This form may be completed in conjunction with a State of Maine Sex Crimes Kit or independently. It should be attached to the medical record with a patient label on each page.

NOTE: The likelihood of evidence retrieval decreases with time. If the sexual assault occurred within 120 hours evidence may be present on the victim’s body, and may be recoverable by proper evidence collection.

Date: ____________________________  24-h time: ________  
Date of Assault: ____________________  24-h time of assault: _________

Locale/Jurisdiction of assault: ______________________________________________________________

Law enforcement notified:  ☐ Yes  ☐ No

1. State of Maine sex crimes kit is/is not (circle one) being completed. (Obtain informed consent to collect forensic evidence using the consent form in the Maine sex crimes kit.)

2. Is the victim under the age of 18 years of age  ☐ Yes  ☐ No? If yes then all health care providers are mandated reporters. Notify Department of Human Services 1-800-452-1999. If notified document who took the intake ___________________. Notify law enforcement.

3. Spurwink child abuse clinic is available for consult if needed. 1-800-260-6160

Past Medical History:

Hepatitis B Immune:  ☐ Yes  ☐ No  Currently pregnant?  ☐ Yes  ☐ No

Other:  _____________________________________________________________________________

Current Medications:  ____________________________________________________________________

Allergies:  _____________________________________________________________________________

History of Present:

Illness:  _______________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________
5. **Review of Systems:**

- □ musculoskeletal  □ genitourinary  □ gastrointestinal  □ skin  □ neurologic

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

6. **Physical Exam:**

Description of patient's outward appearance/clothing: ________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

General body examination looking for signs of trauma. *(Use anatomical drawings on the following page to mark and describe all areas of redness, swelling, bruising, abrasions, lacerations, etc.)*

HEENT: ____________________ □ normal

Chest: ________________________________ □ normal

Back: ________________________________ □ normal

Breasts: ______________________________ □ normal

Heart/Lungs: __________________________ □ normal

Abdomen: ____________________________ □ normal

Extremities: __________________________ □ normal

Neurologic: __________________________ □ normal
TRAUMA SCALE

E = Ecchymosis   P = Pain   PTI = Petechiae
L = Laceration   B = Bleeding FB = Foreign Body
A = Abrasion     BMZ = Bite Marks

Photographs taken □ Yes □ No

If no, why? ________________________________________________________________
__________________________________________________________________________
Genitalia Examination:

**FEMALE:** Note any abnormalities and/or signs of trauma. If normal, so indicate. *Use diagram whenever possible.*

Labia Majora: ________________________________________________________ □ normal

Labia Minora: ________________________________________________________ □ normal

Introitus: ___________________________________________________________ □ normal

Hymen: _____________________________________________________________ □ normal

Posterior Fourchette/Fossa: ____________________________________________ □ normal

Vagina: _____________________________________________________________ □ normal

Cervix _____________________________________________________________ □ normal

Uterus: _____________________________________________________________ □ normal

Adnexa: ____________________________________________________________ □ normal

Perineum: ___________________________________________________________ □ normal

Anus: ______________________________________________________________ □ normal

Rectum: ____________________________________________________________ □ normal

Foley Technique utilized □ Yes □ No

The Female Genitalia
MALE: Note any abnormalities and/or signs of trauma. If normal, so indicate. Use diagrams below whenever possible.

Penis: ____________________________ [ ] normal
Foreskin: [ ] circumcised ____________________________ [ ] normal
Glans: ____________________________ [ ] normal
Urethra: ____________________________ [ ] normal
Scrotum: ____________________________ [ ] normal
Testicles: ____________________________ [ ] normal
Perineum: ____________________________ [ ] normal
Anus: ____________________________ [ ] normal
Rectum: ____________________________ [ ] normal

The Male Genitalia

Mons veneris
Clitoris
Vestibule
Urethral meatus
Labia majora
Labia minora
Vaginal introitus
Hyman
Bartholin gland
duct office
Fourchette
Perineum
Anus
7. **Evidence Collection** *(Complete the Maine state forensic evidence collection form in the kit.)*

8. **Laboratory Specimens:**
   - Urine pregnancy test:  □ N/A  □ Positive  □ Negative
   - Urine toxicology sample obtained and included in sex crimes kit?  □ Yes  □ No
   - Blood toxicology sample obtained and included in sex crimes kit?  □ Yes  □ No
   - Collect urine and blood samples if ingestion was within 24 hours and urine alone if between 24-96 hours.

