New York State Sexual Assault Victim Bill of Rights

The 'New York State Sexual Assault Victim Bill of Rights' is a list of general information about your rights. This copy is for you to keep. If you wish, all the information can be explained to you in more detail before any exam or interview takes place.

General Rights

- You cannot be treated differently based on certain characteristics, such as race, national origin, religion, sexual orientation, disability, age, source of payment, sex, gender identity, or gender expression.
- Your immigration status or national origin cannot affect your emergency care or services. You can ask for an interpreter if it is hard for you to understand or speak English.
- Minors under the age of 17 have certain rights to make their own decisions without a parent or legal guardian.

Hospital Emergency Department Rights

- You can have an advocate from the local rape crisis program stay with you during the exam.
- You can have an exam in any hospital emergency department to collect evidence and provide certain medical care related to the sexual assault at no cost to you. If you do not have health insurance, or you decline to use your health insurance, you can ask the hospital to bill the Office of Victim Services.
- You can have medicine to prevent pregnancy and sexually transmitted infections (STIs, also known as STDs) for free. For HIV prevention, a 7-day pack of medicine can be started at the hospital.
- You will be provided information on appropriate follow-up medical care.

Law Enforcement Rights

- You can choose to report to the police or not.
- You can choose to have or not have an advocate from the local rape crisis program stay with you during your interview with the police or prosecutor.
- You will be given contact information for the police or prosecutor handling your case.
- You can contact the police or prosecutor for information on the criminal investigation or legal proceedings. The police or prosecutor will inform you of any legal action related to your case.
- If you choose to report to the police, your evidence will be tested within 100 days. You may contact the police for information on a DNA match.
- If you choose not to report to the police, your evidence will be stored for 20 years, or until you decide to release it. You will be notified if your evidence is moved and before the storage period ends.

New York State Sexual Assault Victim Bill of Rights
Additional Information

Police Agency:	
Contact Name:	
Phone No.:	
Email:	

Prosecuting Agency:	
Contact Name:	
Phone No.:	
Email:	

If the contact information for the police or prosecutor is unknown, please call:

- If the crime occurred in New York City: New York Police Department Special Victims Division at **646-610-7273**.
- If the crime occurred anywhere else in the State: New York State Police Sexual Assault Hotline at **1-844-845-7269**.

Advocate Agency:	
Contact Name:	
Phone No.:	
Email:	

If the contact information for the rape crisis or victim assistance agency is unknown, please call:

- New York State Hotline for Sexual Assault and Domestic Violence at **1-800-942-6906**.

For more information, please visit www.ovs.ny.gov or www.health.ny.gov/prevention/sexual_violence/

NEW YORK STATE | Office of Victim Services

NEW YORK STATE OFFICE OF VICTIM SERVICES
MEDICAL PROVIDER FORENSIC RAPE EXAMINATION
DIRECT REIMBURSEMENT CLAIM FORM (6/20)

* F R E – 0 1 *

INSTRUCTIONS: This form is to be used when a NYS licensed healthcare provider is directly billing the New York State Office of Victim Services (OVS) for reimbursement of costs associated with providing a forensic exam for a victim of sexual assault.

(1) Fill in all blanks on this form.
(2) Attach: Itemized bill and supporting documentation indicating SOEC Kit was used and/or HIV PEP Meds were provided, if applicable.

All Sections ONE through THREE **must** be completed

(3) Mail the completed form and all attachments to:
NYS Office of Victim Services
Attn: FRE Processing
80 S. Swan Street, 2nd Floor
Albany, New York 12210

SECTION ONE. VICTIM INFORMATION (TO BE COMPLETED BY MEDICAL PROVIDER)

Date of Crime _____ Location of Crime (City) _____ (county) _____ (State) _____

Victim's Name _____

Date of Birth _____ Social Security Number _____

SECTION TWO. BILLING PROVIDER INFORMATION (TO BE COMPLETED BY MEDICAL PROVIDER)

Billing Provider Federal I.D. Number 13-2655001 Date of Exam _____

Billing Provider Name KINGS COUNTY HOSPITAL Operator Certificate or Facility ID.# 70010164

Address 451 CLARKSON AVENUE City BROOKLYN State NY Zip 11203

Billing Department Contact Person JAI PERSAUD Phone Number (718) 245 - 2478

Was a Sexual Offense Evidence Collection (SOEC) Kit Used? ____ **No** ____ **Yes** **SOEC Kit Tracking #** **(Required once tracking is available)** _____

Were HIV PEP Meds Provided? ____ **No** ____ **Yes** **If yes:** ____ **7 Day Starter Pack** ____ **Full Regimen 28 Day Pack**

Please select one option above and indicate on attached invoice.

The billing provider and other service providers, by law, shall not bill the victim for these services. Payment made to the providers by OVS under the Direct Reimbursement Program shall be considered by all providers as payment in full.

SECTION THREE. VICTIM INSURANCE WAIVER (TO BE COMPLETED BY VICTIM/LEGAL GUARDIAN)

- The law requires that the victim be advised orally and in writing that they may decline to provide insurance information.
- I have been fully advised of the options of payment for the forensic exam and the outcomes resulting from my forensic payment decision. I understand that I may use private insurance benefits, including Medicaid, Medicare, HMO or any other insurance program for payment of the forensic exam provided to me. I have also been advised that I will have to use my private insurance if I file a claim with OVS for other medical services outside of the forensic exam.
  Initial your selection for Option #1, #2 or #3 below:

_____ **Option # 1** – I choose not to use my private insurance benefits but request that the OVS be billed directly. I decline to provide such information regarding private health insurance benefits because I believe that the provision of such information would substantially interfere with my personal privacy or safety.

_____ **Option # 2** – I do not have private insurance benefits and request that OVS be billed directly.

_____ **Option # 3** – I choose to use my private insurance benefits for payment, or I choose to pay for my care directly.

Victim/Legal Guardian Name (Print or Type): _____

Victim/Legal Guardian Signature: _____ Date: _____

Examiner Name (Print or Type): _____ Examiner (Signature): _____

Profession: _____ License # _____ Date: _____

If you have questions, call the NYS Office of Victim Services at (800) 247-8035 or (518) 457-8727.

NEW YORK STATE | Office of Victim Services

NEW YORK STATE OFFICE OF VICTIM SERVICES
MEDICAL PROVIDER FORENSIC RAPE EXAMINATION
DIRECT REIMBURSEMENT CLAIM FORM (6/20)

* F R E – 0 1 *

GENERAL INSTRUCTIONS

- Print legibly – illegible claims will be rejected and returned to the billing provider.
- Fill in all blanks on the form – fields left blank will result in the rejection of your claim.
- An itemized bill for services must be attached to each claim form. This bill should be in the same form and substance as that billed to NYS Medicaid; it must include a billable code and charge for each line item (e.g., it is not acceptable for "pharmaceuticals" to be listed as one item), the sum total of all charges, and a valid sexual assault or sexual abuse diagnosis code.
  - NOTE: Billable codes are subject to change. Make sure to use the most current codes.
- If a Sexual Offense Evidence Collection (SOEC) Kit was used and/or HIV Post Exposure Prophylaxis (HIV PEP) Medication was provided, the provider must include supporting documentation.
- Please see the "Supplemental Information" document on our website for additional guidance.

CLAIM FORM - SECTION ONE

- Fill in the date and location of crime including city, county and state. Do not use "unknown" or "not applicable/not available" in these fields.
  - NOTE: If the date of crime cannot be determined, please provide an approximation. This can be a month/year, season/year, or date range.
  - NOTE: If the sexual assault occurs in another state or country, please provide as much information as possible to determine a location of crime.
- Print the victim's name including the first and last name, the victim's date of birth including the month, day and year of birth and the victim's Social Security Number (SSN).
  - NOTE: If the victim does not have or will not share an SSN, you must indicate in this field why you are not providing an SSN. Examples include; "undocumented," "infant," "not issued," "not available," and "N/A."

