

STATE OF VERMONT

Authorization For Reported Collection And Release Of Evidence And Information

I, _____, consent to an examination and collection of evidence concerning sexual assault. This procedure has been fully explained to me, and I understand that this examination will include the collection of other specimens for laboratory analysis and use in court proceedings. Results of the kit analysis can only be released to law enforcement.

I, _____, consent to the taking of photographs as part of the sexual assault evidence collection. I understand that these photographs may be used in court proceedings.

I, _____, authorize _____ and its agents to release the laboratory specimens, medical records, photographs and related information from the sexual assault evidence kit pertinent to this specific visit for sexual assault to the appropriate law enforcement officials, and I herewith release and hold harmless _____ and its agents from any and all liability and claims of injury whatsoever which may in any manner result from the authorized release of such information.

I, _____, give my permission for use of any laboratory specimens and images in research projects, and for educational purposes in which all personal information is removed.

I have been informed that if evidence is found which may contain my assailant's DNA profile, it may be entered into a state and national DNA database. I have also been informed that in the event that evidence collected during this examination results in a match to evidence in an unrelated, unsolved crime, a law enforcement agency may contact me to obtain or seek information about the assault and/or my assailant.

Signature (Parent/Guardian, if applicable)

Witness

Date _____ Time _____ am/pm

Facility _____

Medical Record # _____

Kit# _____

STATE OF VERMONT

**Authorization For Non-Reported Collection And Evaluation Of
Evidence And Information**

I, _____, consent to an examination and collection of evidence related to this sexual assault. This procedure has been fully explained to me. I do not wish to report this assault to law enforcement personnel at this time. I understand that the material collected is considered evidence and may be examined and documented confidentially at the Vermont Forensic Lab. Results of kit analysis can only be released to law enforcement.

I, _____, consent to the taking of photographs as part of the sexual assault evidence collection. I understand that these photographs may be used in court proceedings if I choose to report the assault.

I, _____, give my permission for use of any laboratory specimens and images in research projects, and for educational purposes in which all personal information is removed.

I have been informed that if evidence is found which may contain my assailant's DNA profile, it may be entered into a state and national DNA database. I have also been informed that in the event that evidence collected during this examination results in a match to evidence in an unrelated, unsolved crime, a law enforcement agency may contact me to obtain or seek information about the assault and/or my assailant.

Signature (Parent/Guardian, if applicable)

Witness

Date _____ Time _____ am/pm

Facility _____

Medical Record # _____

Kit# _____

STATE OF VERMONT
SEXUAL ASSAULT PATIENT HISTORY

Name _____ Date of Birth _____ Preferred Gender Pronoun _____

Race: Caucasian Hispanic African-American Other _____

Date and time of assault _____ City/town assault occurred _____

Specify location of assault: House ___ Apartment ___ Dorm ___ Hotel/Motel ___
Other _____

Was the location of assault: Patient's Residence ___ Perpetrator's Residence ___ Unknown ___

Number of assailants _____ Gender(s) M ___ F ___

Relationship(s) to patient: Spouse ___ Relative ___ Acquaintance ___ Date ___ Unknown ___

Assault reported to police by patient: Yes [] No [] Reported by Other _____

Exam Date _____ Time _____

Medication taken within 24 hrs. prior to or after the assault (list name of drug and date/time taken) _____

Current health problems/disabilities/ability to communicate _____

History of anal/genital injury, surgery, diagnostic procedures or medical treatment within 60 days prior to assault? _____

Date of consensual intercourse within 72 hrs. prior to the assault? _____

If yes, was a condom used during consensual intercourse? Yes [] No []

Was a condom used during the assault? Yes [] No [] Unknown []

Was there penile penetration of the vagina? Yes [] No [] Unknown []

Was there penile penetration of the oral cavity? Yes [] No [] Unknown []

Was there penile penetration of the anus/rectum? Yes [] No [] Unknown []

