# NYC Health + Hospitals

## COMPREHENSIVE SEXUAL ASSAULT ASSESSMENT FORM PAGE 1 OF 9

*PLEASE PRINT CLEARLY* →
*Please Indicate Patient Name, Patient Number, Facility Name, and date*

Patient Name: _____ ☐ Female ☐ Male Date of Birth: _____

Date: _____ Medical Record #: _____

Name of Clinician: _____ SAFE Trained: ☐ Yes ☐ No

Nurse/P.C.A./Nurse's Aide: _____

Attending Physician: _____ Department: ☐ ED ☐ OBS-GYN ☐ Other _____

Advocate Contacted: ☐ Yes ☐ No

Advocate Present: ☐ Yes ☐ No

Primary Language if not English: _____ ☐ Interpreter used Identify _____

Person(s) accompanying patient to the E.D.: _____

## PATIENT AUTHORIZATION

I understand that if I consent, an examination for evidence of sexual assault will be conducted. I may withdraw consent at any time for any portion of the examination. I understand that the medical documentation and collection of evidence may include photographing injuries, which may include injuries to the genital and rectal area. A forensic collection kit will be used to gather evidence, such as secretions for DNA testing. I understand that if I consent, such evidence will be released to the police at this time; and that if I do not consent to release, such evidence will be preserved at a designated storage facility for a minimum of 20 years.

I consent to:

| | | |
|---|---|---|
| Physical examination: | ☐ Yes | ☐ No |
| Photographing of injuries: | ☐ Yes | ☐ No |
| Collection of evidence: | ☐ Yes | ☐ No |
| I received a copy of the Victim's Bill of Rights (VBOR): | ☐ Yes | ☐ No |
| Staff explained the VBOR to me: | ☐ Yes | ☐ No |
| The Forensic Rape Exam (FRE) form was explained to me: | ☐ Yes | ☐ No |

Signature of Patient: _____ Date: _____

Signature of Witness: _____ Date: _____

Print Name of Witness: _____ Date: _____

## LOG OF ITEMS TAKEN FROM PATIENT FOR EVIDENCE

1. 4.
2. 5.
3. 6.

## CHAIN OF CUSTODY

Name of Staff Member Releasing Evidence: _____ Signature: _____

Name of Person Receiving Evidence: _____ Signature: _____

ID# / Shield#: _____ Precinct: _____

Date: _____ Time: _____



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## COMPREHENSIVE SEXUAL ASSAULT ASSESSMENT FORM PAGE 2 OF 9

*PLEASE PRINT CLEARLY* ⟶
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## 1. PERTINENT PAST MEDICAL HISTORY

Past Medical History: _____

LMP: _____ Last Tetanus Immunization: _____

Allergies: _____ Hepatitis B Immunization: ☐ Yes ☐ No

Medications: _____

## 2. SEXUAL ASSAULT HISTORY

Time of Initial Contact: _____ HRS Date _____ Start Time of Exam: _____ HRS Date _____

Date of Sexual Assault: _____ Time of Sexual Assault: _____ HRS

Location of Sexual Assault *(include exact address if known)*: _____

Loss of Consciousness: ☐Yes ☐ No Physical Restraints used: ☐ Yes; Type: _____ ☐ No