CLAIM FORM - SECTION TWO

- This section is to be completed by the facility where the forensic exam is performed. This may be the hospital or other Article 28 health care facility, a clinic, a private physician's office, a child advocacy center, etc.
- Print the date that the forensic exam was performed including the month, day and year of the exam.
- Print the billing provider's federal tax identification number, billing provider name, operator certificate/facility ID#.
  - NOTE: If the facility is not a hospital or other Article 28 facility and does not have an operator's certificate or facility ID#, mark this field with "not applicable" or "N/A" and indicate the type of facility; i.e., "N/A – Child Advocacy Center."
- Print the name and telephone number of the billing department representative and the address of the billing provider. This is the address where all correspondence will be mailed.
- Indicate whether a Sexual Offense Evidence Collection (SOEC) Kit was used. You must indicate yes or no. If an SOEC Kit was used, you must include the SOEC Kit tracking information.
  - NOTE: If kit tracking is not yet available, you may indicate "N/A" in this field.
- Indicate whether HIV Post Exposure Prophylaxis (HIV PEP) Medication was provided. You must indicate yes or no. If HIV PEP was provided you must indicate whether it was a 7-day starter pack or full 28-day regimen.
  - NOTE: OVS reimbursement for HIV PEP will not exceed that of which is required under the law.

CLAIM FORM - SECTION THREE

- Read the payment options to the victim and make sure that the victim understands their options.
  - NOTE: Please see the "Supplemental Information" document for translations in seven (7) additional languages.
- Have the victim or legal guardian initial one selection of Option #1, #2 or #3.
- Have the victim or legal guardian print their name, sign and date the form.
  - NOTE: A minor may sign their own claim form so long as it is reasonable to conclude that they understand both the form and the payment options.
  - NOTE: Claim forms must bear the original signature of the victim or their legal guardian. Unsigned claim forms or photocopied signatures will be rejected. Verbal authorizations cannot be accepted.
- The licensed health care provider who performed the forensic exam must print their name, sign and date the form.
  - NOTE: Claim forms must bear the original signature of the licensed health care provider. Unsigned claim forms or photocopied signatures will be rejected.
- The licensed health care provider must record their license number and profession on the form.
  - NOTE: Profession means the provider's professional designation; i.e., MD, DO, NP, PA, and RN.

If you have questions, call the NYS Office of Victim Services at (800) 247-8035 or (518) 457-8727, or visit www.ovs.ny.gov

NEW YORK STATE | Division of Criminal Justice Services

Part A – Sexual Offense Evidence Collection Kit
Information and Instructions

If you have any questions, please contact the Division of Criminal Justice Services (DCJS) Office of Forensic Services (OFS) at kits@dcjs.ny.gov or 518-457-1901.

To Order Additional Kits

The Sexual Offense Evidence Collection Kit (SOECK) order form is available on the DCJS website at the following web address:
https://www.criminaljustice.ny.gov/ofpa/pdfdocs/sexual_offense_kit_2020_order_form.pdf.
Completed order forms should be returned electronically to kits@dcjs.ny.gov.

Background

DCJS provides New York State SOECKs free of charge to approved medical providers in the State.

The NYS SOECK was developed and updated through the collaborative efforts of DCJS, the New York State Department of Health (DOH), the New York State Office of Victim Services (OVS), the New York State Office for the Prevention of Domestic Violence (OPDV), New York State public forensic laboratories, as well as medical and legal practitioners.

The NYS SOECK, and recommended evidence collection protocol, is informed by the following documents from the US Department of Justice (DOJ):

- National Best Practices for Sexual Assault Kits: A Multidisciplinary Approach (2017)
- A National Protocol for Sexual Assault Medical Forensic Examinations (2013)
- A National Protocol for Sexual Abuse Medical Forensic Examinations, Pediatric (2016)
- National Training Standards for Sexual Assault Medical Forensic Examiners (2018)

(It is generally recommended to refer to latest available DOJ guidance and documentation on sexual assault)

NYS DOH also administers the State's Sexual Assault Forensic Examiner (SAFE) Program. Please refer to the DOH website for additional information: https://www.health.ny.gov/professionals/safe/

General Notes

- Every hospital in New York State is required to provide care and evidence collection to sexual assault patients.
- Evidence can be collected by any registered nurse, nurse practitioner, physician's assistant, or physician.
    - It is recommended that providers be SAFEs and/or Sexual Assault Nurse Examiners (SANEs).
- Evidence collection kits are designed to assist in the uniform collection of evidentiary specimens in any case in which the crime/incident involved is a sexual assault.
- These kits may be used for an adult, adolescent, or pediatric sexual assault patient.
    - With prepubertal patients please refer to the included Prepubertal Patient Information Sheet and Step 11 envelope instructions.
- It is acknowledged that while the completion of every evidence collection step is generally recommended, the medical practitioner may elect to not complete one or more steps based on the physical and/or emotional wellbeing of the patient, or the patient's history.
- It is also acknowledged that the patient has the right to refuse one or more individual steps without relinquishing the right to have evidence collected.
- Medical practitioners are asked to appropriately document deviations from the recommended examination procedure.

- The patient is not required to report the assault to the police to receive evidence collection.
- Each individual kit is designed to collect evidence from only one sexual assault patient.
- Medical providers should not analyze collected evidence.

Pre-Sexual Offense Evidence Collection Considerations

- Triage and Medical Treatment: Every sexual assault patient should be given a complete medical exam before evidence collection. Generally, the patient must be medically stable and able to provide consent before evidence collection can begin.
- Medical Provider Notes:
  - Practitioners should change gloves for each step.
  - Please document the names of all medical personnel present during the examination in the patient's medical record.
- Patient Rights: The New York State Sexual Assault Victim Bill of Rights must be provided to every presenting sexual offense victim before a medical facility commences a physical examination of a sexual offense victim. The medical practitioner conducting the exam shall inform the victim of the victim's rights by providing a copy of the sexual assault victim bill of rights and offering to explain such rights. This document details a patient's legal rights. Patients must also be provided with the contact information for the police agency, prosecutorial agency, or other law enforcement agency personnel who are trained in trauma and victim response.
- Consent: The entire sexual assault medical forensic exam is conducted at the patient's discretion. Written or oral, informed consent must be obtained and documented for the medical exam, evidence collection, photography, and evidence storage or release of evidence and information to law enforcement. If a patient is unconscious and unable to give consent, please refer to medical provider's policy.
- Advocacy: Hospital personnel shall advise sexual assault patients of the availability of services from a local rape crisis program, if any, to accompany the patient through the medical-forensic exam. If the patient wishes the presence of an advocate, the hospital shall contact the appropriate organization and request that one be provided.

SOECK Components

There are two distinct NYS Sexual Offense Evidence Collection Kits, **Part A** and **Part B**.

- The Part A Kit is to be used for the collection and preservation of sexual offense forensic evidence. This kit is generally used within 120 hours of a sexual assault.
- The Part B Kit is to be used **only** in cases where there is a suspicion of a drug facilitated sexual assault. The Part B Kit **must** be used in conjunction with the Part A Kit and cannot be used on its own. This kit is also generally used within 120 hours of a sexual assault.

Part A Kit

The Part A Kit includes twelve (12) examination steps. The individual instructions for each examination step are printed on the corresponding sample envelope, which are included sequentially in the kit. The Part A Kit is generally ordered for the examination to proceed from "head-to-toe."