Was there oral manipulation of the patient's genitals by the assailant? Yes [] No [] Unknown []

If yes, describe: _____

Were fingers or other foreign objects used in vaginal or rectal penetration? Yes [] No [] Unknown []

If yes, describe: _____

Did the assailant kiss, lick, spit, bite or make other oral contact with the patient? Yes [] No [] Unknown []

(Note well: If yes, remember to collect foreign debris swabs)

Describe debris suspected (seminal fluid, saliva, etc.) and location(s) on body: _____

Were weapons or objects used in the assault? Yes [] No [] Describe: _____

Any injuries to the assailant(s) resulting in the assailant's bleeding? Yes [] No [] Unknown []

SANE/Practitioner Signature

Date/Time

Kit#

Facility

Medical Record#

Since the assault, has the patient

- | | | | | | |
|-----------------------------------|------------------------------|-----------------------------|-----------------|------------------------------|-----------------------------|
| Had consensual sexual intercourse | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Changed clothes | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Bathed/showered/washed | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Urinated | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Defecated | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Brushed teeth | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Washed hair | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Brushed hair | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

- Was the patient menstruating at the time of the assault? Yes No
- Is the patient menstruating at the time of the exam? Yes No
- Is the patient's tampon/sanitary napkin in the kit? Yes No N/A

Describe the patient's emotional demeanor at examination (agitated, crying, withdrawn, eye contact, etc.)

Describe the victim's outward appearance and level of physical intactness (torn/missing clothes, apparent injuries, etc.)

Describe in narrative form, the victim's account of the assault. The victim may disclose to you evidence useful to the Vermont Forensic Laboratory. Please note any specific details described to you by the victim (i.e. wiping themselves off, discarding clothes etc.) Whenever possible, use the victim's own words in quotations. Use additional paper as needed. **Write firmly and legibly.**

SANE/Practitioner Signature

Date/Time

Kit#

Facility

Medical Record#

STATE OF VERMONT
COLLECTION INVENTORY CHECKLIST

Check if done or make a notation next to those that were not done.

		COLLECTED	NOT COLLECTED	COMMENTS
Step 1	Clothing Collection (briefly describe each item of clothing)			
Step 2	Underpants			
Step 3	Floor Paper Sheet			
Step 4	Oral Swabs and Smears			
Step 5	Victim DNA Standards			
Step 6	Fingernail Scrapings			
Step 7	Foreign Debris (list the area of the body from which foreign debris was taken)			
Step 8	Pubic Hair Combing			
Step 9	Rectal Swabs and Smears			
Step 10	Vaginal/Penile Swabs and Smears			
Step 11	Control Swab(s)			
		Dry		
		Sterile Water		
		Tap Water		
		T-Blue		
	Other (describe)			

Hospital Testing/Samples (Do Not Send to Vermont Forensic Lab)