**Type of Violations Perpetrated against Patient during Sexual Assault:**

| | | | | If "Yes" describe (e.g. by mouth, by penis, by hand, by foreign object, etc.) |
|---|---|---|---|---|
| Breast Contact | ☐ Yes | ☐ No | ☐ Unsure | _____ |
| Vaginal Contact | ☐ Yes | ☐ No | ☐ Unsure | _____ |
| Anal Contact | ☐ Yes | ☐ No | ☐ Unsure | _____ |
| Condom Used | ☐ Yes | ☐ No | ☐ Unsure | _____ |
| Use of Foreign Object | ☐ Yes | ☐ No | ☐ Unsure | _____ |
| Foam/Jelly/Lubricant | ☐ Yes | ☐ No | ☐ Unsure | _____ |
| Weapon Shown | ☐ Yes | ☐ No | ☐ Unsure | _____ |
| Oral Contact (offender to patient) | ☐ Yes | ☐ No | ☐ Unsure | _____ |
| Oral Contact (patient to offender) | ☐ Yes | ☐ No | ☐ Unsure | _____ |
| Suspected use of "Date Rape Drugs" | ☐ Yes | ☐ No | ☐ Unsure | _____ |
| Alcohol or Drug Use | ☐ Yes | ☐ No | ☐ Unsure | ☐ Patient ☐ Offender ☐ Both |
| Ejaculation Occurred | ☐ Yes | ☐ No | ☐ Unsure | _____ |

Other _____

**Brief Narrative of Assault** _____

_____

_____

**Actions Before or After Assault**

Has the patient had other sexual intercourse within the last 96 hours?

Consensual ☐ Yes ☐ No ☐ Unsure If yes, when _____

Non-Consensual ☐ Yes ☐ No ☐ Unsure If yes, when _____

After the sexual assault, has the patient:

Urinated: ☐ Yes ☐ No Bathed/Showered: ☐ Yes ☐ No Changed underwear: ☐ Yes ☐ No

Defecated: ☐ Yes ☐ No Douched: ☐ Yes ☐ No ☐ N/A Changed clothes: ☐ Yes ☐ No

Vomited: ☐ Yes ☐ No Brushed teeth: ☐ Yes ☐ No Changed sanitary product: ☐ Yes ☐ No ☐ N/A

Comsumed Food or Liquid: ☐ Yes ☐ No

Other: _____



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# NYC Health + Hospitals

## COMPREHENSIVE SEXUAL ASSAULT ASSESSMENT FORM PAGE 3 OF 9

*PLEASE PRINT CLEARLY* →
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## 3. PHYSICAL EXAMINATION

**General Appearance (physical/emotional)**

**General Medical Examination (including lacerations, scratches, abrasions, ecchymosis, etc.) (use Traumagram on last page as appropriate)**

**Pelvic/Genital/Colposcopic Examination (use Traumagram on last page as appropriate)**

**** FEMALE***

| | | Visualization Direct | Visualization Colposcopic | | | Visualization Direct | Visualization Colposcopic |
|---|---|---|---|---|---|---|---|
| Labia majora | _____ | ☐ | ☐ | Vagina | _____ | ☐ | ☐ |
| Labia minora | _____ | ☐ | ☐ | Hymen | _____ | ☐ | ☐ |
| Clitoris | _____ | ☐ | ☐ | Cervix | _____ | ☐ | ☐ |
| Posterior fourchette | _____ | ☐ | ☐ | Perineum | _____ | ☐ | ☐ |
| Fossa navicularis | _____ | ☐ | ☐ | Anus | _____ | ☐ | ☐ |
| Periurethral | _____ | ☐ | ☐ | Rectum | _____ | ☐ | ☐ |
| Vestibule | _____ | ☐ | ☐ | Other | _____ | ☐ | ☐ |

**** MALE***

| | | Visualization Direct | Visualization Colposcopic | | | Visualization Direct | Visualization Colposcopic |
|---|---|---|---|---|---|---|---|
| Penis | _____ | ☐ | ☐ | Rectum | _____ | ☐ | ☐ |
| Perineum | _____ | ☐ | ☐ | Scrotum | _____ | ☐ | ☐ |
| Anus | _____ | ☐ | ☐ | Other | _____ | ☐ | ☐ |

