

Name	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Age	Time	Date
Hospital Number				
Police Report Made <input type="checkbox"/> Yes <input type="checkbox"/> No	Phone		Alternate Phone	
Police Department	Case #	Accompanied by		Relationship
CPS Report <input type="checkbox"/> Yes <input type="checkbox"/> No	Interpreter <input type="checkbox"/> Yes <input type="checkbox"/> 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 _____
<input type="checkbox"/> 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#
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STAFF INVOLVED IN MEDICAL CARE

Print name	Title	Department	Date

HOSPITAL #

NAME

DOB

SEXUAL ASSAULT REPORT

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 _____		TIME SINCE ASSAULT _____ hrs /days (circle one) <input type="checkbox"/> Unk		
Age of alleged <input type="checkbox"/> Adult <input type="checkbox"/> Teen (13-17) <input type="checkbox"/> Child <input type="checkbox"/> Unk		Yes	No	Unk
RELATIONSHIP	<input type="checkbox"/> Friend/acquaintance <input type="checkbox"/> Stranger	Ejaculation? Site _____	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Spouse current/ex <input type="checkbox"/> Unknown/unsure	Condom used?	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/> Partner current/ex <input type="checkbox"/> Other	FORCE/COERCION		
	<input type="checkbox"/> Relative	Threat to harm	<input type="checkbox"/>	<input type="checkbox"/>
TYPE OF CONTACT (by assailant to victim)		Restrained	<input type="checkbox"/>	<input type="checkbox"/>
<u>Penis</u> to	<input type="checkbox"/> Vagina <input type="checkbox"/> Mouth <input type="checkbox"/> Anus <input type="checkbox"/> Other	Weapon If yes, specify:	<input type="checkbox"/>	<input type="checkbox"/>
<u>Mouth</u> to	<input type="checkbox"/> Vagina <input type="checkbox"/> Anus <input type="checkbox"/> Skin site _____	Choked / strangled	<input type="checkbox"/>	<input type="checkbox"/>
<u>Hand</u> to	<input type="checkbox"/> Vagina <input type="checkbox"/> Anus <input type="checkbox"/> Skin <input type="checkbox"/> Other	Hit kicked thrown	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Foreign object/Other contact		Bitten (human bite)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Not known OR /not able to report		Exploitation (abuse of authority / peer stress)	<input type="checkbox"/>	<input type="checkbox"/>
		Perceived life threat	<input type="checkbox"/>	<input type="checkbox"/>
Examiner Name (print)		Signature		Date

HOSPITAL #

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SEXUAL ASSAULT REPORT

MENTAL STATUS	Yes	No	Unknown /Unsure	REVIEW OF SYSTEMS	Yes	No	Unknown /Unsure
Alert and oriented x3 If no, describe				Skin injury/pain			
Impaired consciousness ("out of it") before assault				Limb pain/injury			
Loss of memory of assault events				Headache			
Partial memory of assault events				Neck/ throat pain			
Recent voluntary substance use If yes Specify				Difficulty swallowing			
Suspects "date-rape" drug				Difficulty breathing at assault/ now			
Forced drug? <input type="checkbox"/> Oral <input type="checkbox"/> Injected Describe				Nausea/vomiting			
POST ASSAULT ACTIVITY DID PATIENT				Abdominal pain			
Rinse mouth /eat/ drink				Vaginal bleeding			
Bathe / shower				Menstruating now?			
Urinate				Rectal bleeding			
Defecate				Other			
Douche				PAST MEDICAL HISTORY			
Take any medication or substances If yes, describe				Significant past medical history/chronic illnesses/hospitalizations			
Change clothes				Primary medical provider			
Bring clothes worn at assault?				Current medications			
Give clothes to police at scene				Hepatitis vaccine <input type="checkbox"/> Completed 3 doses <input type="checkbox"/> Not completed/known			
Were clothes damaged in assault? If yes, describe:				ALLERGIES TO MEDICATION <input type="checkbox"/> None			
PEDIATRIC ADDITIONAL HISTORY				OB/GYN HISTORY			
Child resides with				Gravida _____ Para _____			
Prior or current CPS involvement <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Describe				Past surgery/disease			
Other children at risk				CURRENT CONTRACEPTION			
				<input type="checkbox"/> None <input type="checkbox"/> Condom			
				<input type="checkbox"/> Depo provera Last dose date _____			
				<input type="checkbox"/> Tubal ligation <input type="checkbox"/> OC's No Missed pills			
				<input type="checkbox"/> Other			
Child interviewed by medical staff <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, attach near-verbatim record				Last menstrual period			
				Last consensual intercourse _____ days weeks months			
				<input type="checkbox"/> Not known <input type="checkbox"/> No prior intercourse			
Examiner Name (print)		Signature			Date		

HOSPITAL #

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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

B = Bite

C = Contusion / bruise
(indicate color/size)

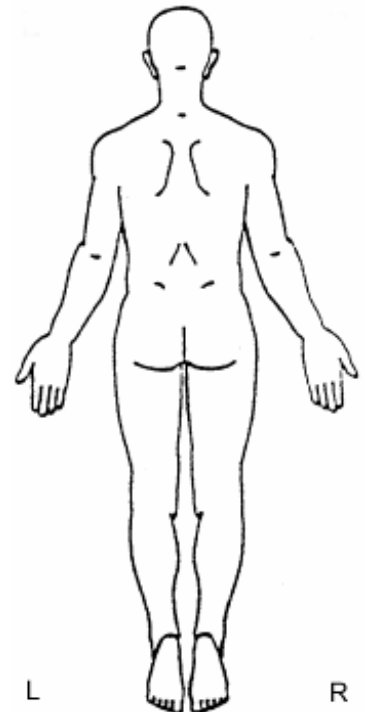
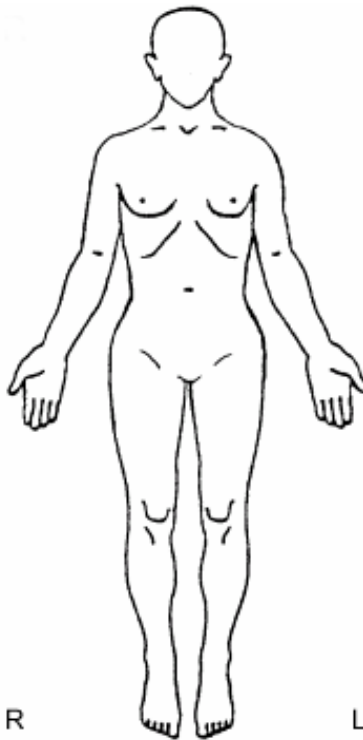
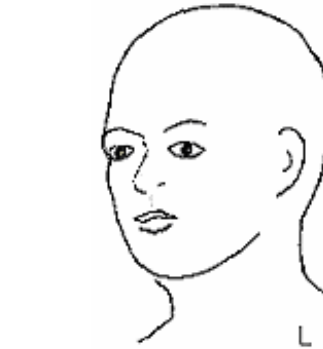
L = Laceration
(indicate size)

R = Redness

S = Swelling

T = Tenderness

SS = Skin swab locations



Examiner name (print)

Examiner signature

Date

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SEXUAL ASSAULT REPORT