_____ Wet prep for Motile Sperm Results _____

_____ Predatory Drug Panel

SANE/Practitioner Signature

Date/Time

Kit#

Facility

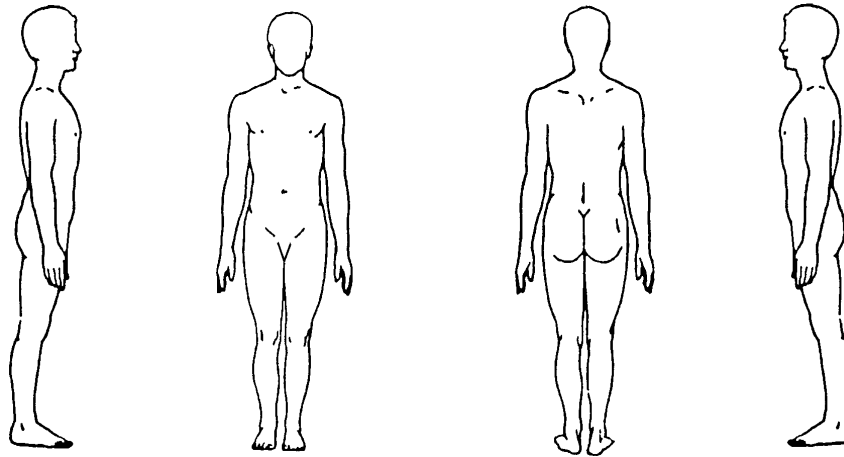
Medical Record#

STATE OF VERMONT

PHYSICAL EXAMINATION/ANATOMICAL DRAWING FORM

PHYSICAL EXAMINATION: (Include all details of trauma, abrasions, lacerations, bite marks, insertion of foreign objects, presence of blood or other secretions).

USING THE SET OF ANATOMICAL DRAWINGS, MARK AND DESCRIBE ALL BRUISES, SCRATCHES, LACERATIONS, BITEMARKS, AREAS OF FLUORESCENCE FROM ALTERNATIVE LIGHT SOURCE, ETC.



Were photographs taken? Yes [] No [] Was Toluidine Blue used? Yes [] No []

FEMALE GENITAL EXAMINATION—Note all signs of trauma, use speculum lubricated with tap water only. (Note well: Remember control swab.)

EXTERNAL GENITALIA: _____
VAGINA: _____
CERVIX: _____
PERINEUM: _____
ANUS: _____

MALE GENITAL EXAMINATION—Note all signs of trauma, i.e. bruises, petechiae, discharges, sphincter tone. Also note any traces of lubricants or rectal soiling.

PENIS: _____
SCROTUM: _____
MEATUS: _____
GLANS: _____
TESTICLES: _____
PERINEUM: _____
ANUS: _____

SANE/Practitioner Signature

Date/Time

Kit#

Facility
REV2013

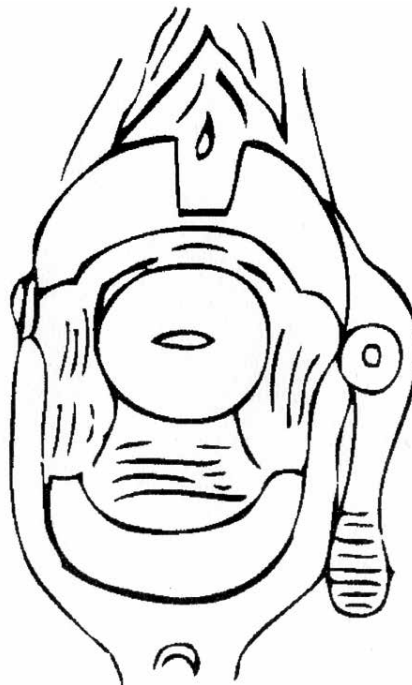
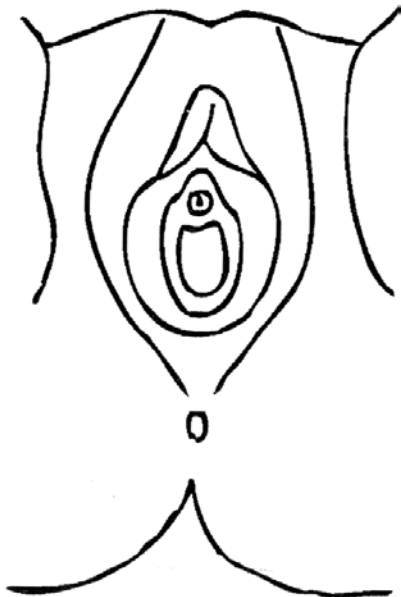
White Copy - Medical Record

