Name	Gender ☐ M ☐ F	Age	Time	Date
Hospital Number				
Police Report Made ☐ Yes ☐ No	Phone		Alternate Phone	
Police Department Case #	Accompanied by		Relationship	
CPS Report ☐ Yes ☐ No	Interpreter ☐ Yes ☐ No Language			
CPS Office Intake Worker	Interpreter Name			

CONSENT: EXAMINATION, EVIDENCE COLLECTION, PHOTOGRAPHY, EMERGENCY CONTRACEPTION

I hereby consent to a forensic medical examination for evidence of sexual assault. The examination has been explained to me and I understand and agree to collection of (please initial):

____ Swabs, blood sample, hair samples for DNA evidence
____ Urine to test for alcohol or drugs I have taken, or may have been given
____ Photographs of body/facial injuries (for police department, if I report the assault)
____ Photographs of genital (private parts) and anal areas (for medical use)

____ I understand that I may refuse any part of this examination at any time.

____ I have been informed that this examination is paid by Washington State Crime Victims Compensation and that I may apply for further CVC financial assistance for medical and counseling expenses, loss of wages and job re-training.

____ I request that **emergency contraception** ("morning after pill") be given to me and understand that it is 75% effective in preventing pregnancy if taken within 72 hours. Information about how this medicine works has been explained to me and my questions, if any, have been answered.

____ Release of medical record and evidence to law enforcement – --See HIPAA compliant release form

Signature of patient (or legal guardian) _____ Witness _____ Date _____

☐ Patient is a _____ year old minor and demonstrates a level of understanding and maturity consistent with ability to sign for examination and treatment.	Witness	Date

EVIDENCE TRANSFER

I hereby certify that I have received from _____ the following items:

☐ Evidence kit ☐ Clothing #bags _____ ☐ Other

Officer /Dept Phone Case#

STAFF INVOLVED IN MEDICAL CARE

Print name	Title	Department	Date
Print name	Title	Department	Date
Print name	Title	Department	Date
Print name	Title	Department	Date
Print name	Title	Department	Date

Current concerns Perceived needs History Include pt. quotes as appropriate Reporting plans Appearance Emotional State For children, reason for concern, child's prev. statements, physical & behavioral symptoms	History from ☐ patient ☐ other _____

NUMBER OF ASSAILANTS_____

Age of alleged ☐ Adult ☐ Teen (13-17) ☐ Child ☐ Unk

RELATIONSHIP	☐ Friend/acquaintance	☐ Stranger
	☐ Spouse current/ex	☐ Unknown/unsure
	☐ Partner current/ex	☐ Other
	☐ Relative	

TYPE OF CONTACT (by assailant to victim)

Penis to	☐ Vagina	☐ Mouth	☐ Anus	☐ Other
Mouth to	☐ Vagina	☐ Anus	☐ Skin site _____	
Hand to	☐ Vagina	☐ Anus	☐ Skin	☐ Other

☐ Foreign object/Other contact

☐ Not known OR /not able to report

TIME SINCE ASSAULT _____ **hrs /days** (circle one) ☐ **Unk**

	Yes	No	Unk
Ejaculation? Site _____	☐	☐	☐
Condom used?	☐	☐	☐
FORCE/COERCION			
Threat to harm	☐	☐	☐
Restrained	☐	☐	☐
Weapon If yes, specify:	☐	☐	☐
Choked / strangled	☐	☐	☐
Hit kicked thrown	☐	☐	☐
Bitten (human bite)	☐	☐	☐
Exploitation (abuse of authority / peer stress)	☐	☐	☐
Perceived life threat	☐	☐	☐

Examiner Name (print)	Signature	Date

HOSPITAL #

NAME

DOB

SEXUAL ASSAULT REPORT

MENTAL STATUS	Yes	No	Unknown /Unsure
Alert and oriented x3			
If no, describe			
Impaired consciousness ("out of it") before assault			
Loss of memory of assault events			
Partial memory of assault events			
Recent voluntary substance use			
If yes Specify			
Suspects "date-rape" drug			
Forced drug? ☐ Oral ☐ Injected			
Describe			

REVIEW OF SYSTEMS	Yes	No	Unknown /Unsure
Skin injury/pain			
Limb pain/injury			
Headache			
Neck/ throat pain			
Difficulty swallowing			
Difficulty breathing at assault/ now			
Nausea/vomiting			
Abdominal pain			
Vaginal bleeding			
Menstruating now?			
Rectal bleeding			
Other			

POST ASSAULT ACTIVITY DID PATIENT			
Rinse mouth /eat/ drink			
Bathe / shower			
Urinate			
Defecate			
Douche			
Take any medication or substances			
If yes, describe			
Change clothes			
Bring clothes worn at assault?			
Give clothes to police at scene			

Were clothes damaged in assault?

