Maine Medical Center
Emergency Department

SEXUAL ASSAULT RECORD

143619

PATIENT NAME LABEL

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: _____

_____

_____

_____

_____

_____

_____

_____

PATIENT NAME LABEL

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

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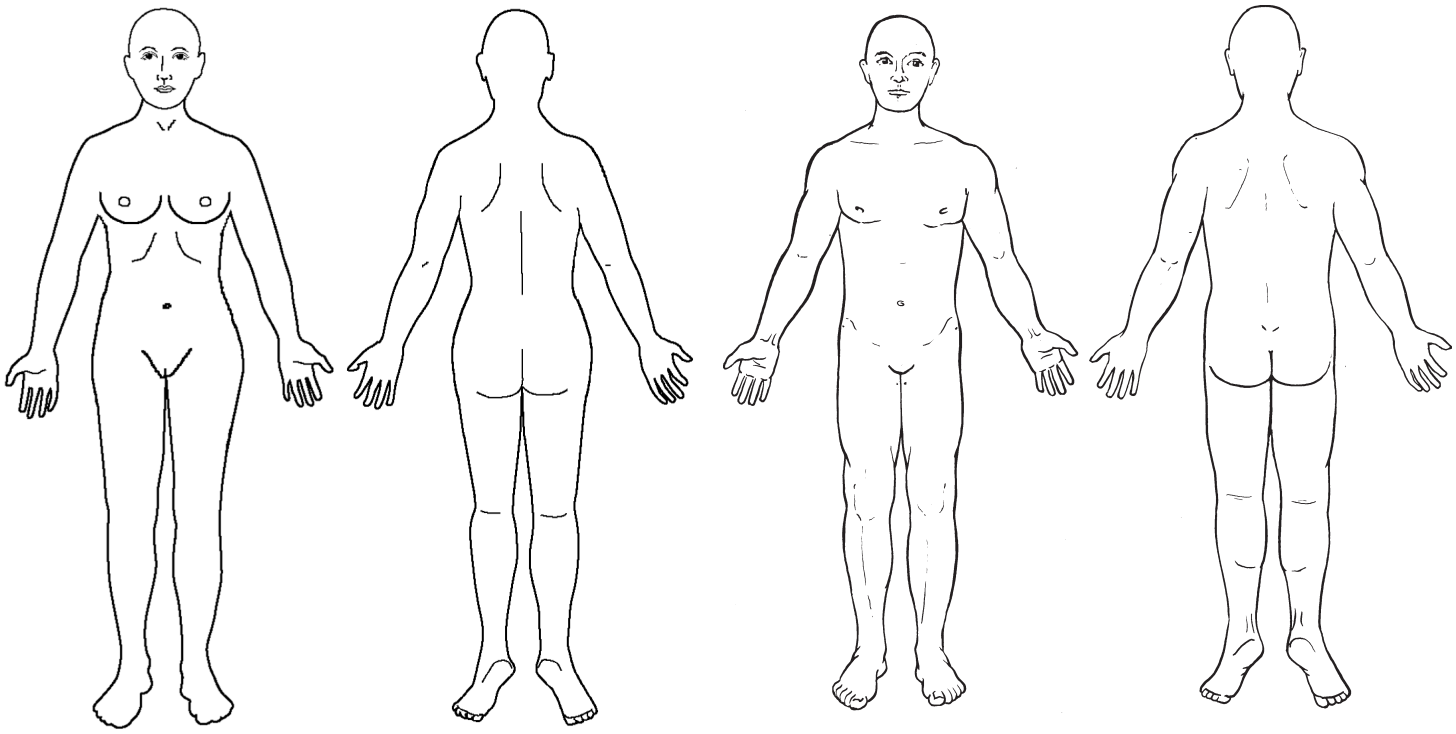

Front Back Front Back

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? _____

_____

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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