The Part A Kit examination steps are:
Step 1 – Trace Evidence & Debris
Step 2 - Underwear
Step 3 - Clothing (no envelope provided for this step, collected clothing items must be packaged separately in paper bags)
Step 4 - Oral Swabs
Step 5 - Buccal Swab
Step 6 - Fingernail Swabs
Step 7 - External Dried Secretion & Bitemark Swabs (non-genital)
Step 8 - Pubic Hair Combings
Step 9 - Perianal & Anal Swabs

Step 10 - Vulvar or Penile Swabs
Step 11 - Vaginal / Cervical Swabs (combined swabbing; in same envelope)
Step 12 - Tampon / Pad / Liner

The Part A Kit also includes the following documents and forms:

For the Provider –

- Patient Consent Form
- Part B Kit Information Sheet
- Prepubertal Patient Information Sheet
- Provider Reimbursement Claim Form and Instructions
- Forensic Laboratory Supplemental Information Form
- Evidence Seals

For the Patient –

- Patient Reimbursement Claim Applications and Instructions
- HIV Testing Pamphlet (English & Spanish)
- Emergency Contraception Pamphlet

For medical providers that do not utilize their own documentation forms, the following are also available for download on the DCJS website at https://www.criminaljustice.ny.gov/evidencekit.htm:

- Medical Record Sexual Assault Form
- Patient Information Form
- Patient Diagram Form

Part B Kit

As indicated above, the Part B Kit is to be used **only** in cases where there is a suspicion of a drug facilitated sexual assault. If asked, please advise the patient that Part B Kit evidence has limited probative value without the collection of corresponding Part A Kit evidence.

The Part B Kit contains:

- Blood and Urine Specimen Collection Instructions
- Drug Facilitated Sexual Assault Patient Examination Form
- Authorization Form for Release to Law Enforcement for Drug Screening
- Antiseptic Prep Pad
- 2x 6ml Gray Top Blood Tubes
- 100 ml Urine Specimen Bottle
- Urine Specimen Bottle Ziplock Bag
- Liquid Absorbing Sheet
- Evidence Seals
- Security Seal

Medical Provider and Victim Reimbursement

The Office of Victim Services directly reimburses medical providers for forensic rape examinations if victims of sexual assault do not have access to private health insurance or choose not to use their private health care insurance for the examination.

OVS also provides compensation to victims and certain other parties for compensation of out-of-pocket expenses not covered by insurance or other resources.

Medical Providers

Please see the enclosed Medical Provider Forensic Rape Examination Direct Reimbursement Claim Form. Also refer to the following OVS webpage for additional information:
https://ovs.ny.gov/forensic-rape-examination-fre-direct-reimbursement-program

Victims

Please see the enclosed Claim Application and Instructions. Also refer to the following OVS webpage for additional information:
https://ovs.ny.gov/victim-compensation

Post-Sexual Offense Evidence Collection Considerations

- Photography: Taking photographs may be a part of the medical forensic exam process. However, do not include photographs in the SOECK. Any photos should be stored in the patient's medical record, and/or released to the investigating officer as determined by the institution's policy.
- Completing the SOECK: Make sure each envelope used contains all requested items and information. Be sure to indicate no or declined on any envelopes that were not used. Return all envelopes to the kit. Sign the Evidence Seal and use it to seal the kit. Do not seal patient documents or consent form inside kit. Fill in all Medical Provider Information on box top.
- Procedures for Release of Evidence: If the patient has consented to notify and release evidence to law enforcement, the sealed kit and clothing bags must be given to the investigating law enforcement officer. If the officer is not present, the evidence must be temporarily stored in the hospital or a contracted entity.
- Procedure for Storage of Evidence: Patients may choose not to authorize notification or release of evidence at the time of examination. The hospital, or a contracted entity, must maintain sexual offense evidence in a locked, separate, and secure area, for no less than twenty years. At any time thereafter, the patient may direct the hospital to surrender their evidence to the police, or for certain kinds of evidence, the police may request its surrender.
- Proper Storage of Evidence: Where appropriate, clothing and swabs must be dried, stored in paper bags, and labeled. Part B Kit evidence must be refrigerated. Evidence must be kept in a locked, separate, and secure area. For more information on storage condition recommendations, refer to the hospital's local forensic laboratory. Please also refer to DOJ best practice recommendations.
- Chain of Custody: Chain of custody refers to a chronological log of who handled evidence and the area where it was maintained. The area must have limited access and all access must be logged. The log must also reflect any movement of the evidence from one area to another. All evidence must be properly labeled and sealed. Each item of evidence must be marked and logged with a number corresponding to the sexual assault victim's medical record.
- Patient Discharge and Follow-up: Prior to discharge, review all materials with the patient, as appropriate. Also prior to discharge, hospital personnel must assess the patient's medical and mental health needs, and safety concerns. The hospital must provide information and referrals, as needed. Patient's must also be provided with oral and written medical instructions, and arrangements for follow-up care.

NEW YORK STATE | Division of Criminal Justice Services

Prepubertal Patient Information Sheet

This SOECK is designed for any registered nurse, nurse practitioner, physician's assistant or physician to obtain sexual assault evidence.

- Under NO circumstances should a child be forced, restrained or sedated for the purpose of evidence collection.
- Clinicians only need reasonable concern that sexual abuse may have occurred.
- Remember that children frequently do not disclose the full extent of what has happened.

DO NOT INTERVIEW THE PATIENT
AVOID UNNECESSARY TRANSFER OF PATIENT TO ANOTHER FACILITY
CONSIDER PHONE CONSULT WITH AVAILABLE SANE, CHILD ABUSE PEDIATRICIAN, OR CHILD ADVOCACY CENTER

Evidence collection is recommended when children disclose or there is concern for:	• Any suspected and/or reported sexual assault/sexual abuse **within past 120 hours**. This includes, but is not limited to sexual touching/fondling (however slight), licking, biting, or penetration of the body cavities. • Anogenital injury, bleeding, or discharge consistent with reported history. • Possible ejaculate or saliva on child's body • History of abduction or suspicious report of child missing • Suspicious/unusual circumstances based on clinical judgement.
Evidence collection is NOT recommended:	• Sexual assault/sexual contact is suspected and/or reported to have occurred **more than 120 hours** before ED presentation • Solely based on behavioral changes such as bedwetting, masturbation, or sexualized behaviors, which may have another etiology.

A CHILD WITH AN INTERNAL INJURY AND/OR BLEEDING, OR A FOREIGN BODY MAY REQUIRE SEDATION FOR EXAM AND/OR EVIDENCE COLLECTION.

When Completing the Evidence Collection Kit:

1. If the child provides spontaneous case related information, document their remarks using quotations.
2. Obtain a brief history from the parent or caregiver accompanying the child. Ensure that this is completed outside the presence of the child.

Mandated Reporting

When it is suspected that sexual abuse/assault has occurred, whether or not forensic evidence is collected, a hotline report should be made:

- ☐ NYS Central Register 1-800-342-3720

Considerations for Contacting Law Enforcement

Clinicians can assist parents/guardians who choose to report to law enforcement.
Inform parents/guardians that early law enforcement involvement can be helpful:

- A timely crime scene investigation helps minimize evidence loss.

NEW YORK STATE | Division of Criminal Justice Services

Part A Kit – Sexual Assault
Patient Consent Form for Evidence Collection and Release or Storage

ATTACH PATIENT LABEL
Or Enter Patient Name: _____

Additional Information			
Patient Phone:		Patient Email:	
Facility Name:			

Instructions: This form is to be used when a sexual assault patient or guardian authorizes the collection of evidence. Please include patient's / guardians' initials on designated lines; complete signatures are required at the bottom of the form.

