A. General Information

Exam Date: _____ Exam Location:_____ Room:_____

1. Name of Patient Kit number

2. Address City County State Phone

3. Age Date of Birth Gender Ethnicity

B. Jurisdiction

City or County: Reported? Y / N If no, do you want to report? Y / N

Officer/Detective: Advocate: Case number:

C. Patient Consent

____ I have been informed that this examination will be eligible for payment by Idaho State Crime Victims Compensation (CVC)Fund and that I may apply for further CVC financial assistance for medical and counseling expenses, loss of wages and job re-training.

____ I consent to Sexual Assault Examination, and understand that I may refuse any part of this examination at any time.

____ I consent to a Sexual Assault Kit collection potentially including: swabs and blood sample for DNA evidence

____I consent to the collection of urine and blood to test for alcohol or drugs I have taken, or may have been given

____ I consent to photographs of injuries, including photographs of genital (private parts) and anal areas (for documentation and peer review); and to the release of these, to investigating authorities only if requested.

____ I consent to blood and/or urine sampling for sexually transmitted diseases and pregnancy testing (if applicable)

____ I request medications for the prophylaxis of sexually transmitted diseases and/or pregnancy prevention.

____I understand that this record will be reviewed for process improvement and training purposes.

____ I consent to the release of this medical record to law enforcement. **OR**

____ I do not consent to the release of this medical record to law enforcement.

_____ ☐ ☐ ☐

Signature Date Patient Parent Guardian

_____

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Witness Signature Date

D. Medications and Allergies

1. Allergies: □ No Known Drug Allergies

2. Medications: □ No home medications

Contraceptives: □ None □ Oral contraceptive: Missed doses? _____ □IUD x____ yrs □ Condoms
□ Depo-Provera: Last dose _____ □ Contraceptive implant x ____ yrs □ Other method _____

E. Diagnostics/ Treatment

1. Lab Testing performed

	Pregnancy Urine/Blood + or -		GC/Chlamidia
			Syphilis

2. Prophylactic Medications

	Azithromycin ☐ 1 gram PO ☐ 2 gram PO	
	Ceftriaxone ☐ 500 mg IM ☐1000 mg IM	Injection site:
	Metronidazole (Flagyl) 2 grams PO	If ETOH in last 24 hours: Dispense to take at home ☐
	Promethazine 12.5mg or 25mg	
	Ondansetron (Zofran) 4 mg PO	
	Plan B levonorgestrel 1.5mg	
	Other:	

F. Patient History

1. Name of person providing history: Relationship to patient:

2. Medical/Surgical/Mental Health History:

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3. Any recent (60 days) anal-genital injuries, surgeries, diagnostic procedures, or medical treatments that may affect the interpretation of current physical findings?

6. Any other recent pre-existing physical injuries, prior to assault?

7. Menstrual history:

LMP:	Menstrual cycle comments:

8. OB history:

Gravida:	Para:	Abortion:

9. Bowel history:

Diarrhea: Y / N	Constipation Y / N	Hemorrhoids Y / N	Last Bowel Movement:

10. Hepatitis B:

Completed vaccinations #	History of infections Y / N	Unknown

11. Any previous history of sexual assault, rape and/or domestic violence?

G. Consensual Sexual Activity History:

Last consensual Sexual Activity:

Date/time:
Was consensual partner Assailant? Yes / No

H. Impairment:

Impaired consciousness at time of assault? □ Asleep □ Substance □ Other					Yes	No	Unsure
Memory loss for assault event? □ Partial □ Total					Yes	No	Unsure
Involuntary ingestion of alcohol?	Yes	No	Unsure	Involuntary ingestion of drugs?	Yes	No	Unsure
Recent voluntary substance use:					Yes	No	Unsure

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Date/Time:	Type/amount:

I. Post-assault hygiene/activities

Urinated	Yes	No		Oral gargle /rinse	Yes	No	
Defecated	Yes	No		Brushed Teeth	Yes	No	
Vomited	Yes	No		Ate and/or drank	Yes	No	
Genital Wipe	Yes	No		Inserted anything into vagina	Yes	No	N/A
Douched	Yes	No	N/A	Removed anything from vagina	Yes	No	N/A
Bath/Shower	Yes	No		Changed clothing	Yes	No	

J. Assault history/narrative

1. Date of Assault(s): Time of Assault(s):

2. Site:

Own home	Other home	Vehicle	Outdoors	Unknown
Address if known for safety planning:				

3. Pertinent Physical Surroundings of Assault(s) that may have contributed to injury:

4. Patient's own verbal account of assault:

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☐ See attached **Addendum (4B**) for typed or handwritten nursing note.

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K. Acts Described by the Patient

Any penetration of the genital or anal opening, however slight, constitutes the act. If more than one assailant, identify by number.

1. Penetration of vagina by:

Penis	Yes	No	Unsure
Finger	Yes	No	Unsure
Object	Yes	No	Unsure
If yes, describe object:			

2. Penetration of anus by:

Penis	Yes	No	Unsure
Finger	Yes	No	Unsure
Object	Yes	No	Unsure
If yes, describe object:			

3. Oral copulation of genitals: (requires only contact)

Of patient by assailant	Yes	No	Unsure
Of assailant by patient	Yes	No	Unsure

4. Oral copulation of anus: (requires only contact)

Of patient by assailant	Yes	No	Unsure
Of assailant by patient	Yes	No	Unsure

5. Non-genital act(s): Where on the body?

Licking	Yes	No	Unsure	
Kissing	Yes	No	Unsure	
Sucking	Yes	No	Unsure	
Biting	Yes	No	Unsure	
Injury	Yes	No	Unsure	
Other	Yes	No	Unsure	

6. Did ejaculation occur?

Yes	No	Unsure	If yes, where?

7. Contraceptive or Lubricants:

Condom	Yes	No	Unsure
Lubricant	Yes	No	Unsure
Foam	Yes	No	Unsure
Jelly	Yes	No	Unsure
Saliva	Yes	No	Unsure

8. Methods used by Assailant(s): Details/location noted:

Weapons	Yes	No	Unsure	
Slap	Yes	No	Unsure	
Closed fist punch	Yes	No	Unsure	
Grabbing/Holding	Yes	No	Unsure	
Physical Restraints	Yes	No	Unsure	
Pressure to Neck	Yes	No	Unsure	
Burns (chemical/thermal)	Yes	No	Unsure	
Threat(s) of harm	Yes	No	Unsure	
Other methods	Yes	No	Unsure	

9. Were injuries inflicted upon the assailant(s) during the assault?

Yes	No	Unsure	If yes, describe injuries, locations and how they were inflicted:

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L. General Physical Examination

Present for Exam:	Stated Height: Weight:
General appearance:	
General demeanor:	