## 4. EXAMINATION TECHNIQUES

| | | | | | |
|---|---|---|---|---|---|
| Direct Visualization | ☐ Yes | ☐ No | Evidence Kit Collected | ☐ Yes | ☐ No |
| Bimanual Exam | ☐ Yes | ☐ No | Photos Taken | ☐ Yes | ☐ No |
| Speculum Exam | ☐ Yes | ☐ No | | | |
| Colposcopic Exam | ☐ Yes | ☐ No | | | |
| Toluidine Blue | ☐ Yes | ☐ No | | | |
| Wood's Lamp | ☐ Yes | ☐ No | | | |
| Wet Mount | ☐ Yes | ☐ No | | | |
| Anoscope | ☐ Yes | ☐ No | | | |

How many? _____

Area(s) of body photographed: _____

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## COMPREHENSIVE SEXUAL ASSAULT ASSESSMENT FORM PAGE 4 OF 9

*PLEASE PRINT CLEARLY* ⟶
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## 5. RECOMMENDED DIAGNOSTIC TESTS

Pregnancy Test: Offered: ☐ Yes ☐ No ☐ N/A
Accepted: ☐ Yes ☐ No ☐ N/A

Hepatitis C: Offered: ☐ Yes ☐ No ☐ N/A
Accepted: ☐ Yes ☐ No ☐ N/A

Hepatitis B Titer
Offered: ☐ Yes ☐ No ☐ N/A Accepted: ☐ Yes ☐ No ☐ N/A

Was drug facilitated SA kit utilized? ☐ Yes ☐ No ☐ N/A
Was seperate consent obtained? ☐ Yes ☐ No ☐ N/A

## 6. STI PROPHYLAXIS:

Chlamydia Treatment: Offered: ☐ Yes ☐ No ☐ N/A Accepted: ☐ Yes ☐ No
Gonorrhea Treatment: Offered: ☐ Yes ☐ No ☐ N/A Accepted: ☐ Yes ☐ No
Trichomonas Treatment: Offered: ☐ Yes ☐ No ☐ N/A Accepted: ☐ Yes ☐ No
HB1G (Passive Immunization): Offered: ☐ Yes ☐ No ☐ N/A Accepted: ☐ Yes ☐ No
(Given only if perpetrator is known positive)
Hepatitis B First of Series: Offered: ☐ Yes ☐ No ☐ N/A Accepted: ☐ Yes ☐ No

## 7. HIV POST-EXPOSURE PROPHYLAXIS

HIV Medications Offered: ☐ Yes ☐ No ☐ N/A
Accepted: ☐ Yes ☐ No ☐ N/A

Number of Days of HIV PEP Recommended: _____

Informed about the full 28 Day course of HIV PEP
☐ Yes ☐ No ☐ N/A

## 8. POST-COITAL CONTRACEPTION

Offered: ☐ Yes ☐ No ☐ N/A
Accepted: ☐ Yes ☐ No ☐ N/A

## 9. TETANUS TOXOID: Recommended/Offered

Td Offered: ☐ Yes ☐ No ☐ N/A
Accepted: ☐ Yes ☐ No

## 10. REFERRALS GIVEN BY ED STAFF

☐ S/A Treatment Program Name of Program _____
☐ Information Package Date of Referral _____
☐ GYN Clinic Date _____
☐ Virology/ID Clinic Date _____
☐ Primary Care Clinic Date _____
☐ Other _____ Date _____

