection may persist for at least 3 years and possibly longer
- Infection may be asymptomatic
- Urine for nuclear amplification test (NAAT) has a lower positive predictive value when used in a low risk population such as children
- **If non-culture methods are used, confirmation of positives by another method should be obtained before diagnosis is made. This confirmation may be by a different non-culture technique (PCR, LCR) or by culture**
  - For confirmation, urethral, vaginal and rectal cultures (females and males) are recommended
HUMAN PAPILLOMAVIRUS  GENITAL WARTS

Assessment of the probability that HPV has been acquired via sexual transmission depends on age at onset, child’s statements regarding abuse, and other risk factors

- Genital warts may be vertically (perinatally) transmitted, sexually transmitted, or in rare cases acquired through household fomite transmission or by autoinoculation
- Perinatally transmitted warts are usually evident by 3 years of age
- Vertical transmission is possible even if the mother has no history of genital warts or abnormal pap (infection may be asymptomatic)
- Diagnosis is by visual inspection; wart typing is not recommended at this time
- Referral to a specialist in child abuse for evaluation or dermatology for treatment may be necessary

HEPATITIS B

- If immunizations are incomplete or history of vaccine uncertain, consider Hepatitis B vaccine administration
- Hepatitis B vaccine may prevent acquisition of Hepatitis B from infected contact if given within 2 weeks of contact
- HBIG is not recommended

SYPHILIS

- Serologic testing is not generally recommended in low prevalence communities
- If special concerns, serology is best done 6 – 12 weeks after last contact

HIV

- If there is a history of semen to mucosal contact, especially with a high risk assailant, the clinician may recommend HIV testing
  - High risk assailants are men who have sex with men, IV drug users, and persons suspected of having HIV
  - Tests should be done at baseline, 6 weeks, 3 months and 6 months after abuse or assault
- Parent or guardian must sign consent for testing. For children in state dependency, DSHS must sign consent

TOXICOLOGY TESTS

Obtain when

- Patient appears impaired, intoxicated, or has altered mental status
- Patient reports blackout, memory lapse, or partial or total amnesia for event
- Patient or parent is concerned that he or she may have been drugged

When toxicology tests are indicated, both stat hospital test (for immediate information) and forensic toxicology specimens (for legal purposes and testing for some drugs which require special methods) should be obtained

FORENSIC TOXICOLOGY SPECIMENS

- Specimen collection: Use State Toxicology Laboratory Kit, if available
- If <24 hours, collect 2 gray top blood tubes and 50 ml urine
- If >24 hours, collect 50 ml urine only
- Seal specimen container with tape or adhesive seal, place patient ID label on container

Storage for transfer to law enforcement

- Do not seal urine or blood tubes in Evidence Kit box
- Place in locked cabinet or refrigerator (blood and urine) or freezer (urine only) outside Evidence Kit box
- Transfer with other evidence to law enforcement
IX.  TREATMENT, DISCHARGE, AND FOLLOW-UP

STD PROPHYLAXIS

Prophylactic treatment of STDs should not be given to children, as it may compromise assessment and conclusions about abuse or assault

- Treatment should be initiated only after confirmation of infection: see STD testing above
- For recommended treatment regimens, see CDC Sexually Transmitted Diseases Treatment Guidelines, or the American Academy of Pediatrics Red Book

EMERGENCY CONTRACEPTION

By law, hospitals must provide information about emergency contraception, and, unless medically contraindicated, provide emergency contraception to victims of sexual assault (RCW 70-41.350)