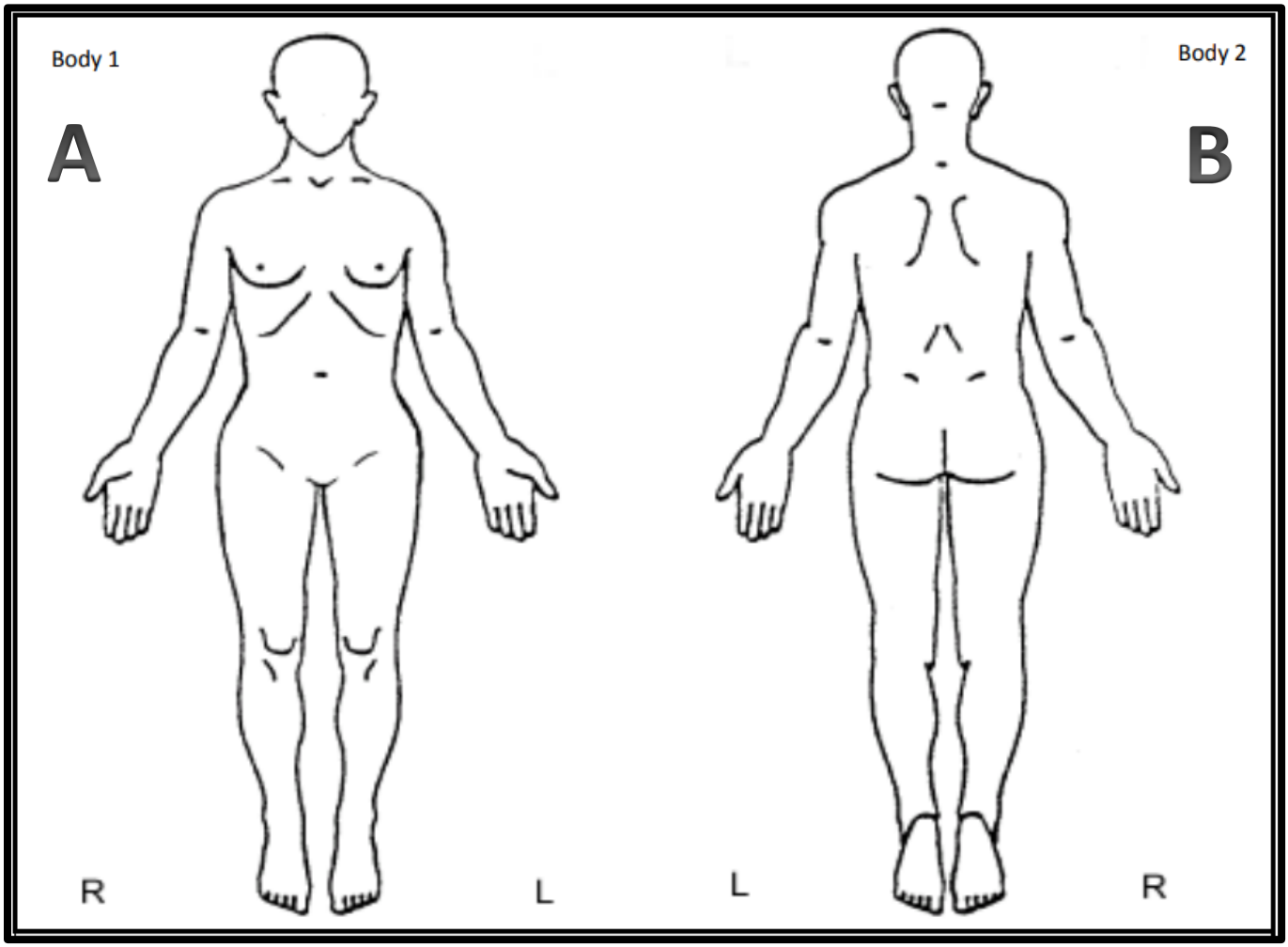
Trauma Response Behaviors Observed			
	None		Giddy Affect
	Limited Eye Contact		Laughing/joking
	Poor Linear Recall		Guarded
	Hesitancy		Easily startled
	Fragmented Recall		Jumpy
	Flat/Blunted Affect		