A mature minor who presents at a hospital emergency department may consent or may choose not to consent, without parental involvement, to a forensic exam, in the course of post-sexual assault care.

This consent form is not meant to describe all components of a sexual assault medical forensic exam. Fully informed consent must be obtained from the patient throughout the exam through ongoing verbal communication between the provider, the patient and the guardian, if any. Save this form in the patient's electronic medical record. A copy may be distributed to the authorizing person (patient and or guardian) and law enforcement, if released.

Consent for Sexual Offense Evidence Collection

I agree to let the provider examine me and collect sexual assault evidence using the *New York State Sexual Offense Evidence Collection Kit, Part A*. I understand that this may include asking me about my personal and medical history, examining me for possible injuries or other medical issues, and taking samples for evidence. I may also choose to consent to photographs of injuries, if needed. This evidence will be used if I want to report the crime to law enforcement.

I understand that I can say no to any or all parts of this exam and evidence collection at any time. The provider has told me about my rights by giving me a copy of the "New York State Sexual Assault Victim Bill of Rights" and offering to explain it to me.

Please put your initials next to your choice:

Collection of Evidence Yes _____ No _____

Photographs Yes _____ No _____

... continue to Page 2

Pursuant to New York Executive Order No. 26 "Statewide Language Access Policy," translated versions of this document are available in the designated languages at https://www.criminaljustice.ny.gov/evidencekit.htm

Consent for Release or Storage of Sexual Offense Evidence

I can decide to let law enforcement know about my case and to give the information and evidence collected from me to law enforcement. Evidence may include the *New York State Sexual Offense Evidence Collection Kit Part A*, *New York State Sexual Offense Evidence Collection Kit Part B*, photographs, and/or any other personal items collected during the exam. Law enforcement will give my evidence to a forensic lab for testing.

Or, I can decide that I do not want to notify law enforcement or allow my evidence and information collected to be given to them. I have been told that my collected evidence will be kept in secure storage for 20 years. If I do not want my evidence given to law enforcement within the 20-year storage period, it will subsequently be discarded in accordance with state and local laws.

I understand that I may choose to release my evidence to law enforcement at any time until it has been discarded. To release my evidence, I can contact the medical provider that collected it, law enforcement, victim assistance programs, or the secure storage facility. If my evidence is going to be moved, and before it is discarded, someone will make a diligent effort to notify me.

I understand that my clothes and any other personal items collected as evidence will be returned to me if I ask for them.

Please put your initials next to your choice:

Notify Law Enforcement	Yes _____ No _____
Release Evidence to Law Enforcement (If responding no, evidence will be sent to long-term storage)	Yes _____ No _____
Release Photography to Law Enforcement	Yes _____ No _____
Release Other Items (specify) _____	Yes _____ No _____

Person authorizing consent is: ☐ Patient ☐ Patient's Parent ☐ Patient's Guardian

☐ Other (specify): _____

Signature of Authorizing Person	Print Name	Date
Signature of Medical Provider	Print Name	Date
Signature of Interpreter (if any)	Print Name	Date

Distribution: Original in patient medical record; Copy to patient;
Copy to law enforcement, if notifying

Do not place consent form in Part A Kit box

Pursuant to New York Executive Order No. 26 "Statewide Language Access Policy," translated versions of this document are available in the designated languages at https://www.criminaljustice.ny.gov/evidencekit.htm

NEW YORK STATE | Division of Criminal Justice Services

Part B – Drug Facilitated Sexual Assault Kit

Evidence Collection Information and Instructions

If you have any questions, please contact the Division of Criminal Justice Services (DCJS) Office of Forensic Services (OFS) at kits@dcjs.ny.gov or 518-457-1901.

The Part B Kit is to be used **only** in cases where there is a suspicion of a drug facilitated sexual assault. The Part B Kit **must** be used in conjunction with the Part A Kit and cannot be used on its own. This kit is generally used within 120 hours of a sexual assault. Collected kits must be refrigerated.

Collect **both** blood and urine specimens from patients in all cases.
Urine specimens should be collected as soon as possible, but not before completing the Part A Kit evidence collection. The first urine after the drugging is critical; every time the patient urinates the chance of detecting a drug, if present, diminishes. Therefore, every effort should be made to obtain the first urine specimen. If a urine specimen is collected at the start of the exam for a pregnancy test, the leftover urine should not be thrown out.

The Part B Kit contains:

- Blood and Urine Specimen Collection Instructions
- Drug Facilitated Sexual Assault Laboratory Information Form
- Patient Consent Form for Evidence Collection and Release or Storage
- Antiseptic Prep Pad
- 2x 6ml Gray Top Blood Tubes
- 100 ml Urine Specimen Bottle
- Ziptop Bag
- Liquid Absorbing Sheet
- 3x Evidence Seals
- Security Seal

Instructions

STEP 1 The provider should review and complete the Part B Kit - Drug Facilitated Sexual Assault Patient Consent Form with the authorizing patient or guardian.

STEP 2 Fill out the Drug Facilitated Sexual Assault Forensic Laboratory Information Form.

Blood Specimen Collection

Blood specimen collection must be performed by a physician, registered nurse, or trained phlebotomist. If the provided blood tubes have expired, use two gray top tubes from the medical provider's supply.

STEP 3 Cleanse the blood collection site with the provided alcohol-free prep pad. Following normal provider procedure, use the provided gray top blood tubes to collect blood specimens from the patient. *Fill both tubes to the maximum volume.*

Immediately after blood collection, assure proper mixing of anticoagulant powder by slowly and completely inverting the blood tube several times. Do not shake vigorously.

STEP 4 Write the patient's name directly on the white label on the blood tube. Fill in the date on two of the three provided evidence seals. Affix center of the seals to the top of the blood tube rubber stoppers and press ends of seals down the sides of the blood tubes. Return filled and sealed tubes to specimen holder.

Urine Specimen Collection

STEP 5 Have the patient void directly into the provided urine specimen bottle. Do not use clean catch method. Collect 100 ml. of urine, or as much as possible.

STEP 6 After specimen collection, replace cap and tighten down to prevent leakage.

STEP 7 Fill in the date on the remaining evidence seal. Affix center of seal to the top of the bottle cap and press ends of seal down the sides of the bottle. Return filled and sealed bottle to specimen holder.

STEP 8 Place specimen holder inside the provided ziptop bag, then squeeze out excess air and close bag. Be sure to place liquid absorbing sheet inside ziptop bag. Place specimen holder in kit box.

STEP 9 Make three copies of the Drug Facilitated Sexual Assault Forensic Laboratory Information Form. Place the original in the Part B Kit box, retain a copy in the patient's medical record, provide a copy to the patient, and provide the third copy to law enforcement, if releasing evidence.

STEP 10 Close the Part B Kit box, fill in the date and provider's initials on the security seal, and seal the Part B Kit box.

STEP 11 Complete information requested on Part B Kit box top.

STEP 12 Place completed, sealed kit in a secure and refrigerated storage area, in accordance with medical provider's protocol. If the patient consented to releasing evidence, give sealed Part B Kit to law enforcement official. If the Part B Kit is not being released to law enforcement, coordinate the transfer of collected evidence to the long term storage facility. Be sure to properly document chain of custody.

NEW YORK STATE | Division of Criminal Justice Services

Part B Kit – Drug Facilitated Sexual Assault
Patient Consent Form for Evidence Collection and Release or Storage

AFFIX PATIENT LABEL
Or Enter Patient Name: _____

Additional Information			
Patient Phone:		Patient Email:	
Facility Name:			

Instructions: This form is to be used when a sexual assault patient or guardian authorizes the collection of sexual assault evidence **and there is suspicion of a drug facilitated sexual assault**. Please include patient's / guardians' initials on designated lines; complete signatures are required at the bottom of the form.