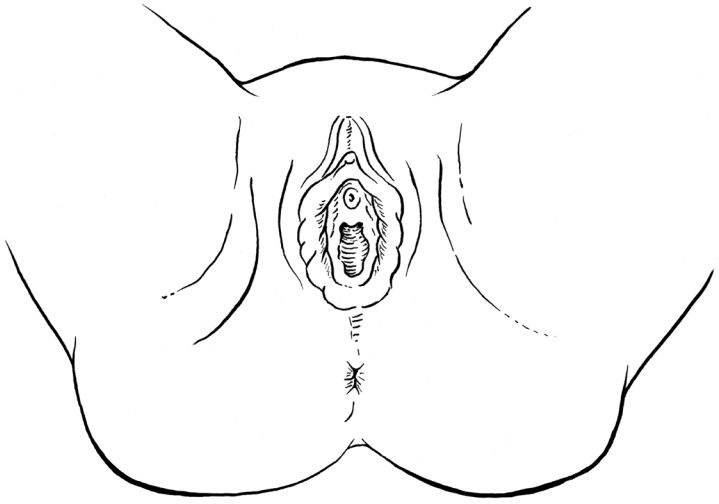
Perineum: _____ ☐ normal

Anus: _____ ☐ normal

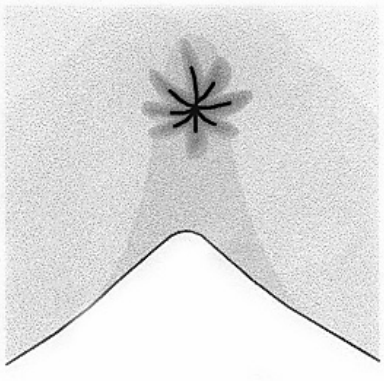
Rectum: _____ ☐ normal

Foley Technique utilized ☐ Yes ☐ No

The Female Genitalia



Anal



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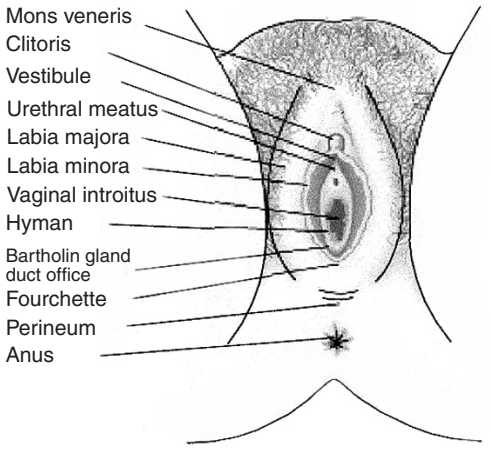
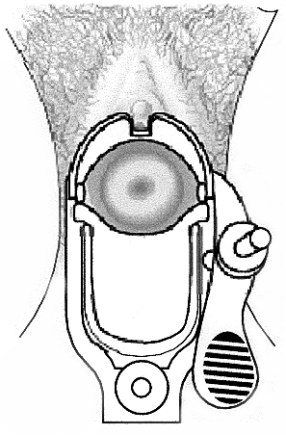
Traumagram - Genital



Cervical observation



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

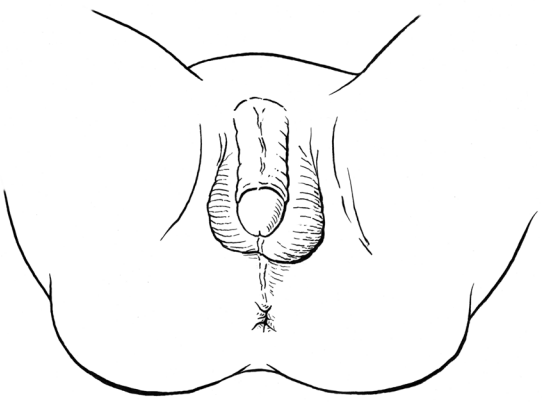
Testicles: _____ ☐ normal

Perineum: _____ ☐ normal

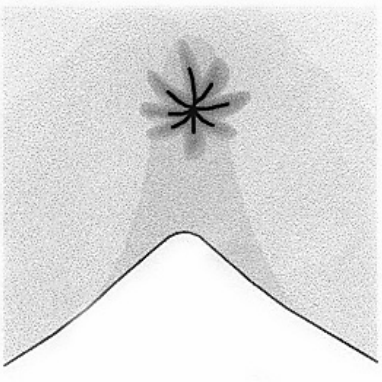
Anus: _____ ☐ normal

Rectum: _____ ☐ normal

The Male Genitalia



Anal



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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

Doxycline 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

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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:_____

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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: _____