## 11. COMPLETION OF EXAMINATION BY SAFE

Condition of Patient at Completion of Exam: ☐ Stable ☐ Other _____

Time of Endorsement: _____ HRS To Whom: _____

## 12. PROVIDER'S SIGNATURE

| _____ | _____ | _____ |
|---|---|---|
| **PRINT NAME / TITLE** | **SIGNATURE** | **DATE** |

**NOTE: PLACE ALL DOCUMENTATION IN DESIGNATED AREA FOR PROGRAM COORDINATOR**



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## COMPREHENSIVE SEXUAL ASSAULT ASSESSMENT FORM PAGE 5 OF 9

*PLEASE PRINT CLEARLY* →
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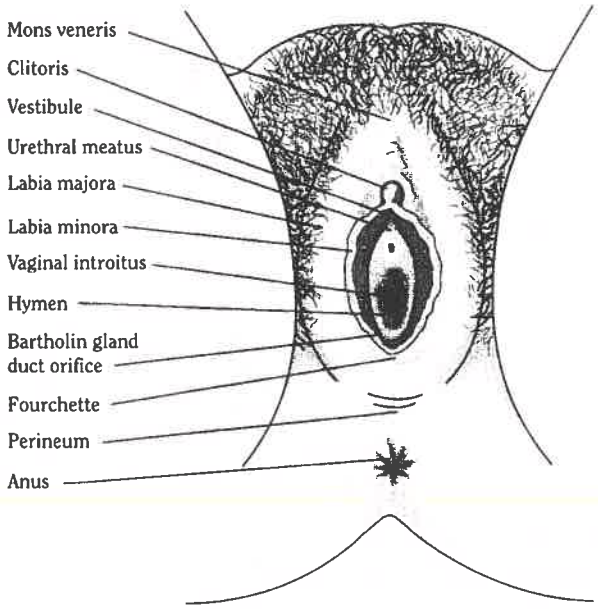
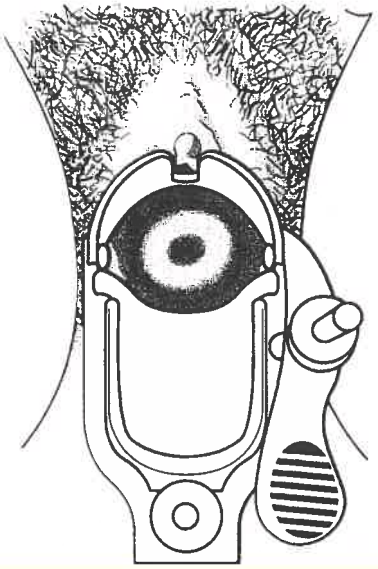
**Traumagram – Genital**