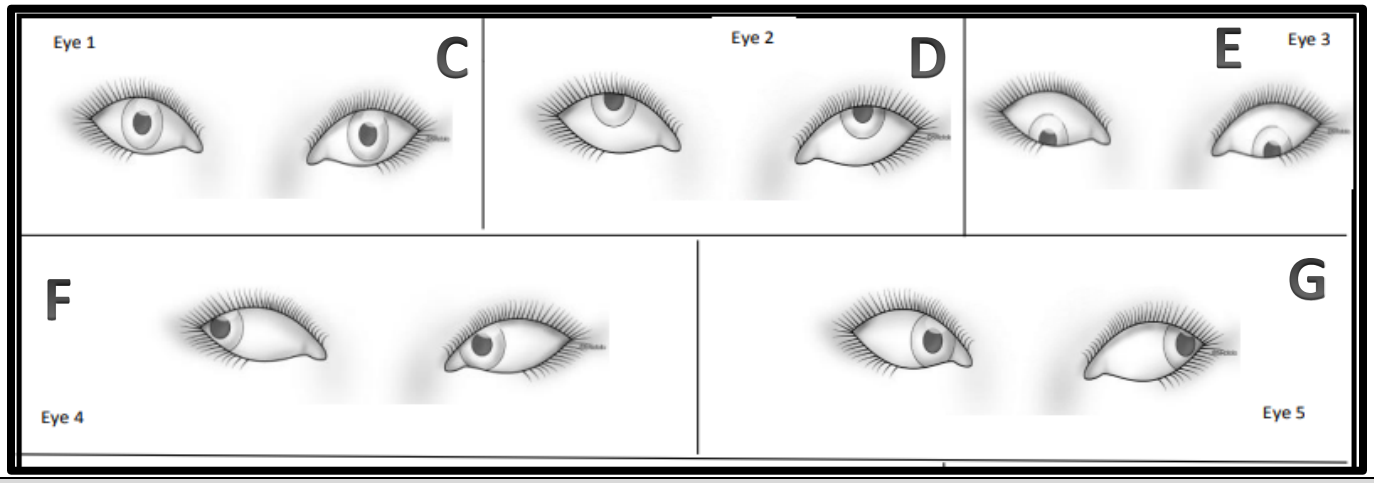
Sexual Maturity Rating

Stages		**Pubic Hair Scale**		**Breast Development**		**Male Genitalia**
Stage 1		No hair		No glandular tissue		
Stage 2		Downy Hair		Breast bud under areola		4-8ml/2.5 to 3.3 cm long
Stage 3		Scant terminal Hair		Breast tissue outside areola		9-12ml/3.4 to 4.0 cm long
Stage 4		Terminal hair fills pubic triangle		Areola elevated above the contour of the breast		15-20ml/4.1 to 4.5 cm long
Stage 5		Terminal hair extends beyond inguinal crease		Areola mound recedes into breast contour, nipple		>20ml/> 4.5 cm long

Vital Signs					
Time	BP:	Temp:	Pulse:	Resp:	O2sat:

General Physical Exam	Pelvic/Genital Exam
Skin: □ Warm dry no acute injury □ Injuries: See body map documentation	□ Speculum □ Foley balloon □ Anoscope
Head: □ Non tender, no visible injuries □ Injuries: See body map documentation	Exam position/ methods: Supine: □ Separation □ Traction □ Knee chest Prone: □ Separation □ Traction □ Knee chest Side lying L / R: □ Separation □ Traction □ Direct visualization □ Other_____
Ears: □ No visible injuries □ Injuries: See body map documentation	Posterior fourchette/fossa: □ No acute injury □ Injuries: See body map documentation
Eyes: □ Clear, without petichiae/hemorrhage □ Injuries: See body map documentation	Hymen: □ No acute trauma noted □ Injuries: See body map documentation
Mouth: □ Mucosa WNL □ No lesions/frenulum intact □ Injuries: See body map documentation	Vagina: □ Normal rugae □ No acute injury visible □ Injuries: See body map documentation
Neck: □ Supple, full range of motion □ Injuries: See body map documentation	Cervix: □ No acute trauma □ Not visualized □ Injuries: See body map documentation
Chest: □ CTA, no visible injury □ Injuries: See body map documentation	Perineum: □ No acute injury visible □ Injuries: See body map documentation
Abdomen: □ Soft non-tender, no visible injury □ Injuries: See body map documentation	Anus: □ Normal folds □ No acute injury visible □ Injuries: See body map documentation
Back: □ No visible injury □ Injuries: See body map documentation	Scrotum: □ No acute trauma visible □ Injuries: See body map documentation
Extremities: □ Non-tender, no visible injury □ Injuries: See body map documentation	Penis: □ No acute injury Circumcised? □ Yes □ No □ Injuries: See body map documentation
☐ Strangulation Addendum Indicated: See attached	





