STATE OF VERMONT SEXUAL ASSAULT EXAMINATION DOCUMENTATION TOOL

ATTACHMENT A

Consent for Reported Medical Forensic Examination and Collection of Biological Samples

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

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 ____________________________ (facility name) and its agents to release the facility laboratory results, 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. This information may be used in court proceedings. I herewith release and hold harmless ____________________________ (facility name) 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. All identifying information will be removed.

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

PATIENT/PARENT OR GUARDIAN SIGNATURE

STAFF (WITNESS) SIGNATURE

DATE ____________________________ TIME ____________________________

KIT # ____________________________ FACILITY ____________________________

White Copy - Medical Record       Yellow Copy - Sexual Assault Kit

REY2019
STATE OF VERMONT SEXUAL ASSAULT EXAMINATION DOCUMENTATION TOOL

ATTACHMENT A, PAGE 2

Consent for Non-Reported Medical Forensic Examination and Collection of Biological Samples

I, ______________________________, consent to an examination and collection of evidence concerning sexual assault. This procedure has been fully explained to me. I understand that this examination will include the collection of samples for forensic laboratory analysis. I do not wish to report this assault to law enforcement personnel at this time. Results of forensic laboratory analysis will be documented confidentially. The results of forensic laboratory analysis will only be released to law enforcement. I understand that the law enforcement agency will only be able to contact me through the SANE Program unless I have reached out to the agency and given consent.

I, ______________________________, understand that if the sexual assault occurred outside of Vermont, and I do not wish to report this assault to law enforcement personnel, the biological evidence may not be analyzed in the state where the assault occurred.

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 these laboratory specimens and images in research projects, and for educational purposes. All identifying information will be removed.

I have been informed that if forensic laboratory analysis isolates tissue which may contain my assailant's DNA profile, it may be entered into a state and national DNA database. I have been informed that in the event that samples collected during this examination results in a match to evidence in an unrelated crime, a law enforcement agency may contact me through the sexual assault nurse examiner to obtain or seek information about the assault and/or my assailant.

PATIENT/PARENT OR GUARDIAN SIGNATURE

STAFF (WITNESS) SIGNATURE

DATE

TIME

em/pm

KIT #

FACILITY

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Yellow Copy - Sexual Assault Kit

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STATE OF VERMONT SEXUAL ASSAULT
EXAMINATION DOCUMENTATION TOOL

ATTACHMENT B
Sexual Assault Patient History

Name: __________________________ Date of Birth: _______________________
Preferred Gender Pronoun: __________________________ Gender Assignment at Birth: _______________________
Race: Caucasian ☐ Hispanic ☐ Black/African-American ☐ Asian ☐ 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/Intimate Partner ☐ Relative ☐ Acquaintance ☐ Unknown ☐
Assault Reported to Police by Patient: Yes ☐ No ☐ Reported by Other: _______________________
Medication taken within 24 hours prior to or after the assault (list name of drug and date/time taken):

Has the patient had consensual intercourse in the three days prior to the assault? Yes ☐ No ☐
If yes, date of consensual intercourse? _______________________
If yes, was a condom used during consensual intercourse? Yes ☐ No ☐

During the Assault
Was a condom used? Yes ☐ No ☐ Unknown ☐
Was there penile penetration of the vagina? Yes ☐ No ☐ Unknown ☐
Was there penile penetration of the mouth? 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 to penetrate the mouth, vagina, or anus? Yes ☐ No ☐ Unknown ☐
If yes, describe: _______________________
Did the assailant kiss, lick, spit, bite or make other oral contact with the patient? Yes ☐ No ☐ Unknown ☐
Describe debris suspected (seminal fluid, saliva, etc.) and location(s) on body: _______________________

Did assailant place hands around neck? Yes ☐ No ☐ Unknown ☐
Were weapons or objects used in the assault? Yes ☐ No ☐ Unknown ☐
If yes, describe: _______________________
Did the assailant(s) sustain any injuries resulting in bleeding? Yes ☐ No ☐ Unknown ☐

SANE/PRACTITIONER SIGNATURE DATE TIME KIT # FACILITY

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REV2017
STATE OF VERMONT SEXUAL ASSAULT EXAMINATION DOCUMENTATION TOOL

ATTACHMENT B, Page 2

Sexual Assault Patient History

Since the assault, has the patient:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
<th>Changed clothes</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Had consensual sexual intercourse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bathed/showered/washed</td>
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<tr>
<td>Defecated</td>
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<td></td>
<td></td>
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<tr>
<td>Urinated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Washed hair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brushed teeth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brushed hair</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Was the patient menstruating at the time of the assault?  
Is the patient menstruating at the time of the exam?  
Is the patient's tampon/sanitary napkin in the kit?