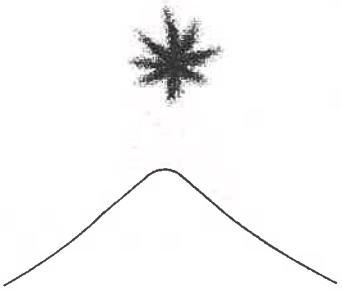
*Female genitalia*



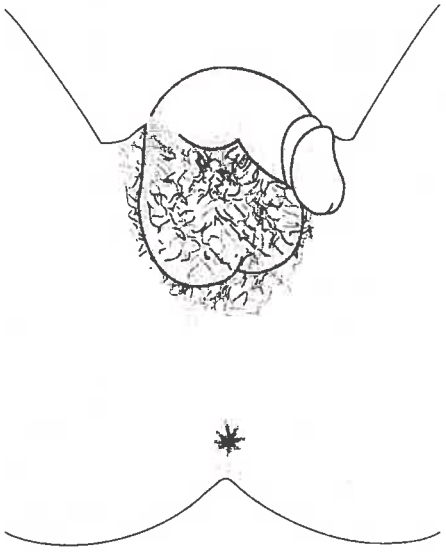

*Cervical observation*



*Anal*



*Male genitalia*





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# NYC Health + Hospitals

## COMPREHENSIVE SEXUAL ASSAULT ASSESSMENT FORM PAGE 6 OF 9

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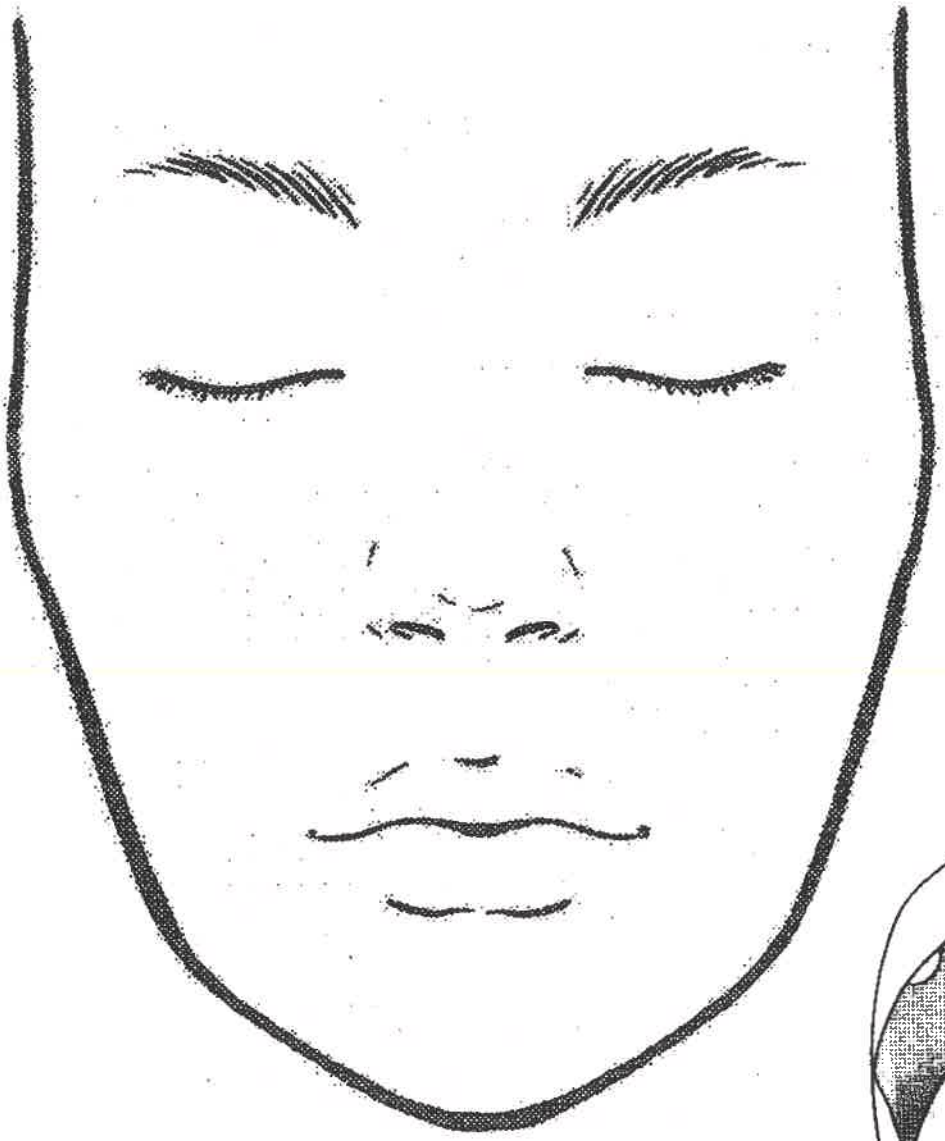