Types of Findings		
AB: Abrasion	EC: Ecchymosis	PE: Petechiae
BI: Bite	ER: Erythema/redness	SW: Swelling
BU: Burn	FB: Foreign body	TE: Tenderness
BR: Bruise (color/size)	IN: Induration	
DE: Debris	IW: Incised wound	ALS: Alternate light source finding
DS: Dry secretion	LA: Laceration (size)	SS: Skin swab location (Indicate suspected fluid type)
MS: Moist secretions	OI: Other injury	

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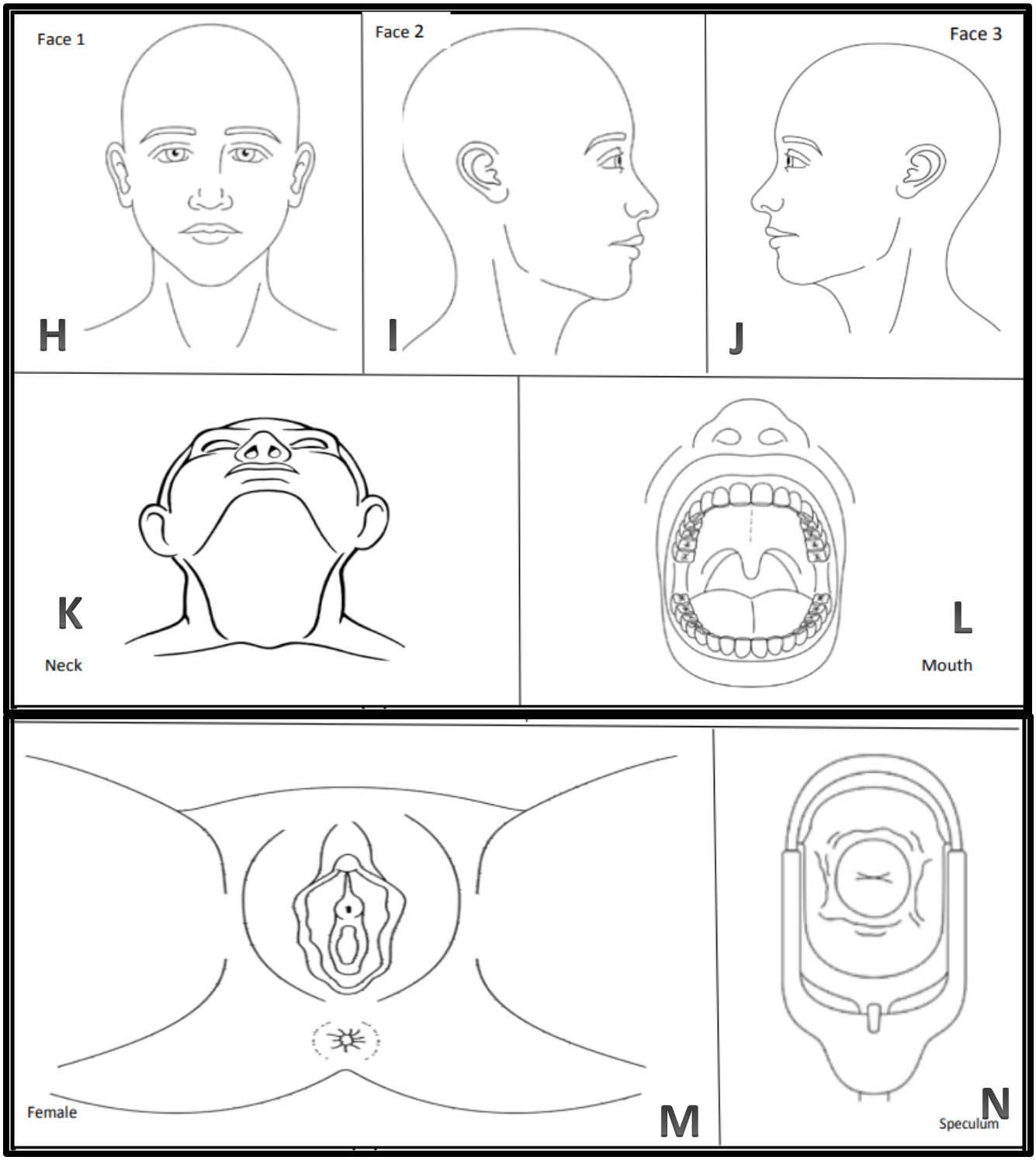