- Emergency contraception (EC) should be offered when
  - There may have been semen to vulvar or vaginal contact within the previous 5 days AND
  - The patient is post-menarchal, or is a girl Tanner stage III or above
- At times the history may be incomplete. Consider that EC is extremely safe and has very few side effects and may be highly desired by patient and family
- EC (levonorgestrel) decreases the risk of pregnancy by approximately 85%. It does not cause abortion
- Legally, the child can provide consent and be provided confidentiality for reproductive health care. The patient must provide informed consent, understanding of the risks and benefits of treatment and non-treatment.
- If the patient is not able to give informed consent, consent must be obtained from parents, guardian, or surrogate decision-maker
- When the parent is aware and participates in decision making, it is preferable that both the patient and parent should sign consent for EC
- Since EC is more effective if taken soon after unprotected intercourse, patient should be given medication while still in the medical setting
- Advise patient and family that withdrawal bleeding similar to a menstrual period may occur within a few days or weeks of emergency contraception
- Prescribe: Plan B
  - Levonorgestrel 1 tab (0.75 mg) po immediately and 1 tab 12 hours later
  - Preferred alternative: 2 tabs immediately
  - Anti-nausea medication is not required with this medication

DISCHARGE INSTRUCTIONS

- Discuss medical findings
- Explain tests, if any, which were obtained
- Explain follow-up for medical test results
- Explain if CPS or law enforcement will be contacted by medical provider, as required by law
- Assess support systems and immediate safety of child
- Offer patient education materials
- Give written discharge instructions
- Arrange referral to community resources for case management, legal advocacy, and psychosocial care
MEDICAL FOLLOW UP VISIT

Recommended when
- The initial visit has been a limited evaluation or
- There is need for medical re-evaluation, photo-documentation, assessment of healing, or STD evaluation

BILLING
- Crime Victim’s Compensation (CVC) does not routinely cover the follow up visit
- Application to CVC may be made, and if approved, CVC may be the secondary insurer
Appendix 1

Guidelines Development Process

These guidelines were developed during 2006 – 2007 by a multidisciplinary ad hoc committee convened through Harborview Center for Sexual Assault and Traumatic Stress and Washington State Childrens Administration. Participants were professional experts in child abuse, including physicians, nurses, nurse practitioners, attorneys, advocates, therapists, and community leaders. Participation was solicited from all regions in Washington State. The guidelines aim to summarize a practical approach to best practice in this field. The guidelines should not supersede professional medical judgment in the care of individual patients.

This work was sponsored by the Washington State Childrens Administration, Department of Social and Health Services.

Appendix 2

Washington State Law Mandatory Reporting of Child Abuse

RCW 26.44.030

Reports -- Duty and authority to make -- Duty of receiving agency -- Duty to notify -- Case planning and consultation -- Penalty for unauthorized exchange of information -- Filing dependency petitions -- Interviews of children -- Records -- Risk assessment process -- Reports to legislature.

(1)(a) When any practitioner, county coroner or medical examiner, law enforcement officer, professional school personnel, registered or licensed nurse, social service counselor, psychologist, pharmacist, licensed or certified child care providers or their employees, employee of the department, juvenile probation officer, placement and liaison specialist, responsible living skills program staff, HOPE center staff, or state family and children's ombudsman or any volunteer in the ombudsman's office has reasonable cause to believe that a child has suffered abuse or neglect, he or she shall report such incident, or cause a report to be made, to the proper law enforcement agency or to the department as provided in RCW 26.44.040.

(b) The reporting requirement also applies to department of corrections personnel who, in the course of their employment, observe offenders or the children with whom the offenders are in contact. If, as a result of observations or information received in the course of his or her employment, any department of corrections personnel has reasonable cause to believe that a child has suffered abuse or neglect, he or she shall report the incident, or cause a report to be made, to the proper law enforcement agency or to the department as provided in RCW 26.44.040.

(d) The report must be made at the first opportunity, but in no case longer than forty-eight hours after there is reasonable cause to believe that the child has suffered abuse or neglect. The report must include the identity of the accused if known...

RCW 26.44.040

Reports -- Oral, written -- Contents.