Medical Record#

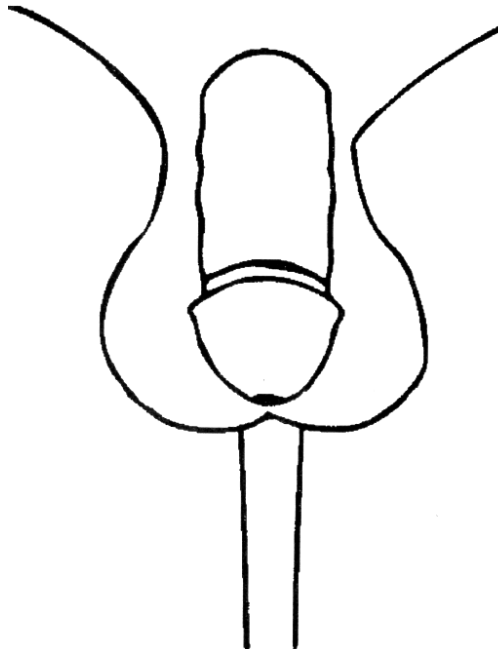
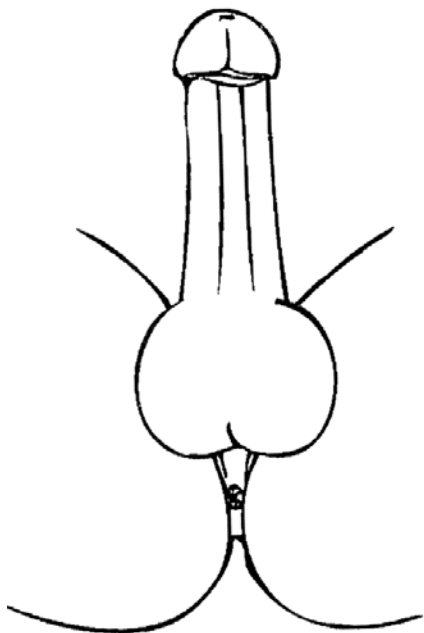
Yellow Copy - Sexual Assault Kit

VT2003D

STATE OF VERMONT
FEMALE GENITAL EXAMINATION



MALE GENITAL EXAMINATION



SANE/Practitioner Signature

Date/Time

Kit#

Facility
REV2013

White Copy - Medical Record

Medical Record#

Yellow Copy - Sexual Assault Kit

VT2003D2

STATE OF VERMONT
STANDING ORDERS FOR VICTIMS OF SEXUAL ASSAULT

Known Allergies: _____

- ☐ NKDA

Please check all that apply:

1. Determine Clinical Status

- ☐ Obtain Serum HCG/Urine
☐ Wet Prep for Motile Sperm
☐ Hepatitis B Antibody Titre

2. Pregnancy Prophylaxis

- ☐ Plan B: .75mg tab now and 1 tab in 12 hours
OR
☐ Plan B: 1.5mg tab now

3. STD Prophylaxis

- ☐ Ceftriaxone 250mg I.M. in a single dose
PLUS
☐ Azithromycin 1g orally in a single dose, or if allergic give;
☐ Doxycycline 100mg, orally twice a day for 7 days
AND
☐ Hepatitis B Vaccine; 1st dose Recombivax now if no previous history of Hepatitis B infection or previous vaccine

4. Pain & Nausea

- ☐ Ondansetron ODT; 4mg, (4 to take home) 1 tablet by mouth every 6 hours
OR
☐ Phenergan Suppository; 25mg suppository, (2 to take home)
1 suppository per rectum every 12 hrs. for nausea

5. HIV Prophylaxis

- ☐ _____

6. Tetanus Prophylaxis

- ☐ Td 0.5ml I.M.; if >10 yrs. since last dose and evidence of a break in skin integrity (laceration or abrasion)

- 7. ☐ Other: _____

SANE/Practitioner Signature

Date/Time

Kit#

Facility

Medical Record#

STATE OF VERMONT

SEXUAL ASSAULT TESTING & TREATMENT DISCHARGE GUIDELINES

During your examination, the following test were done (check all that apply):

☐ Pregnancy Test—Positive/Negative (circle) ☐ S/A Drug Screen ☐ Other _____

You were given medication to prevent the following: (check all that apply)