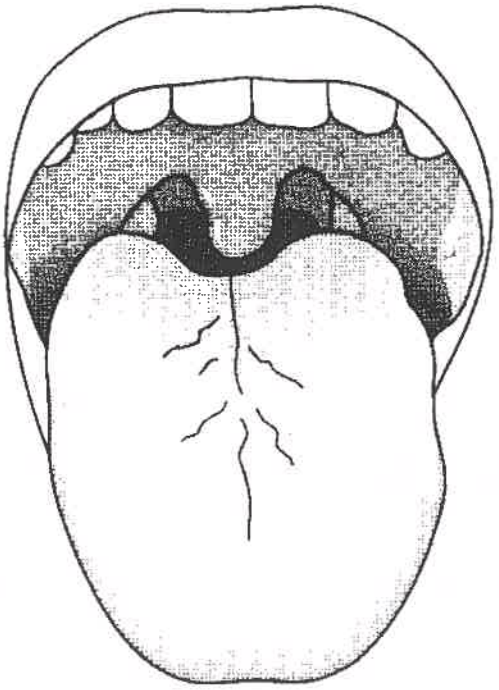



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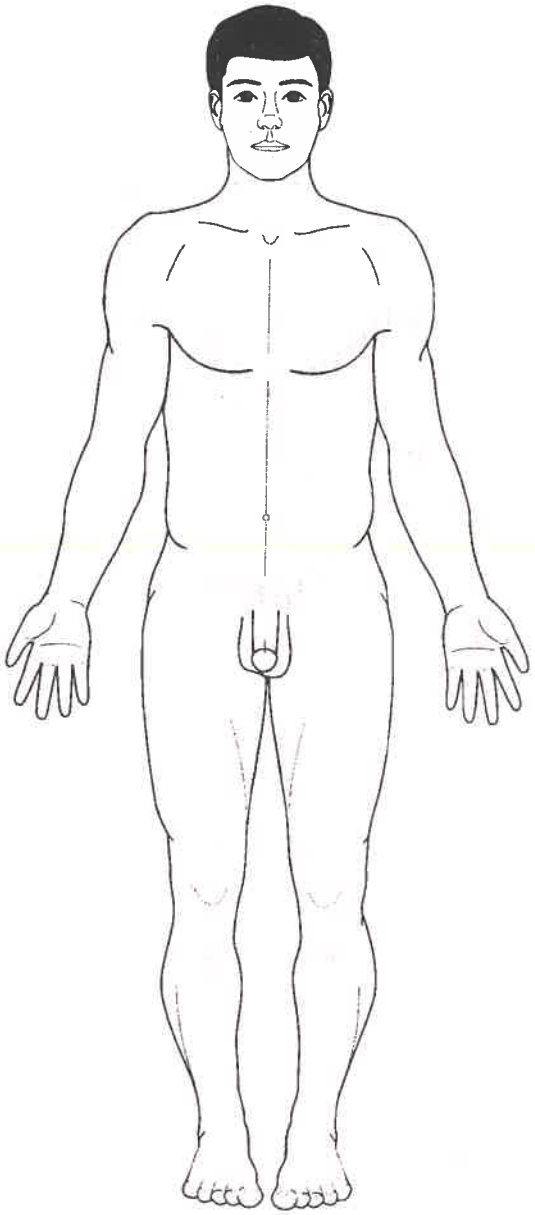