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

________________________________________________________________________

________________________________________________________________________

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

________________________________________________________________________

________________________________________________________________________

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

________________________________________________________________________

________________________________________________________________________

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________________________________________________________________________
STATE OF VERMONT SEXUAL ASSAULT
EXAMINATION DOCUMENTATION TOOL

ATTACHMENT C

Physical Examination

Include all details of trauma, i.e., abrasions, lacerations, bite marks, foreign objects, presence of blood or other secretions. Use the anatomical drawings on Attachment C, Page 2 to mark all described trauma as well as areas of fluorescence from an alternative light source.

GENITAL EXAMINATION: Does the patient have any history of anal/genital injury, surgery, diagnostic procedures or medical treatment within 60 days of the assault? Yes ☐ No ☐ If yes, describe: ____________________________

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

FEMALE: Lubricate speculum with water soluble lubricate only.

External Genitals: ____________________________
Hymen: ____________________________
Vagina: ____________________________
Cervix: ____________________________
Perineum: ____________________________
Anus: ____________________________

MALE: Penis: ____________________________
Scrotum: ____________________________
Meatus: ____________________________
Glans: ____________________________
Testicles: ____________________________
Perineum: ____________________________
Anus: ____________________________

Were photographs taken? Yes ☐ No ☐ Was toluidine blue used? Yes ☐ No ☐
Was urine collected for DFSA? Yes ☐ No ☐

SANE/PRACTITIONER SIGNATURE ______________________ DATE __________ TIME __________ KIT # __________ FACILITY __________

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REV2010
Full Body Diagrams

Genital Examination Diagrams

FEMALE GENITAL DIAGRAM

MALE GENITAL DIAGRAM
Check "Collected" or "Not Collected." If sample is not collected, enter rationale for not collected.

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Collected</th>
<th>Not Collected</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>Clothing Collection (Briefly describe each item of clothing.)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Step 2</td>
<td>Underpants</td>
<td></td>
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<tr>
<td>Step 3</td>
<td>Floor Paper Sheet</td>
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<tr>
<td>Step 4</td>
<td>Oral Swabs and Smears</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Step 5</td>
<td>Patient DNA Standards</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step 6</td>
<td>Fingernail Scrapings</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Step 7</td>
<td>Foreign Debris (List collection site and suspected foreign debris/body fluid collected.)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Step 8</td>
<td>Pubic Hair Comblings</td>
<td></td>
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</tr>
<tr>
<td>Step 9</td>
<td>Anal Swabs and Smears</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step 10</td>
<td>External Genital Swabs &amp; Smears</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step 11</td>
<td>Vaginal/ Penile Swabs &amp; Smears</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
Known Allergies: □ NKDA

Please check all that apply: (Refer to CDC Guidelines for most up-to-date information regarding STI prophylaxis.)

1. Determine Clinical Status
   □ Obtain Serum or Urine HCG
   □ Hepatitis B Antibody Titre

2. Pregnancy Prophylaxis
   □ Levonorgestrel (Plan B): 1.5mg tablet now

3. STI Prophylaxis
   □ Ceftriaxone 250mg I.M. now
   PLUS
   □ Azithromycin 1g orally now;
   OR, IF ALLERGIC, GIVE
   □ Doxycycline 100mg, orally twice a day for 7 days
   AND
   □ Metronidazole 2g orally now (if alcohol has been consumed, give after 48 hours of last alcohol consumption.)