Gonorrhea: ☐ Ceftriaxone 250mg injection

Chlamydia: ☐ Azithromycin 1gm orally ☐ Doxycycline 100mg by mouth now and prescription for: 100mg twice daily for 7 days

Pregnancy: ☐ Plan B: .75mg tab now and 1 tab in 12 hours ☐ Plan B: 1.5mg tab now

Nausea & Vomiting: ☐ Ondansetron ODT 4mg, (4 to take home) 1 tablet by mouth every 6 hours OR ☐ Phenergan: 25mg (2 to take home) 1 suppository per rectum every 12 hours as needed for nausea.

Tetanus: ☐ Td 0.5ml I.M.

Other: _____

We recommend abstinence or the use of condoms for sexual intercourse, at least until cleared by your follow-up provider.

We advise that you be alert to the following:

- 1. Vaginal/penile discharge
2. Abdominal pain
3. Vaginal bleeding not associated with your period
4. Pain during sex or urination
5. Nausea and vomiting that lasts for more than 24 hours

If you have any of these symptoms, contact your health care provider or go to your local Emergency Department.

SANE/Practitioner Signature

Date/Time

Kit#

Facility

Medical Record#

STATE OF VERMONT

SEXUAL ASSAULT TESTING & TREATMENT DISCHARGE GUIDELINES

We recommend that you have a follow-up examination in two to three weeks. You can make an appointment with your personal health care provider or follow-up with one of the providers recommended to you at the time of your discharge. The purpose of this examination is to make sure that the medication you received was effective and that any physical injuries have healed. At the same time, you will have the opportunity to ask questions that you might have since your initial examination.

Many people who have been sexually assaulted are concerned about AIDS. We recommend that you have a baseline test as soon as possible and then again in six months. Anonymous testing is available at _____

Please contact them regarding times when this testing is available or to receive information regarding the full range of services they offer.

We highly recommend that you contact the following resources for follow-up:

Rape Crisis: _____

State's Attorney Victim Advocate: _____

Follow-Up Provider: _____

Other: _____

If at any time you have questions about your examination today, please call _____ and ask to speak with a Sexual Assault Nurse Examiner (SANE). You may receive a follow-up call from a SANE approximately two weeks from now. Please provide a number where you prefer to be reached.

Telephone # _____ Time of Day _____

I have received, read and understand the above information. I understand that it is my responsibility to arrange follow-up care.

Patient/Parent/Guardian Signature

Staff (Witness) Signature

Date _____ Time _____ am/pm

Facility _____

Medical Record# _____

STATE OF VERMONT
DISCHARGE MEDICATION INFORMATION

Ciproflaxin (Cipro) is an antibiotic. It may cause nausea.

Ceftriaxone (Rocephin) is an antibiotic. People who are allergic to Penicillin may also be allergic to this drug. Notify your health care provider immediately if you develop a rash. Seek medical treatment immediately if you develop shortness of breath.

Azithromycin (Zithromax) is an antibiotic. It may cause nausea and upset stomach. People who are allergic to erythromycin should not take this drug.

Doxycycline is an antibiotic. It can make your skin more sensitive to the sun: therefore stay out of direct sunlight while taking this medication. Do not take this medication with antacids.

Ondansetron is a medication to control nausea and vomiting. Side effects include headache, light-headedness, dizziness, drowsiness, or constipation.

Phenergan Suppository is a medication to control nausea and vomiting. It may make you drowsy. Do not drive or drink alcohol while taking this medication.

Plan B is an emergency contraceptive that prevents ovulation, and alters tubal transport of sperm and/or egg. Side effects include nausea and rarely, vomiting. You may also notice that your period is earlier or later and lighter or heavier.

Patient/Parent/Guardian Signature

Staff (Witness) Signature

Date _____ Time _____ am/pm

Hospital _____

Medical Record# _____