An immediate oral report must be made by telephone or otherwise to the proper law enforcement agency or the department of social and health services and, upon request, must be followed by a report in writing. Such reports must contain the following information, if known:

(1) The name, address, and age of the child;
(2) The name and address of the child's parents, stepparents, guardians, or other persons having custody of the child;
(3) The nature and extent of the alleged injury or injuries;
(4) The nature and extent of the alleged neglect;
(5) The nature and extent of the alleged sexual abuse;
(6) Any evidence of previous injuries, including their nature and extent; and
(7) Any other information that may be helpful in establishing the cause of the child's death, injury, or injuries and the identity of the alleged perpetrator or perpetrators.
Appendix 3

Child Advocacy Centers – Washington State

Provide coordinated child abuse investigation

Centers are located in Colville, Grey’s Harbor, Kennewick, Olympia, Spokane, Tacoma, Vancouver.

For current listings and contacts use the internet home page for the National Children’s Alliance, Member Centers, Washington.

http://www.nca-online.org

Appendix 4

Washington State Certified Sexual Assault Programs

Information and referral, Crisis intervention, Legal, Medical and General Advocacy, System Coordination, Prevention Services

For a complete directory of programs in Washington State go to:

www.wcsap.org

http://wcsap.org/pdf/full%20members.pdf
Appendix 4

Medical Specialty Referral Resources

Child and Teen Physical and Sexual Assault Evaluation

PARTNERS WITH FAMILIES AND CHILDREN
P.O. Box 248
Spokane, WA 99210-0248
Tel: 509-473-4811
Fax: 509-473-4840

CENTRAL WASHINGTON HOSPITAL FAMILY HEALTH SERVICES
1201 Miller St.
Wenatchee, WA 98801
Tel: 509-667-3350
Fax: 509-665-6259

CHILDREN’S HOSPITAL AND REGIONAL MEDICAL CENTER
4800 Sandpoint Way NE
Seattle, WA 98105
Tel: 206-987-2194
Fax: 206-987-4057

HARRISON HOSPITAL
2520 Cherry Ave
Bremerton, Washington 98310
Tel: 360 792-6617
Fax: 360 792-6619

HARBORVIEW CENTER FOR SEXUAL ASSAULT
1401 E. Jefferson, 4th Floor
Seattle, WA 98122
Tel: 206-744-1600
Fax: 206-744-1618
www.hcscats.org

KADLEC MEDICAL CENTER
888 Swift Blvd
Richland, WA 99352
Tel: 509-942-2030
Fax: 509-942-2100

MARY BRIDGE CHILDREN’S HOSPITAL CHILD ABUSE INTERVENTION CENTER
1112 S. 5th St.
Tacoma, WA 98405
Tel: 253-403-1478
Fax: 253-403-1582

MOSES LAKE CLINIC
840 Hill Ave.
Moses Lake 98837
Tel: 509-764-6400, ext 8162
Fax: 509-764-6437

PENINSULA CHILDREN’S CLINIC
902 Carolyn Ave.
Pt. Angeles, WA 98362
Tel: 360-457-8578
Fax: 360 457-4841

PROVIDENCE INTERVENTION CENTER FOR ASSAULT AND ABUSE
2722 Colby Ave
Everett, WA 98206
Tel: 425-388-7419
Fax: 425-388-7480

ST. PETER HOSPITAL SEXUAL ASSAULT CLINIC
413 Lilly Rd NE
Olympia, WA 98506
Tel: 360-493-7469
Fax: 360-570-5134

VANCOUVER CLINIC
700 NE 87th Avenue
Vancouver, WA 98664
Tel: 360-397-3250
Fax: 360-253-3506

YAKIMA PEDIATRICS
314-A South 11th Avenue
Yakima, WA 98902
Tel: 509-575-0114
Fax: 509-575-0808

WHATCOM COUNTY CHILDREN’S ADVOCACY CENTER AT BRIGID COLLINS FAMILY SUPPORT CENTER
1231 N. Garden Street
Bellingham, WA 98225
Tel: (360) 734-4616
Fax (360) 734-1763
www.brigidcollins.org