Sample Consent/Refusal and Evidentiary Log

Adapted from a form developed by St. Luke's-Roosevelt Hospital Center

Date: _____ Time of Exam: _____ AM/PM

Patient Name: _____ Contact No.: _____

S.A.F.E. * Examiner(s) 1) _____ Contact No.: _____

2)_____ Contact No.: _____

Provider: _____Dept.: _____ Contact No.: _____
(If not a S.A.F.E.* Examiner)
*Sexual Assault Forensic Examiner

Patient Consent/Refusal

I understand that if I consent, an examination for evidence of sexual assault and collection of possible evidence will be conducted. I understand that I may refuse to consent, or I may withdraw consent at any time for any portion of the examination. I understand that the collection of evidence may include photographing injuries, which may include injuries to the genital area. I understand that if I consent, such evidence will be released to the police now. If I do not consent to release of evidence now, such evidence will be preserved at the Hospital for not less than 30 days.

I consent to:

Physical Examination:	_____Yes	_____No
Photographing of Injuries:	_____Yes	_____No
Collection of Evidence:	_____Yes	_____No
Release of Evidence to Police:	_____Yes	_____No
Verbal Communications by Hospital Personnel with Prosecutorial Agency:	_____Yes	_____No

Signature of Patient_____Date_____

Signature of Witness_____Date_____

Print Name of Witness_____

LOG OF ITEMS TAKEN FROM PATIENT FOR EVIDENCE

1)	4)
2)	5)
3)	6)

COMPREHENSIVE SEXUAL ASSAULT ASSESSMENT FORM

PLEASE PRINT CLEARLY

1. INITIAL ASSESSMENT

Date of Birth: _____ _____Male _____Female

__African Descent __Asian/Pacific Islander __Caucasian __Hispanic Other_____

Physical Disability: ___Yes __No If Yes describe_____

Primary Language if not English _____ Was interpreter used _____

2. PERTINENT PAST MEDICAL HISTORY

_____

LMP: _____ Allergies_____

Medications: _____

Last Tetanus Immunization: _____ Hepatitis B Immunization Yes No If yes date_____

3. SEXUAL ASSAULT HISTORY

Date of Sexual Assault: _____ Time of Sexual Assault: _____ AM/PM

Time Elapsed between Assault and Exam: _____days _____hours

Location of Sexual Assault (include exact address if known): _____

_____

Type of Violations Perpetrated against Survivor during Sexual Assault:

Vaginal Contact	Yes	No	Unsure	Oral Contact (offender to survivor)	Yes	No	Unsure
Anal Contact	Yes	No	Unsure	Oral Contact (survivor to offender)	Yes	No	Unsure
Condom Used	Yes	No	Unsure				
Use of Foreign Object	Yes	No	Unsure	If Yes describe_____			
Foam/Jelly/Lubricant	Yes	No	Unsure	If Yes describe_____			
Use of Weapon	Yes	No	Unsure	If Yes describe_____			

Other: _____

Brief Narrative of Assault (optional)_____

_____

Actions Before or After Assault

Has the survivor had consensual sex within the last 96 hours? Yes No Unsure If Yes when: _____

After the sexual assault, has the survivor:

Urinated?	Yes	No	Bathed/showered?	Yes	No	Changed underwear?	Yes	No
Defecated?	Yes	No	Douched?	Yes	No	Changed clothes?	Yes	No
Vomited?	Yes	No	Brushed teeth?	Yes	No	Changed sanitary product?	Yes	No
			Used mouthwash?	Yes	No	Other: _____		

4. PHYSICAL EXAMINATION General Appearance

General Medical Examination (use Traumagram on pages 6,7,8 as appropriate)

Colposcopy Examination – to be completed prior to pelvic exam and forensic evidence collection
(use Traumagram on pages 6,7,8 as appropriate)

Female

Labia majora_____ Vagina_____

Labia minora_____ Hymen_____

Clitoris_____ Cervix_____

Posterior fourchette_____ Perineum_____

Fossa navicularis_____ Anus_____

Periurethral_____ Rectum_____

Vestibule_____ Other_____

Male

Penis_____ Rectum_____

Perineum_____ Scrotum_____

Anus_____ Other_____

Pelvic/Genital Examination

Female

Labia majora_____ Vagina_____

Labia minora_____ Hymen_____

Clitoris_____ Cervix_____

Posterior fourchette_____ Perineum_____

Fossa navicularis_____ Anus_____

Periurethral_____ Rectum_____

Vestibule_____ Other_____

Male

Penis_____ Rectum_____

Perineum_____ Scrotum_____

Anus_____ Other_____

5. EXAMINATION TECHNIQUES

Direct Visualization	Yes	No	Evidence Kit Collected	Yes	No	
Bimanual Exam	Yes	No	Photos Taken	Yes	No	If Yes How many? _____
Speculum Exam	Yes	No	Area(s) of Body Photographed: _____			
Colposcopic Exam	Yes	No	_____			
Toluidene Blue	Yes	No	_____			
Wood's Lamp	Yes	No	_____			
Anoscope	Yes	No	_____			

6. DIAGNOSTIC TESTS

Pregnancy Test	Yes	No	Chlamydia	Yes	No
Gonorrhea: Cervical	Yes	No	VDRL	Yes	No
Urethral	Yes	No	Hepatitis B Serologies	Yes	No
Rectal	Yes	No	Specimens (urine and/or blood for diagnosis of drug-facilitated		
Pharyngeal	Yes	No	sexual assault)	Yes	No

7. STI PROPHYLAXIS

Gonorrhea Yes No Chlamydia Yes No Trichomonas/BV Yes No Hepatitis B Yes No

8. HIV POST-EXPOSURE PROPHYLAXIS

Referral Sheet Completed (see next page) Yes No

9. POST-COITAL CONTRACEPTION

Yes No

10. REFERRALS GIVEN

Rape Crisis or Crime Victims Treatment Center ___ Gyn Clinic___ Patient's Primary Care MD___

11. CHAIN OF CUSTODY

Name of Person Receiving Evidence_____

ID#/Shield#_____

Agency_____

ADDITIONAL NOTES OR COMMENTS

PROVIDER SIGNATURE

SAMPLE SEXUAL ASSAULT PATIENT HIV PEP: REFERRAL SHEET

PLEASE PRINT CLEARLY

Patient Name: _____

Patient MR#: _____ Age of Patient: _____

Date of Assault: _____ Time of Assault: _____

Date of Emergency Department Visit: _____

Date of Patient's Follow-up Appointment: _____

Time 1st Dose of PEP Given: _____ Date (if different from ED Visit): _____

PEP Medications Given: _____

Labs Sent: CBC ☐ Yes ☐ No Chem 18 (Admission Panel) ☐ Yes ☐ No
Hepatitis B serology ☐ Yes ☐ No
Hepatitis C serology ☐ Yes ☐ No
Urine pregnancy test result: ☐ Positive ☐ Negative

Patient Rx'ed for GC, Chlamydia and Syphilis: ☐ Yes ☐ No Hep B Vaccine: ☐ Yes ☐ No

Emergency Contraception Provided: ☐ Yes ☐ No

Check here if patient requests **HIV testing only** (without HIV PEP): ☐

Provider Name: _____ ☐ MD ☐ PA ☐ NP ☐ RN
(Please print)

NOTE: Arrange for timely referral to clinic or provider for HIV PEP management.

Referral made to: _____