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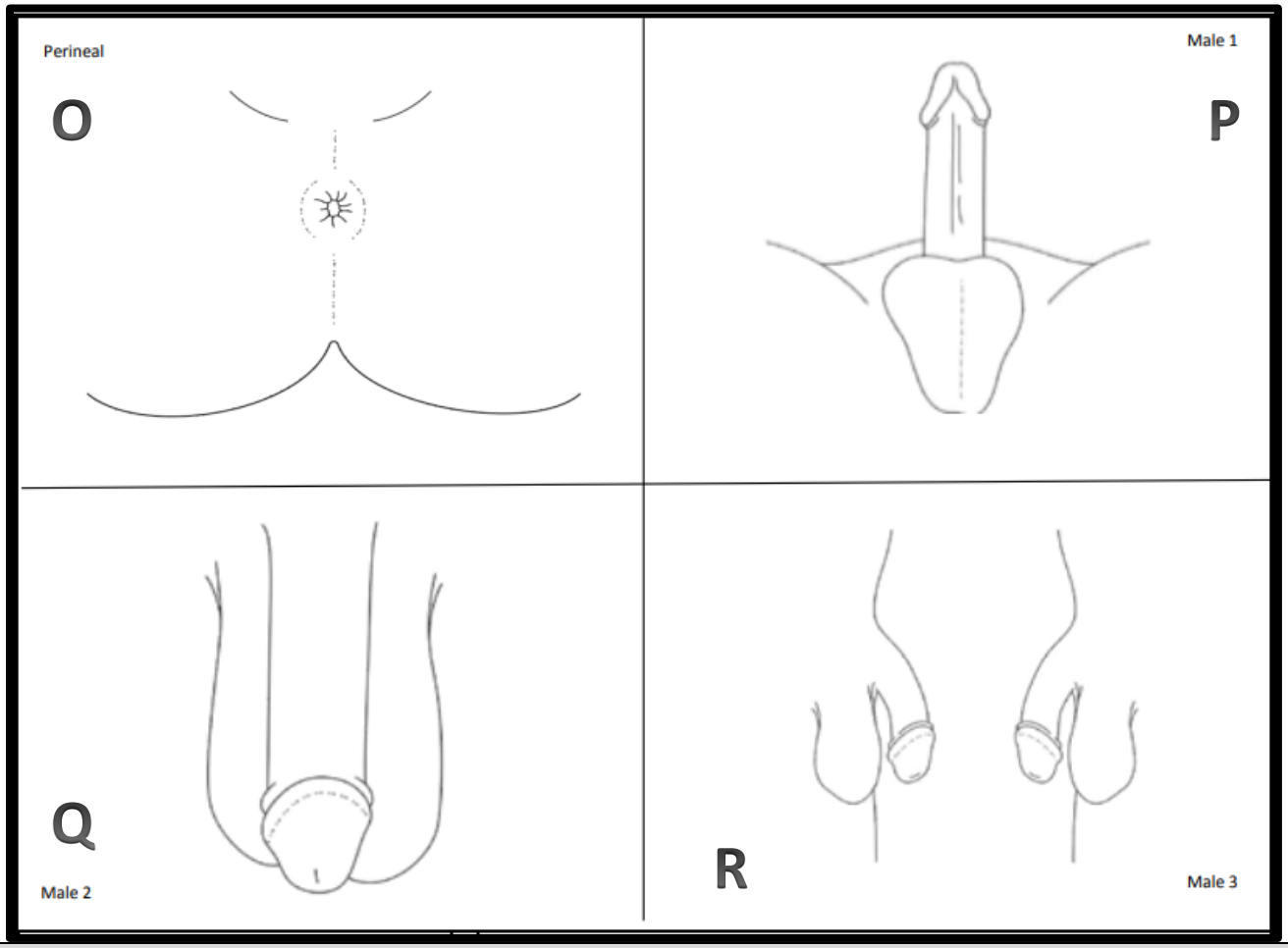