9. **Medical Decision Making:**

   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

10. **Treatment Recommendations:**

    **Tetanus Toxoid 0.5 mL IM**
    Given:  □ Yes  □ No  □ N/A (up to date)

    **Gonorrhea Prophylaxis:**
    - Ceftriaxone 250 mg IM x 1 (will also treat incubating Syphilis)  Given:  □ Yes  □ No
    - Or
    - Cefixime tab 400 mg 1 tab PO stat x1  Given:  □ Yes  □ No

    **Chlamydia Prophylaxis:**
    - Azithromycin 1gm PO x 1  Given:  □ Yes  □ No
    - Or
    - Doxycycline 100 mg BID for 7 days for macrolide allergies:  Given:  □ Yes  □ No

    **Bacterial Vaginosis and Trichomoniasis:**
    - Metroindazole 2 gms PO x 1  Given:  □ Yes  □ No
    - If there is a suspicion of recent ingestion of alcohol have the patient wait 72 hrs prior to taking this medication and wait another 72 hours before having another drink of alcohol.

    **Hepatitis B. Prophylaxis**
    - Patient's weight ____________kg
    - Nonformulary medication Engerix-B Hepatitis B Vaccine IM  20 mcg/mL, 1 mL IM stat if patient has not received the full series of vaccines  Given:  □ Yes  □ No

    **Pregnancy Prophylaxis:**
    - Plan B: levonorgestrel 0.75 mg x 2 tablets now.  Given:  □ Yes  □ No
Treatment, continued

Antiemetic:
Zofran 4 mg 1 tablet now and 2 to go. Given: □ Yes □ No

11. Diagnosis: ________________________________________________

12. Victims Compensation Board Gross Sexual Assault Forensic Examination Claim Form
Completed □ Yes □ No

13. Disposition/Referrals
A. If a sex crimes kit was completed:
   1. Kit released to officer: ____________________________ (name) from
      ____________________________________________ Police Department at
      ___________ (time)
   2. Give patient the Patient Information Card found in the kit.
B. Followup appointment in two weeks for STD cultures, HIV baseline testing
   with: ________________________________
C. Give patient information folder from Sexual Assault Response Services

Community Resources:
□ Sexual Assault Response Services
Name of SARSSM Advocate: ____________________________________________
□ Trauma Intervention Program
□ Amistad Peer Support □ Youth/Alternative Ingraham
□ Sweetser □ Other ____________________________________________
Patient/______________________________________agrees to offered resources □ Yes □ No
Identify family/friend
□ Resources activated for patient/family prior to admission

Was anyone else present in room during exam? □ Yes □ No
If so, who:______________________________________________
Discharged to: ________________________________

- □ Ambulatory  □ Via wheelchair  □ With Support Person
- □ Via Taxi  □ With Police
  □ Appropriately dressed for weather

Discuss/develop safety plan for discharge and document below:

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

Patient confirms that they feel safe for discharge  □ Yes  □ No
If no, refine plan and document.

Signature of RN: ________________________________________________________________________
Printed Name of RN: ___________________________________________________________________
Date:_______________________ 24-h time: __________________

Is RN a SAFE (Sexual Assault Forensic Examiner)  □ Yes  □ No

Signature of Attending Physician: _____
Printed Name of Attending Physician: ______________________________________________________
Date:_______________________ 24-h time: __________________

Signature of Resident: ________________________________________________________________
Printed Name of Resident: ______________________________________________________________
Date:_______________________ 24-h time: __________________