   If hepatitis status of assailant is unknown and the patient has not been previously vaccinated:
   □ Hepatitis B vaccination

   If assailant is known to be HBsAg-positive and the patient is unvaccinated:
   □ Hepatitis B Immune Globulin (Follow-up doses of vaccine should be administered 1–2 months and 4–6 months after the first dose).

   If patient has been previously vaccinated but did not receive post-vaccination testing,
   □ Hepatitis B vaccination

4. Nausea
   □ Ondansetron ODT 4mg (4 to take home) 1 tablet by mouth every 6 hours as needed
   OR
   □ Promethazine 25mg suppository (2 to take home). 1 suppository per rectum every 12 hours as needed.

5. HIV Prophylaxis - Consult with infectious disease specialist for recommendations.
   □

6. Tetanus Prophylaxis - If >10 years since last dose and evidence of a break in skin integrity.
   □ Tdap 0.5ml IM

7. Other: ____________________________

______________________________
SANE/PRACTITIONER SIGNATURE

DATE       TIME       KIT #       FACILITY

White Copy - Medical Record  Yellow Copy - Sexual Assault Kit
During your examination, the following test(s) were done (check all that apply):

☐ Pregnancy Test – Positive/Negative (circle)  ☐ Sample for drug screening  ☐ Other ____________

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

☐ Ceftriaxone 250mg injection (for prevention of gonorrhea).
☐ Azithromycin 1gm orally (for prevention of chlamydia)

OR
☐ Doxycycline 100mg orally and 100mg twice daily for 7 days (for prevention of chlamydia).
☐ Metronidazole 2gm orally in single dose; if alcohol consumed, take 48 hours after last alcohol ingestion
  (for prevention of trichomoniasis).
☐ Levonorgestrel 1.5mg tablet orally (for prevention of pregnancy).
☐ Ondansetron ODT 4mg; 4 tablets to take home; 1 tablet by mouth every 6 hours as needed (for nausea)

OR
☐ Promethazine 25mg suppository; 2 to take home; 1 suppository per rectum every 12 hours as needed (for
  nausea).
☐ Tetanus, diphtheria and pertussis (Tdap) 0.5ml IM

☐ Other ____________

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

Contact your provider or seek care if you experience any of the following symptoms:

• Vaginal or penile discharge
• Abdominal pain
• Vaginal bleeding (not associated with menstruation) or rectal bleeding
• Pain during sex or urination
• Nausea or vomiting that lasts more than 24 hours
We recommend that you have a follow-up examination in 2–4 weeks. You can make an appointment with your personal health care provider or follow up with one of the providers listed below. The purpose of this follow-up examination is to make sure that the medication you received was effective, that any physical injuries have healed, and to address any concerns or issues that might have arisen since your initial examination.

Many people who have been sexually assaulted are concerned about HIV, the virus that causes AIDS. We recommend that you have a baseline test as soon as possible and then again in six months. This can be done through the providers listed below or anonymously through the Vermont HIV/AIDS Hotline: (800) 882-2437.

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

Confidential Advocate: ________________________________

State’s Attorney Advocate: ________________________________

Follow-Up Provider: ________________________________

Other: ________________________________

If, at any time, you have questions about your examination today, please call ________________________________ (SANE Program contact number). You may receive a call from a SANE Program representative to check in. Please provide a number where you can be contacted. Telephone # ________________________________ Is it safe to leave a message identifying who we are?  □ Yes  □ No

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

_________________________  ____________________________
PATIENT / PARENT OR GUARDIAN SIGNATURE  STAFF (WITNESS) SIGNATURE

_________________________  ____________________________
DATE  TIME  am/pm  KIT #  FACILITY

White Copy - Medical Record  Yellow Copy - Patient

REV2017
Ceftriaxone: 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: Antibiotic. It may cause nausea and vomiting.

Doxycycline: 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: Medication to control nausea and vomiting. Side effects include headache, light-headedness, dizziness, drowsiness or constipation.

Promethazine: Medication to control nausea and vomiting. It may make you drowsy. Do not drive or drink alcohol while taking this medication.

Levonorgestrel: 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.

Metronidazole: Antibiotic. Side effects can include nausea, unusual taste in your mouth. Do not drink alcohol while taking this medication and for at least three days after you have completed treatment.