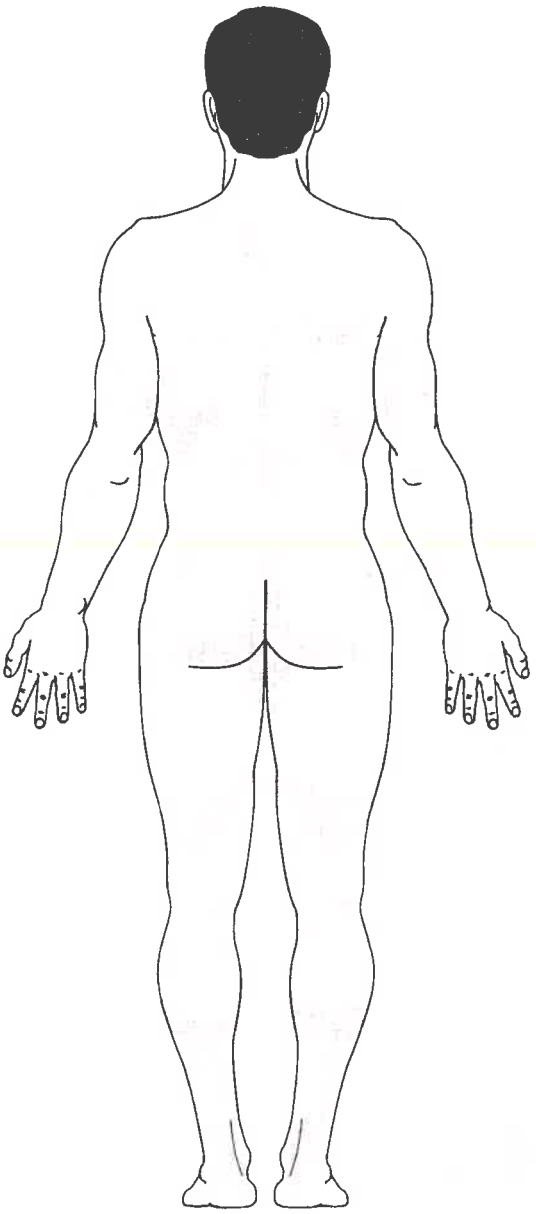



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## COMPREHENSIVE SEXUAL ASSAULT ASSESSMENT FORM PAGE 8 OF 9

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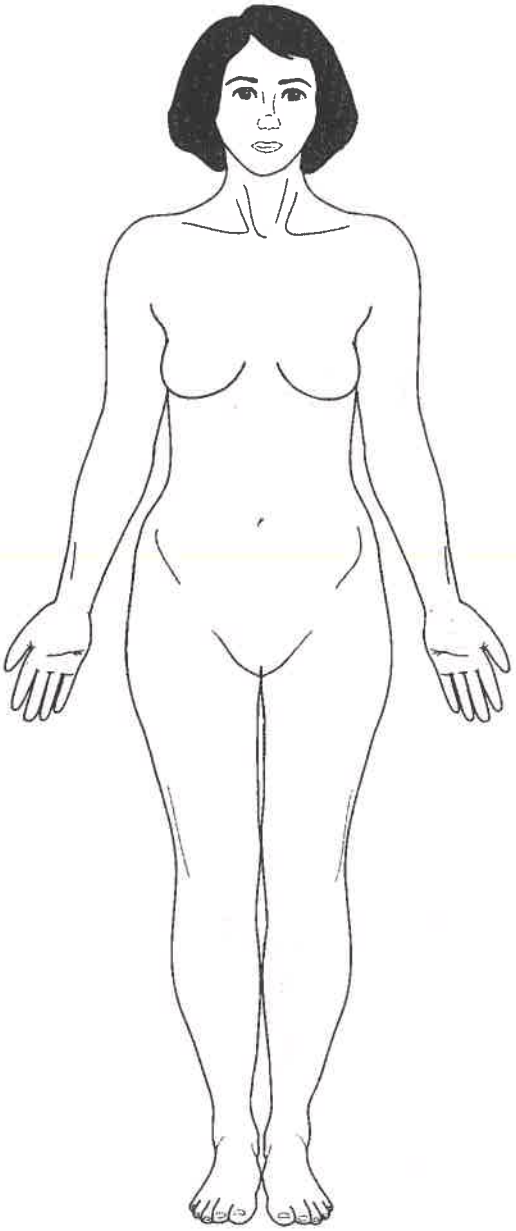