A mature minor who presents at a hospital emergency department may consent or may choose not to consent, without parental involvement, to a forensic exam, in the course of post-sexual assault care.

This consent form is not meant to describe all components of a sexual assault medical forensic exam. Fully informed consent must be obtained from the patient throughout the exam through ongoing verbal communication between the provider, the patient and the guardian, if any. Save this form in the patient's electronic medical record. A copy may be distributed to the authorizing person (patient and or guardian) and law enforcement, if released.

Consent for Drug Facilitated Sexual Offense Evidence Collection

I agree to let the provider collect blood and urine specimens using the *New York State Sexual Offense Evidence Collection Kit, Part B*. I understand that this is for the purpose of identifying the presence of drugs as a part of a sexual assault exam. This evidence will be used if I want to report the crime to law enforcement.

I understand that I can say no to any or all parts of this exam and evidence collection at any time. The provider has told me about my rights by giving me a copy of the "New York State Sexual Assault Victim Bill of Rights" and offering to explain it to me.

Please put your initials next to your choice:

Collection of Blood Yes _____ No _____

Collection of Urine Yes _____ No _____

Consent for Release or Storage of Drug Facilitated Sexual Offense Evidence is included in the Part A Consent for the kit as a whole.

... continue to Page 2

Pursuant to New York Executive Order No. 26 "Statewide Language Access Policy," translated versions of this document are available in the designated languages at https://www.criminaljustice.ny.gov/evidencekit.htm

Person authorizing consent is: ☐ Patient ☐ Patient's Parent ☐ Patient's Guardian

☐ Other (specify): _____

Signature of Authorizing Person	Print Name	Date
Signature of Medical Provider	Print Name	Date
Signature of Interpreter (if any)	Print Name	Date

Distribution: Original in patient medical record; Copy to patient

Do not place consent form in Part B Kit box

Pursuant to New York Executive Order No. 26 "Statewide Language Access Policy," translated versions of this document are available in the designated languages at https://www.criminaljustice.ny.gov/evidencekit.htm

NEW YORK STATE | Division of Criminal Justice Services

Drug Facilitated Sexual Assault Forensic Laboratory Information Form

Patient's Name: _____

Patient's Height (approximate): _____ Weight (approximate): _____

Did the patient experience unconsciousness and for how long? _____

Date and time of the Alleged Drugging: _____

Specimen Collection:

Blood (2 gray top tubes): Date: _____ Time: _____

Urine (bottle): Date: _____ Time: _____ cc's collected: _____

Since the incident, how many times did the patient void prior to this collection? _____

How much alcohol did the patient consume? _____ Type of alcohol? _____

Please circle *"Hx"* (patient history) or *"Obs"* (observed by examiner). Circle both, if appropriate.

Disturbance of Consciousness	Memory Impairment	Neurological	Psycho physiological	GI/GU
Drowsiness Hx Obs	Confusion Hx Obs	Muscle Relaxation Hx Obs	Excitability Hx Obs	Nausea Hx Obs
Sedation Hx Obs	Memory Loss Hx Obs	Dizziness Hx Obs	Aggressive Behavior Hx Obs	Vomiting Hx Obs
Stupor Hx Obs		Weakness Hx Obs	Sexual Stimulation Hx Obs	Diarrhea Hx Obs
Loss of Consciousness Hx Obs		Slurred Speech Hx Obs	Loss of Inhibitions Hx Obs	Incontinence Urine/Feces Hx Obs
		Paralysis Hx Obs	Hallucinations Hx Obs	
		Seizures Hx Obs	Dissociation Hx Obs	
		Pupil Size Hx Obs		

List any drugs taken prior to and after the incident, include recreational, prescription, and OTC drugs.

	Name	Date	Time	Amount
Prior to incident:				
After incident:				

Medical Provider: _____ Date: _____ Time: _____

Distribution: Original in Part B Kit box; Copy in patient medical record

NEW YORK STATE | Division of Criminal Justice Services

Forensic Laboratory Supplemental Information Form

Medical Facility Name
Examination Performed By
Date of Examination
Form Completed By
Form Completion Date

Patient's Name: _____ Age: _____
DOB: ___ /___ /___ Sex Classification at Birth: ☐ M ☐ F

Incident information relevant to evidence collection:

1. Date and approximate time of the assault:
   Date: ___ /___ /___
   Time: _____ ☐ AM ☐ PM
2. Where did assault occur (i.e., bed, car, living room)?
   _____
3. ☐ Single assailant ☐ Multiple assailants
   If assailant(s) is known, relationship: _____

Description of assault:

_____
_____

Recent sexual activity:

From **120-hours prior** to the incident **until the time of this examination**, has the patient had sexual contact?
☐ Yes ☐ No
If yes,(Consensual Partner: ☐ M ☐ F) Vaginal date:___ /___ /___ Anal date:___ /___ /___ Oral date:___ /___ /___

Type of sexual contact:

1. Contact with patient's vagina by: ☐ Not applicable (**male** patient) ☐ Penis ☐ Finger/hand ☐ Mouth ☐ Foreign object ☐ Unknown ☐ No contact; Did penetration occur? ☐ Yes / ☐ No / ☐ Unknown
2. Contact with patient's penis by: ☐ Not applicable (**female** patient) ☐ Vagina ☐ Finger/hand ☐ Mouth ☐ Foreign object ☐ Unknown ☐ No contact; Did penetration occur? ☐ Yes / ☐ No / ☐ Unknown
3. Contact with patient's rectum by: ☐ Penis ☐ Finger/hand ☐ Mouth ☐ Foreign object ☐ Unknown ☐ No contact; Did penetration occur? ☐ Yes / ☐ No / ☐ Unknown
4. Oral contact with patient's genitals: ☐ Yes / ☐ No / ☐ Unknown
   If yes, ☐ on patient by assailant(s); ☐ on assailant(s) by patient
5. Did ejaculation occur: ☐ Yes / ☐ No / ☐ Unknown
   If yes, indicate location(s): ☐ Mouth ☐ Vulvar Area ☐ Vagina ☐ Rectum ☐ Body surface_____; ☐ Clothing _____; ☐ Other_____

Did any of the following occur:

Use of condom ☐ Yes ☐ No ☐ Unsure
Sucking/kissing/biting/licking ☐ Yes ☐ No If yes, Location: _____
Patient scratch assailant? ☐ Yes ☐ No ☐ Unsure
If yes, was assailant bleeding? ☐ Yes ☐ No ☐ Unsure
Patient menstruating at time of incident? ☐ Yes ☐ No
If yes, was a tampon/pad utilized during or after the incident? ☐ Yes ☐ No
If yes, was the tampon/pad collected? ☐ Yes ☐ No
Patient wearing underwear at time of incident? ☐ Yes ☐ No
Underwear collected? ☐ Yes ☐ No

Post assault hygiene and activity:

Did the patient bath/shower since the assault? ☐ Yes ☐ No
Changed underwear ☐ Yes ☐ No
Changed clothes ☐ Yes ☐ No
Washed clothes worn during assault ☐ Yes ☐ No

Distribution: Original in Part A Kit box; Copy in patient medical record

NYC HEALTH+ HOSPITALS | Kings County

Emergency Department
451 Clarkson Avenue
Brooklyn, NY 11203

CONSENT FORM

- I have been told about the use of Raltegravir Potassium and Emtricitabine-Tenovir as post-exposure prophylaxis to prevent infection with the Human Immunodeficiency Virus (HIV), the virus that causes AIDS after significant exposure to the blood or body fluids of a person who is known or likely to be infected with HIV.

- I have sustained such an exposure and request prophylactic treatment.