If yes, describe:

PAST MEDICAL HISTORY

Significant past medical history/chronic illnesses/hospitalizations

Primary medical provider

Current medications

Hepatitis vaccine ☐ Completed 3 doses ☐ Not completed/known

PEDIATRIC ADDITIONAL HISTORY

Child resides with

Prior or current CPS involvement ☐ Yes ☐ No ☐ Unk

Describe

Other children at risk

Child interviewed by medical staff ☐ Yes ☐ No

If yes, attach near-verbatim record

ALLERGIES TO MEDICATION ☐ None

OB/GYN HISTORY

Gravida Para

Past surgery/disease

CURRENT CONTRACEPTION

☐ None ☐ Condom

☐ Depo provera Last dose date _____

☐ Tubal ligation ☐ OC's No Missed pills

☐ Other

Last menstrual period

Last consensual intercourse _____ days weeks months

☐ Not known ☐ No prior intercourse

Examiner Name (print)	Signature	Date

HOSPITAL #

NAME

DOB

SEXUAL ASSAULT REPORT

PHYSICAL EXAM

General description of patient (demeanor, mood, posture, state of dress, emotional state during history and exam, etc.). Note state of clothing

Vital signs: BP _____ HR _____ RR _____ T

HEENT

Neck

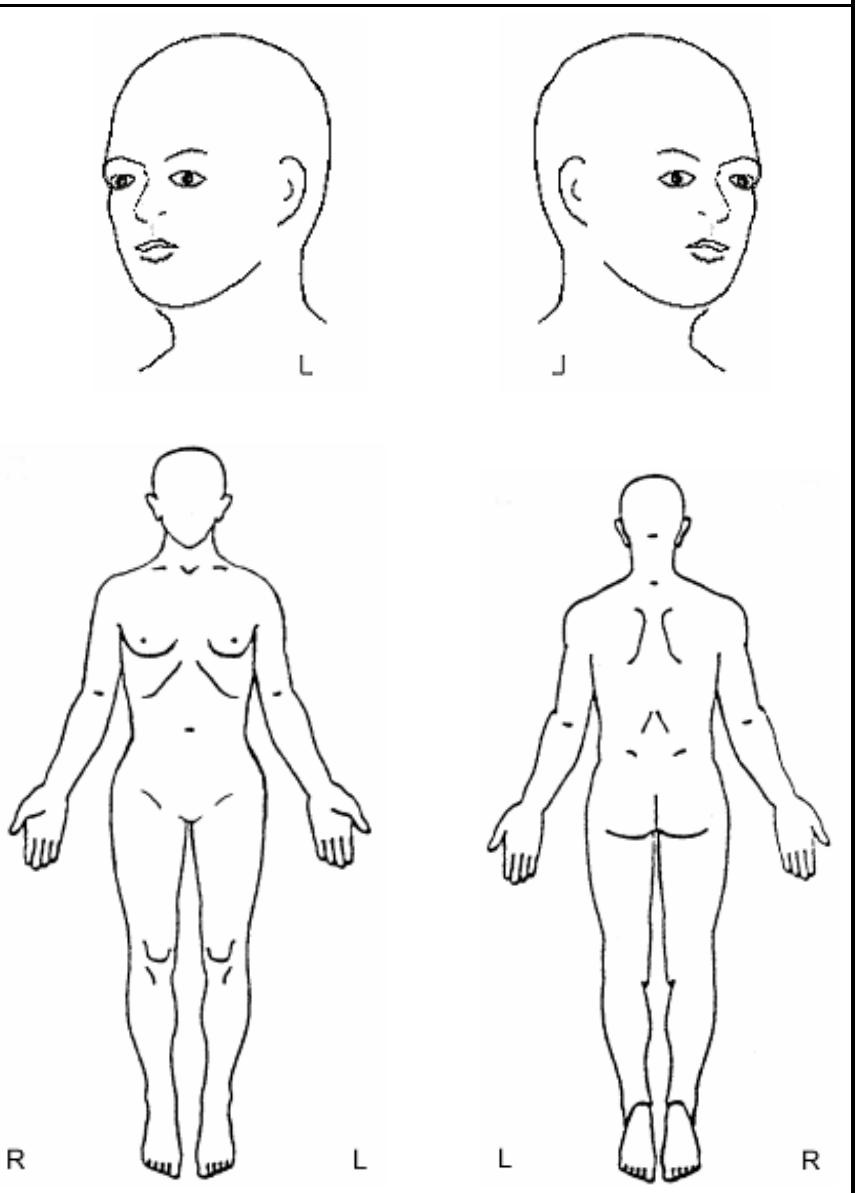
Chest

Heart

Abd

Extremities

Neuro/Mental status



BODY / FACE INJURY PHOTOS ☐ None

☐ Photo of ID label taken

☐ Digital ☐ 35 mm ☐ Poloroid

Taken by:

CODE FOR DRAWING INJURIES

A = abrasion	**R** = Redness
B = Bite	**S** = Swelling
C = Contusion / bruise (indicate color/size)	**T** = Tenderness
L = Laceration (indicate size)	**SS =** Skin swab locations

Examiner name (print)	Examiner signature	Date

HOSPITAL #

NAME

DOB

SEXUAL ASSAULT REPORT

□ Speculum used □ Speculum not used

Vulva

Urethra/Periurethra

Posterior fourchette/Fossa

Hymen

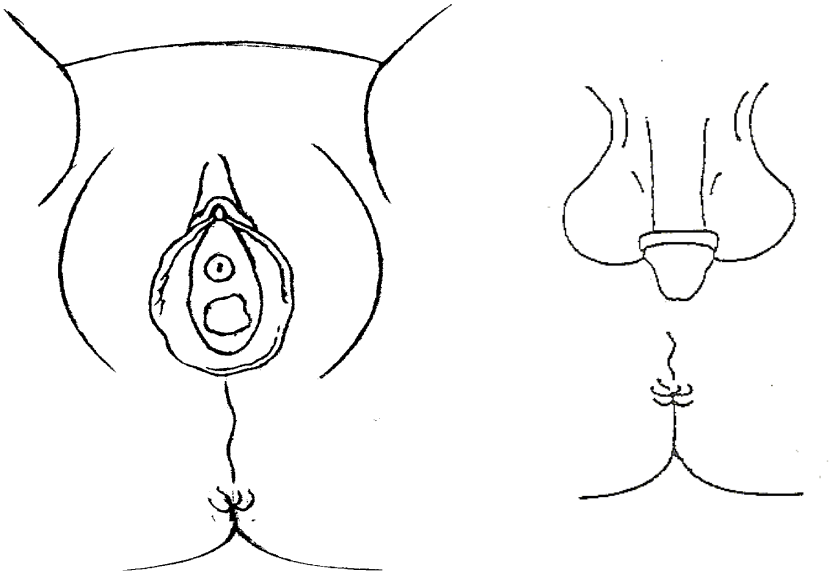
Vagina

Cervix

Uterus/adnexa
□ Bimanual not done

Perineum

Anus



COLPOSCOPY/ MAGNIFIED PHOTOS □ None
□ Photo of ID label taken □ Digital □ 35 mm □ Poloroid
Taken by:

A = abrasion
B = Bite
C = Contusion / bruise (indicate color/size)
L = Laceration (indicate size)
R = Redness
S = Swelling
T = Tenderness
SS = Skin swab locations

LAB

□ Pregnancy test Results _____
□ Gonorrhea □ Chlamydia
□ Tox screen □ Other

NOTES/ PROTOCOL DEVIATIONS

□ see continuation page

ASSESSMENT

1. _____
(History, concern, report of sexual assault)

2. _____
(Acute physical findings)

3. _____
(Other findings / medical conditions)

4. Evidence collected
□ Sexual assault kit □ Clothing □ Other □ None

5. Discharge/personal safety plan

Time spent with patient/ family _____ hr

MEDICATIONS

Allergies □ None known

Indication	Medication/Dose	Initials
Chlamydia prophylaxis	□ Azithromycin 1 gm po	
Gonorrhea prophylaxis	□ Ciprofloxacin 400 mg po <OR> □ Ceftriaxone 125 mg IM <OR>	
Emergency contraception (2^{nd} dose in 12 hours)	□ Levonorgestral (Plan B) 0.75 mg x 2 PO	
Hepatitis B Vaccine	□ Hep B Vac. 1.0 ml IM deltoid	
Open wound (s) No tetanus imuz >5 years	□ Tetanus toxoid 0.5 ml IM	
Other		

Examiner | Signature | Date/Time

HOSPITAL #

NAME
DOB

SEXUAL ASSAULT REPORT