Sample Form For Consent/Refusal and Evidentiary Log
*Adapted from a form developed by St. Luke’s-Roosevelt Hospital Center

<table>
<thead>
<tr>
<th>Date:_______________</th>
<th>Time of Exam:_______________AM/PM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name:_________________________</td>
<td>Contact No.:_________________________</td>
</tr>
<tr>
<td>SAFE * 1)_________________________</td>
<td>Contact No.:_________________________</td>
</tr>
<tr>
<td>Examiner(s) 2)_________________________</td>
<td>Contact No.:_________________________</td>
</tr>
<tr>
<td>Provider: ___________________________ Dept.:__________</td>
<td>Contact No.:_________________________</td>
</tr>
<tr>
<td>(If not a SAFE* Examiner) *Sexual Assault Forensic Examiner</td>
<td></td>
</tr>
</tbody>
</table>

**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 at this time. If I do not consent to release of evidence at this time, 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**

<table>
<thead>
<tr>
<th>1)</th>
<th>4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2)</td>
<td>5)</td>
</tr>
<tr>
<td>3)</td>
<td>6)</td>
</tr>
</tbody>
</table>
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
4. PHYSICAL EXAMINATION  General Appearance

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

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

<table>
<thead>
<tr>
<th>Female</th>
<th>Vagina</th>
<th>Hymen</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labia majora</td>
<td>Labia minora</td>
<td>Clitoris</td>
</tr>
<tr>
<td>Labia minora</td>
<td>Clitoris</td>
<td>Posterior fourchette</td>
</tr>
<tr>
<td>Clitoris</td>
<td>Posterior fourchette</td>
<td>Fossa navicularis</td>
</tr>
<tr>
<td>Periurethral</td>
<td>Fossa navicularis</td>
<td>Vestibule</td>
</tr>
<tr>
<td>Vestibule</td>
<td>Rectum</td>
<td>Anus</td>
</tr>
<tr>
<td>Other</td>
<td>Other</td>
<td>Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Male</th>
<th>Rectum</th>
<th>Scrotum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Penis</td>
<td>Perineum</td>
<td>Anus</td>
</tr>
<tr>
<td>Perineum</td>
<td>Anus</td>
<td>Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pelvic/Genital Examination</th>
<th>Female</th>
<th>Vagina</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labia majora</td>
<td>Labia majora</td>
<td></td>
</tr>
<tr>
<td>Labia minora</td>
<td>Labia minora</td>
<td></td>
</tr>
<tr>
<td>Clitoris</td>
<td>Clitoris</td>
<td></td>
</tr>
<tr>
<td>Posterior fourchette</td>
<td>Posterior fourchette</td>
<td></td>
</tr>
<tr>
<td>Fossa navicularis</td>
<td>Fossa navicularis</td>
<td></td>
</tr>
<tr>
<td>Periurethral</td>
<td>Periurethral</td>
<td></td>
</tr>
<tr>
<td>Vestibule</td>
<td>Rectum</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Male</th>
<th>Rectum</th>
<th>Scrotum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Penis</td>
<td>Rectum</td>
<td>Scrotum</td>
</tr>
<tr>
<td>Perineum</td>
<td>Scrotum</td>
<td></td>
</tr>
<tr>
<td>Anus</td>
<td>Other</td>
<td>Other</td>
</tr>
</tbody>
</table>
### 5. EXAMINATION TECHNIQUES

<table>
<thead>
<tr>
<th>Examination</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Visualization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bimanual Exam</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Speculum Exam</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Colposcopic Exam</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Toluidene Blue</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Wood’s Lamp</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Anoscope</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

#### Evidence Kit Collected
- Yes
- No
- If Yes
- Photos Taken
- Yes
- No
- How many?___________

#### Area(s) of Body Photographed:
- _________________________________________________________
- _________________________________________________________
- _________________________________________________________
- _________________________________________________________

### 6. DIAGNOSTIC TESTS

<table>
<thead>
<tr>
<th>Test</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy Test</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chlamydia</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Gonorrhea: Cervical</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>VDRL</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Urethral</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Hepatitis B Serologies</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Rectal</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Specimens (urine and/or blood for diagnosis of drug-facilitated sexual assault)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Pharyngeal</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

### 7. STD PROPHYLAXIS

<table>
<thead>
<tr>
<th>STD</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gonorrhea</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Trichomonas/BV</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

### 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
_____________________________________________________________________

Page 4 of 8
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: _______________________________________________
Male Traumagram