- I understand that prophylactic treatment with Raltegravir Potassium and Emtricitabine-Tenovir may cause side-effects such as anemia, leukopenia (low white blood cell count), headache, nausea, vomiting, insomnia, and muscle pain. Other antiretrovirals may also cause side-effects. I understand that these side-effects should be discussed with the prescribing physician.

- I understand that pregnancy, breast-feeding, other medical problems such as kidney or liver disease, or the regular use of any medication should be discussed with this physician.

- I agree to take the medication as prescribed and to appear for periodic evaluations as scheduled by this physician during and after treatment.

Signed: _____

Witness: _____

Date: _____

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

Advocate Contacted: ☐ Yes ☐ No ☐ Other _____

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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NYC Health + Hospitals

COMPREHENSIVE SEXUAL ASSAULT ASSESSMENT FORM PAGE 2 OF 9

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

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 ⟶
Please Indicate Patient Name, Patient Number, Facility Name, and date

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

**** MALE***

		Visualization				Visualization	
		Direct	Colposcopic			Direct	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 How many? ____
Speculum Exam	☐ Yes ☐ No	Area(s) of body photographed:	____
Colposcopic Exam	☐ Yes ☐ No		____
Toluidine Blue	☐ Yes ☐ No		____
Wood's Lamp	☐ Yes ☐ No		____
Wet Mount	☐ Yes ☐ No		____
Anoscope	☐ Yes ☐ No		____

NYC Health + Hospitals

COMPREHENSIVE SEXUAL ASSAULT ASSESSMENT FORM PAGE 4 OF 9

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

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): (Given only if perpetrator is known positive)	Offered: ☐ Yes ☐ No ☐ N/A	Accepted: ☐ Yes ☐ No
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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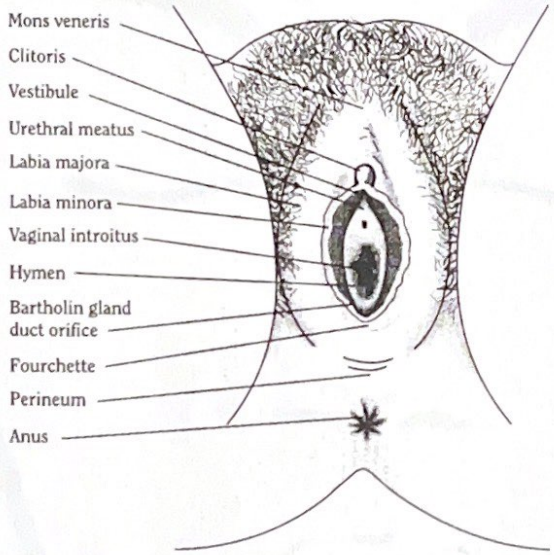
NYC Health + Hospitals

COMPREHENSIVE SEXUAL ASSAULT ASSESSMENT FORM PAGE 5 OF 9

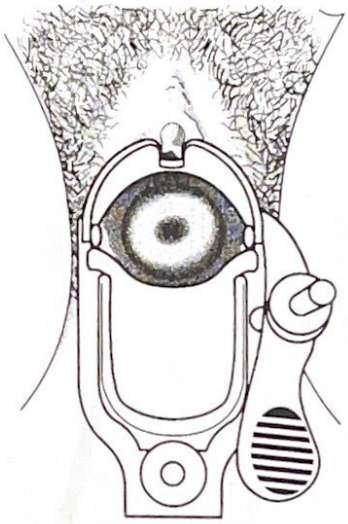
PLEASE PRINT CLEARLY →
Please Indicate Patient Name, Patient Number, Facility Name, and date

Traumagram – Genital

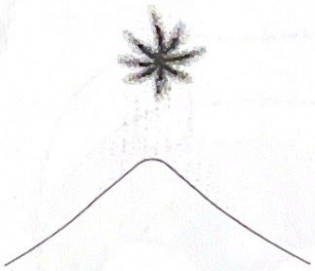
Female genitalia



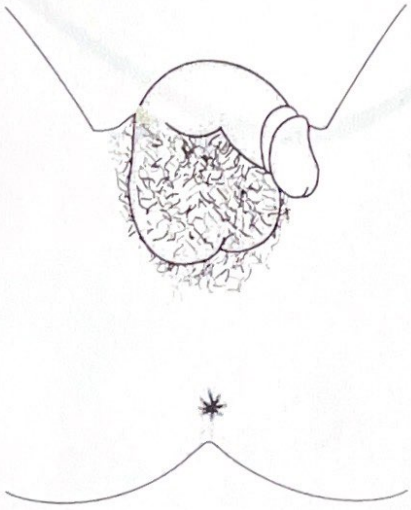
Cervical observation



Anal



Male genitalia



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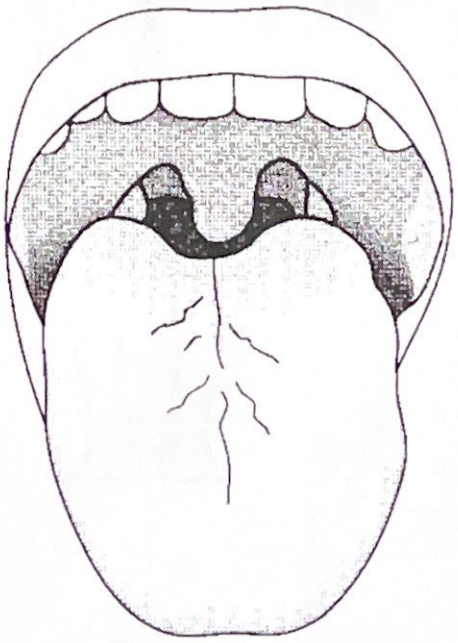
NYC Health + Hospitals

COMPREHENSIVE SEXUAL ASSAULT ASSESSMENT FORM PAGE 6 OF 9

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



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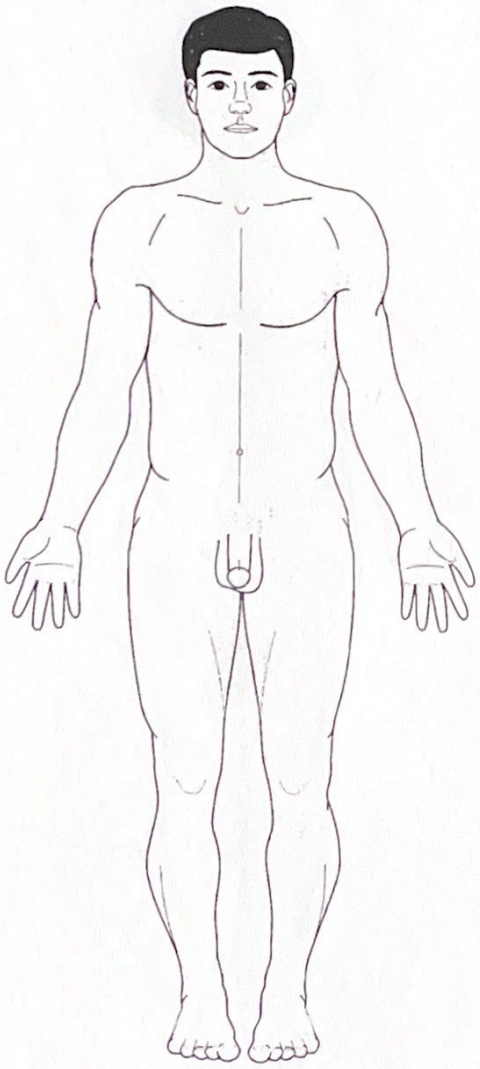
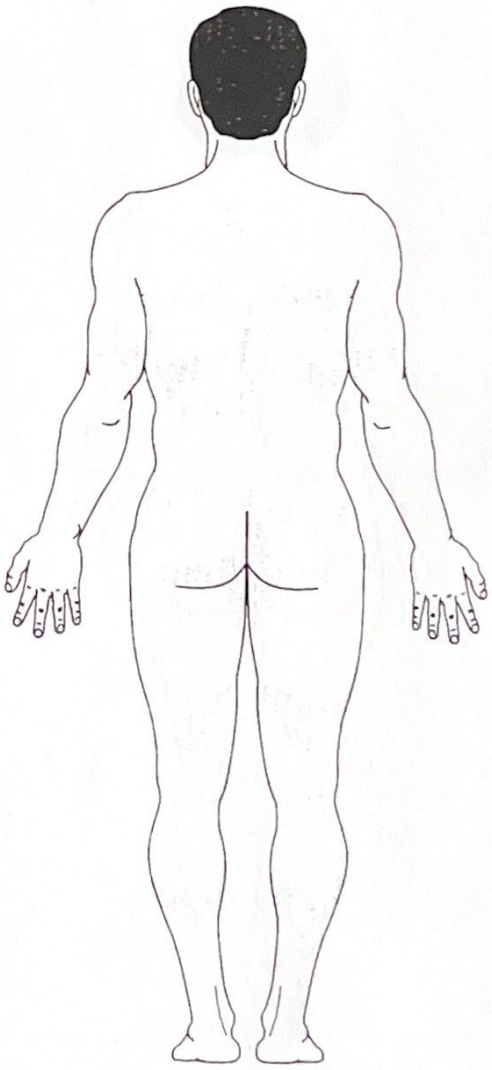
COMPREHENSIVE SEXUAL ASSAULT ASSESSMENT FORM PAGE 7 OF 9