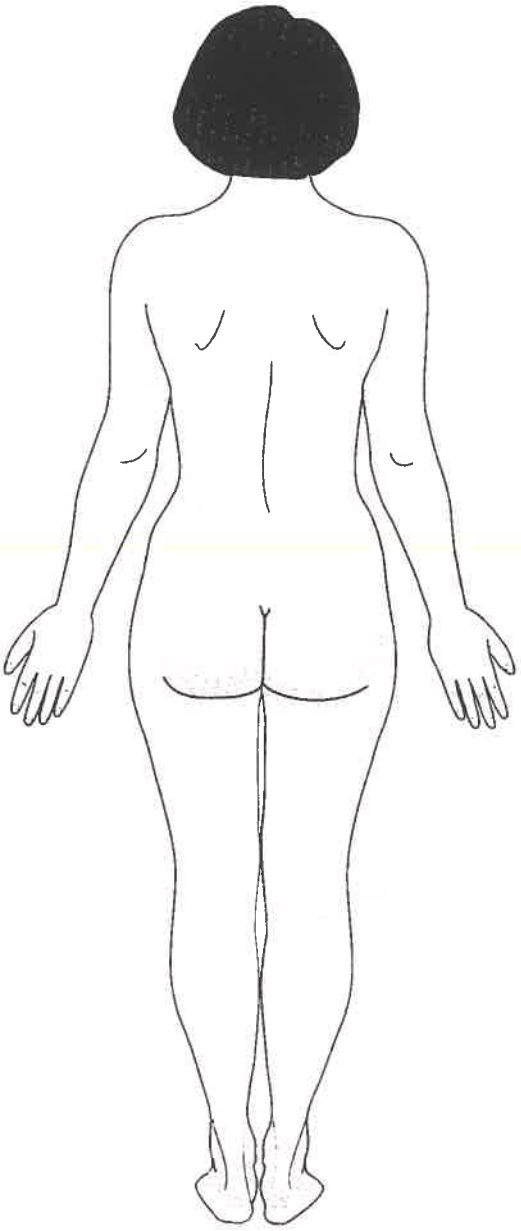



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## COMPREHENSIVE SEXUAL ASSAULT ASSESSMENT FORM PAGE 9 OF 9

*PLEASE PRINT CLEARLY* ⟶
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**SPECIFIC UNDERSTANDINGS**

1. I, or my personal representative, authorize the use or disclosure of my medical and/or billing information as I have described on this form.
2. I understand that my medical and/or billing information could be re-disclosed and no longer protected by federal health information privacy regulations if the recipient(s) described on this form are not required by law to protect the privacy of the information.
3. I understand that if my medical and/or billing records contain information relating to HIV/AIDS, this information will not be released to the person(s) I have indicated unless I check the box for this information, provided below.
4. I understand that I am authorizing the use or disclosure of HIV/AIDS related information, the recipient(s) is prohibited from using or re-disclosing any HIV/AIDS related information without my authorization, unless permitted to do so under federal or state law. I also understand that I have a right to request a list of people who may receive or use my HIV/AIDS related information without authorization. If I experience discrimination because of the use or disclosure of HIV/AIDS related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
5. I understand that I have the right to refuse to sign this authorization and that my health care, the payment for my health care, and my health care benefits will not be affected if I do not sign this form. I also understand that if I refuse to sign this authorization, NYCHHC cannot honor my request to disclose my medical and/or billing information.
6. I understand that I have the right to request to inspect and/or receive a copy of the information described on this authorization form by completing a **Request for Access Form**. I also understand that I have a right to receive a copy of this form after I have signed it.
7. I understand that if I have signed this authorization form to use or disclose my medical and/or billing information, I have the right to revoke it at any time, except to the extent that the hospital has already taken action based on my authorization or that the authorization was obtained as a condition for obtaining insurance coverage. To revoke this authorization, please complete a **Request to Revoke Authorization Form** and return it, signed and dated, to this HHC facility.

***I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.***

| | |
|---|---|
| **Name and contact information of patient whose information will be disclosed?** | |
| **Who will disclose patient's information?** | HHC Facility: _____ |
| **Information to be used or disclosed:** | ☐ HIV/AIDS (If checked, you are authorizing release of this type of information.) **Specific Information:** All protected health information related to this emergency room visit, including all forensic evidence obtained, the contents of my comprehensive sexual assault assessment form, and relevant information from my medical chart. |
| **Who will be given patient's information?** | ☐NYC Police Department ☐ Office of the District Attorney for _____ County. |
| **Expiration date or event:** | Conclusion of the investigation and prosecution of my case. |
| **Reason for authorization:** | Request of patient. |

***I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.***

| | |
|---|---|
| Signature of Patient or Personal Representative | Date |
| Print Name of Patient or Personal Representative | Description of Personal Representative's Authority to Act |
| Name of Translator (if required) | **N.B.** If NYCHHC staff requires this form in a language other than English, please access the HHC Limited English Proficiency Intranet site at: http://lep.nychhc.org |



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