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Locator site map and #	Type	Description	Photo

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Locator site map and #	Type	Description	Photo

M. Evidence Collected and Submitted

1. Clothing Placed in evidence bags by:

Clothing Collected	Condition of Clothing

2. Foreign materials collected Describe, if needed

Dried secretions	Yes	No	N/A	
Fiber/loose hairs	Yes	No	N/A	
Vegetation (soil/debris)	Yes	No	N/A	
Fingernail swabs	Yes	No	N/A	
Matted hair cuttings	Yes	No	N/A	
Pubic hair combings	Yes	No	N/A	
Intra-vaginal foreign body	Yes	No	N/A	
Intra-anal foreign body	Yes	No	N/A	

3. Swabs samples: Collection of swabs determined by medical history.

Expected # of swabs	# of swabs collected	NA	Notes/Reason not collected
Oral 4			
Peri-oral 2			
Neck 2			
Breasts 2			
Abdomen 2			
External Genitalia 2			
Vaginal 4			
Anus 4			
Inner thighs 2			
Other			
Other			
Other			

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7. Toxicology samples: Yes No

Urine ☐ Time collected:_____ Collected by: _____	Blood ☐ Time collected:_____ Collected by:_____

8. Photo Documentation ☐ CortexFlo

Date and Time on Camera: _____	Number of images
Other	

N. Discharge/ Safety Planning

1. Suicide Risk Assessment Tool

COLUMBIA-SUICIDE SEVERITY RATING SCALE	Past Month	
Begin with Questions 1 and 2	**YES**	**NO**
1) Have you wished you were dead or wished you could go to sleep and not wake up?		
2) Have you actually had any thoughts of killing yourself?		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) Have you been thinking about how you might do this?		
4) Have you had these thoughts and had some intention of acting on them?		
5) Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?		
6) Have you ever done anything, started to do anything, or prepared to do anything to end your life?		
If YES, ask: Was this within the past three months?		
☐ Low Risk ☐ Moderate Risk ☐ High Risk		

2. Lethality/Danger Assessment Tool: See IRAD □ Per Advocate □ Not Indicated □

_____

_____

_____

3. Safety Plan: Per Advocate □

_____

_____

Assailants:

Name	Gender	Ethnicity	Known to Patient?
1.			Known / Unknown
2.			Known / Unknown
3.			Known / Unknown

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7. Safe patient phone number for Advocate to call: _____

Code word: _____

8. Discharge instructions sent:

☐ Sexual Assault ☐ Intimate Partner Violence

☐ Strangulation ☐ Medications

☐ Other _____

9. Referrals:

_____

_____

_____

O. Personnel Involved

1. History taken by: _____

Exam performed by: _____

Specimens labeled and sealed by: _____

Signature of Sexual Assault Examiner: _____

Signature of assistant: _____

2. Evidence Distribution

Signature of Officer Receiving Evidence Date Time Agency

Collection Chain of Custody Checklist:

Evidence Kit	
Clothing bags	
Urine Toxicology	
Blood Toxicology	
Copy of Chart	

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