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





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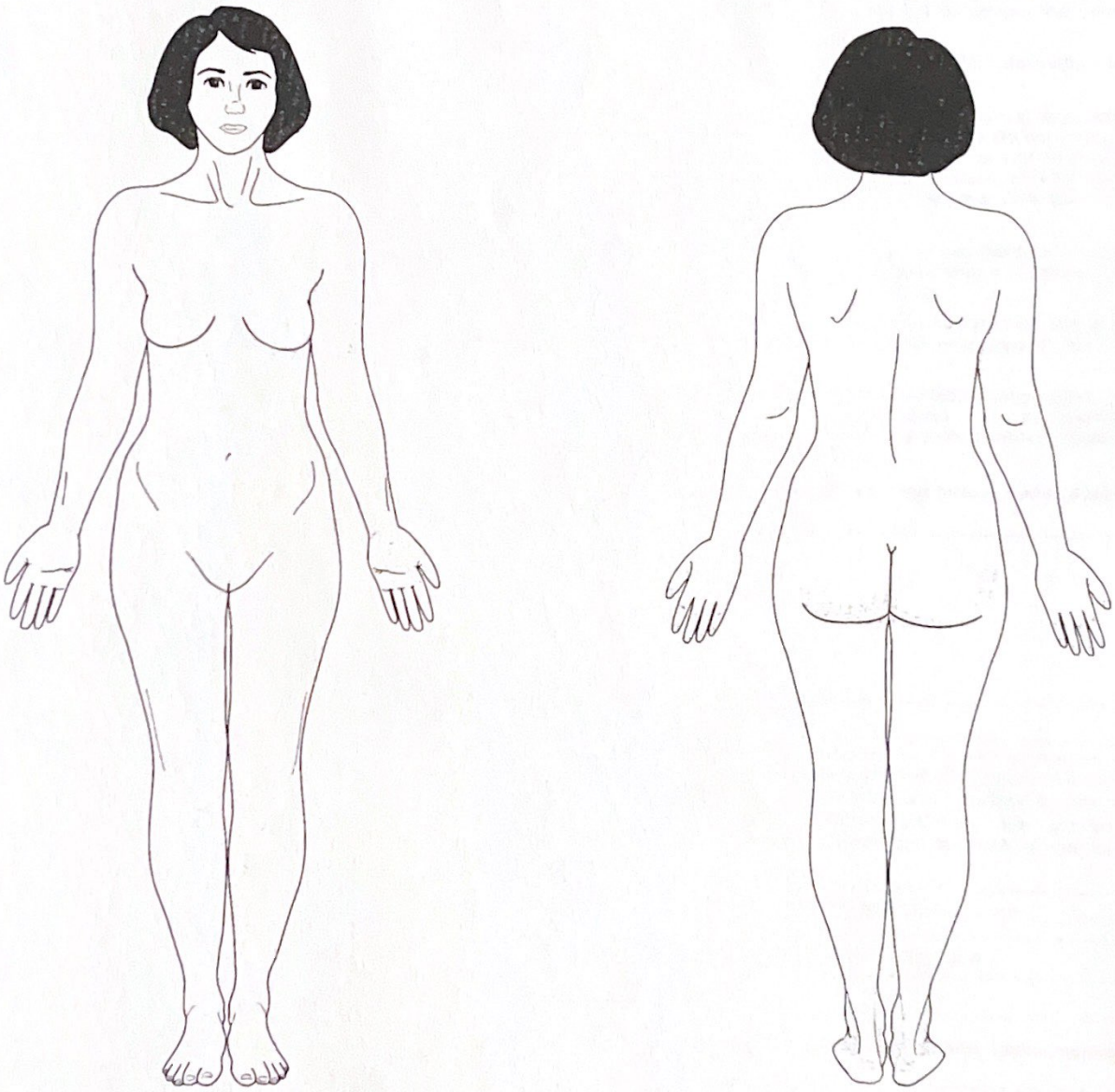
NYC Health + Hospitals

COMPREHENSIVE SEXUAL ASSAULT ASSESSMENT FORM PAGE 8 OF 9

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



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NYC Health + Hospitals

COMPREHENSIVE SEXUAL ASSAULT ASSESSMENT FORM PAGE 9 OF 9

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

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

AFTER SCANNING – PLEASE SHRED

NYC HEALTH+ HOSPITALS | Kings County

Excerpt from Smock B, Green B and Sturgeon S, "Recommendations for the Medical Radiographic Evaluation of Acute Adult/Adolescent, Non/Near Fatal Strangulation." Training Institute for Strangulation Prevention.

Developed by: Alexander B, Agenor K, McGill W, Law SW, Thomas O, Hiana J, Donegal K, Blair A

RECOMMENDATIONS for MEDICAL / RADIOGRAPHIC EVALUATION of ACUTE ADULT, NON-FATAL STRANGULATION

GOALS:

1. *Evaluate for acute medical conditions that require immediate treatment and stabilization*
2. *Evaluate for anoxic brain injury and injury of carotid/vertebral arteries*
3. *Evaluate bony-cartilaginous and soft tissue neck structures*

Chief Complaint: Domestic Violence / Assault / Strangulation / Attempted Suicide / Human Trafficking

History of and / or physical examination with ANY of the following:

- **Loss of consciousness** (anoxic brain injury)
- **Altered mental status**: "dizzy," "confused," "lightheaded," "loss of memory," "any loss of awareness"
- **Visual changes**: "spots", "flashing lights," "tunnel vision"
- **Incontinence** (bladder and / or bowel from anoxic injury)
- **Neurological signs and symptoms**: seizure-like activity, stroke-like symptoms, headache, tinnitus, hearing loss, focal numbness, cortical blindness, movement disorders, abnormal mental status or neurological exam
- **Petechial hemorrhages** (facial, intraoral or conjunctival)
- **Ligature mark** or neck contusions **= HIGH RISK**
- **Soft tissue neck injury** / swelling of the neck / carotid tenderness **= HIGH RISK**
- **Dysphonia / Aphonia / Stridor** (concerning for hematoma, laryngeal fracture, soft tissue swelling, recurrent laryngeal nerve injury)
- **Dyspnea** (concerning for hematoma, laryngeal fractures, soft tissue swelling, phrenic nerve injury)
- **Subcutaneous emphysema** (concerning for tracheal / laryngeal rupture)

NOTE: The absence of external signs of soft tissue trauma does NOT rule-out the presence of significant internal injury.

Consult the on-call forensic examiner for guidance on photodocumentation and evidence preservation/collection

No history concerning for strangulation or life-threatening abnormality on physical exam

Discharge home after the following:

- Inpatient Consult to Social Work (immediately upon arrival to ED)
- Referral to Brooklyn Family Justice Center
- Referral to Mental Health (Kings County)
- Instructions for monitoring for worsening neurological signs/symptoms, dyspnea, dysphonia or odynophagia

Recommended Radiographic Studies to Rule out Life-Threatening Injuries:

- **Head CT without Contrast** – Traumatic Brain Injury
- **CT Angiography of Carotid / Vertebral Arteries** – Arterial Dissection
- **CT Neck with Contrast** of Bony / Cartilaginous Structures

Consider administration of 325 mg of aspirin if any delay in obtaining radiographic imaging

Inpatient consult to GENERAL Neurology / Stroke / Neurosurgery / Trauma for acute vascular injury or stroke

Inpatient consult to ENT for laryngeal trauma, dysphonia and/or odynophagia

Evidence of arterial dissection / ischemic stroke, consider admission and daily aspirin 81 mg WITH **referral to stroke clinic within 7 days** upon discharge

NYC HEALTH+ HOSPITALS | Training Institute on Strangulation Prevention | Police Department City of New York | NYC Mayor's Office to End Domestic and Gender-Based Violence | Fire Department City of New York

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H+H ED Flow Chart for Evaluation of Post-Acute Sexual Assault Patients

Post Sexual assault adult regimen (if indicated) - AFTER SART evaluation:

1. **HIV PEP** *(within 72 hrs)*
   a. Truvada*(Emtricitabine/Tenofovir): 200/300 mg (1 tab po in ED)
   b. Isentress* (Raltegravir): 400 mg (1 tab po in ED)

   7-day supply ordered, dispensed from pyxis and provided to patient.

   Consult pharmacy for pediatric dosing

2. **STI PEP**:
   a. Ceftriaxone: 500 mg IM x 1
   (if weight >150 kg, 1000 mg)
   b. Doxycycline: 100 mg po BID for 7 days **or** Azithromycin 1g PO x1
   c. Metronidazole 2gm po (contraindicated if recent use of alcohol)

3. Emergency Contraception: Levonorgestrel: 1.5 mg *(within 120 hrs)*

4. TdaP, *prn*

5. Ondansetron/Metoclopramide, *prn*

6. HBV, *prn*

Is patient ≥13 years with sexual assault occurring <120 hours, stable, not intoxicated, AND consenting to forensic examination?

No

Stabilize patient

Order **ED Social Work** Consult
Offer appropriate prophylaxis to patients who decline the sexual assault kit.

Order appropriate labs, medications, and provider follow up instructions (as below)

For patients <13 yrs and ages 13-18 follow **Peds Guidelines**

Yes

ED Social Work consult: (All S/A Patients)
Order consult in EPIC

Page via Operator, or call Office (x4628), Voicemail (x4374)

Triage nurse or provider should **activate SART** by calling x3151

Quick assessment and H&P performed by provider
Provider orders **Diagnostic Tests** and **Post-Sexual Assault Medications (if indicated)**

UCG (every female of child bearing age)
RPR
Hepatitis B and C titers
HIV-1 Ab Screen (if consenting to HIV PEP, remember to counsel and consent patients for baseline HIV testing)
CBC (if consenting to HIV PEP)
CMP (if consenting to HIV PEP)
Additional diagnostic testing may be required

Provider arranges patient **disposition** with appropriate follow up (as below)

Initial **HIV PEP** and **doxycycline** should be dispensed directly from Pyxis **for 7 days**

Document **a working telephone number** (home & cell) where patients may be reached

All patients >19 yrs, accepting prophylaxis
STD/ID Clinic: within 7 days for additional HIV meds for a total of 28 days - 718-245-2800
E building 4th fl Tues 1p-4p, Wed 8:30a-11:30a, Fri 1p-4p
Contact: Ms. Singh- Bahadur

Females >19 yrs accepting prophylaxis
E Building 6th floor suite C (must be scheduled)
Gyn Clinic: in 2-4 weeks (718-245-3495)

Males ≥ 19 yrs accepting prophylaxis
STD/ID Clinic: within 7 days (718-245-2800)
E building 4th floor

Patients ≥ 19 declining PEP
STD/ID clinic: Males in 4 wks
Women's Health clinic: Females

Patients 13-18 yrs
Adolescent Medicine Clinic:
Dr. Suss & Dr. Cambridge
E building 4th fl Suite B
Tuesday 12p-4p

*Dispensed **7-day course of prophylactic medications** and scheduled **follow up appointments** are required prior to discharge*

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Equipment List for Sexual Abuse/Assault in Children

- New York State Sexual Offense Evidence Collection Kit (SOECK) Part A;
- New York State Sexual Offense Evidence Collection Kit (SOECK) Part B (for Drug-Facilitated Sexual Assaults)

- Plain envelopes*;
- Paper bags (various sizes);
- Extra cotton swabs
- Tape and stapler*;
- Marking pen or grease pencil, pencil;
- Patient labels (#35 to 40);
- appropriate size gown, cover sheet;
- examination or pelvic light;
- woods lamp (if available);
- GC culture media (3) and swabs,
- culture and sensitivity culturette tubes (micro tip swabs);
- chlamydia culture media (2) and swabs;
- distilled water
- pediatric feeding tube;
- urinalysis cup;
- guaiac cards and indicator;
- Phlebotomy equipment (of age-appropriate gauge)*;
- Pediatric purple top blood tubes*;
- Digital camera
- ruler
- Vaginal speculum (optional).
- Foley Catheter (various sizes)
- Clothing* to replace the clothes which are collected for evidence
- colposcope (optional);

NOTE:

An adult size speculum should never be used to examine a prepubescent child.

If required, a Huffman speculum or pediatric Graves speculum is recommended.

A Pederson speculum can be used in adolescents.

(*) indicates equipment needed for evidence collection.

NYC HEALTH+ HOSPITALS | Kings County

SART Escalation Pathway

Any questions, please contact us (in real-time):

Ms. Alice Blair
SART Coordinator
via operator at extension 3151
or directly at (347) 408 – 5568

Dr. Brigitte Alexander
Brooklyn SART, Medical Director
Forensic Clinical Services, Director
(646) 373 – 5151

OR

Dr. Keesandra Agenor
Clinical Forensic Medicine Fellowship, Director
(929) 465 – 3529

NYC HEALTH+ HOSPITALS | Kings County

Additional Resources

- ❏ **Special Victims Services 24 Hour Hotline:** (646) 610-7272
- ❏ **Brooklyn Special Victims Unit (≥ 13 years old):** (718) 230-4414/15/16
- ❏ **Child Protective Unit (<13 years old):** (718) 330-5600
- ❏ **New York City Youth Hotline:** 1-(800)-246-4646/2626
- ❏ **Crime Victims Advocacy Center (CAC):** (347) 328-8110
- ❏ **Project SAFE (Free Lock Replacement):** (212) 406-3010
- ❏ **SAFE Horizons Hotline:** (718) 577-7777
- ❏ **Domestic Violence National Hotline:** 1-(800)-621-HOPE
- ❏ **National Human Trafficking Hotline:** 1-(888)-373-7888