NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

COMPREHENSIVE SEXUAL ASSAULT ASSESSMENT FORM PAGE 2 OF 7

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 Survivor 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 survivor)	☐ Yes ☐ No ☐ Unsure	
Oral Contact (survivor 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 *(optional)* _____

_____

_____

Actions Before or After Assault

Has the survivor 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 survivor:

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: _____

MEDICAL RECORDS COPY

PLEASE TEAR OUT THIS SHEET AFTER COMPLETING THIS SECTION AND BEFORE COMPLETING NEXT SECTION

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

COMPREHENSIVE SEXUAL ASSAULT ASSESSMENT FORM PAGE 3 OF 7

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 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 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		_____

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

COMPREHENSIVE SEXUAL ASSAULT ASSESSMENT FORM PAGE 4 OF 7

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: (Needs separate red tube)
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

☐ 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 SEXUAL ASSAULT COORDINATOR

MEDICAL RECORDS COPY

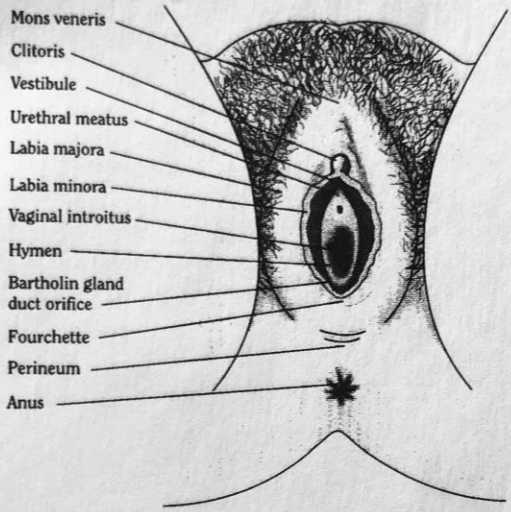
NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

COMPREHENSIVE SEXUAL ASSAULT ASSESSMENT FORM PAGE 5 OF 7

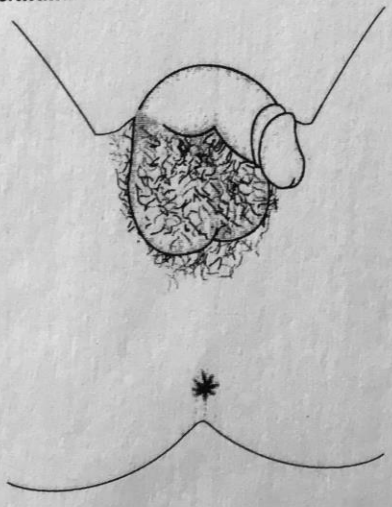
PLEASE PRINT CLEARLY
Please Indicate Patient Name, Patient Number, Facility Name, and date

Traumagram – Genital

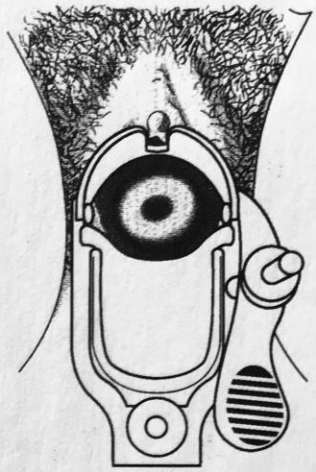
Female genitalia



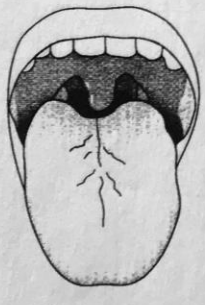
Male genitalia



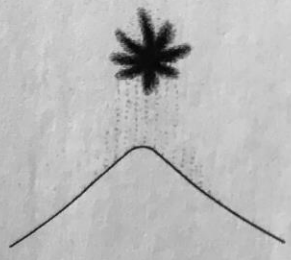
Cervical observation



Oral

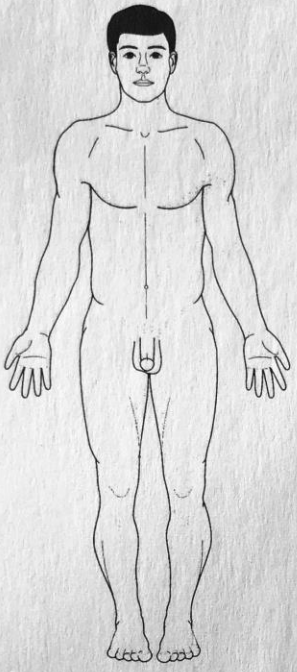


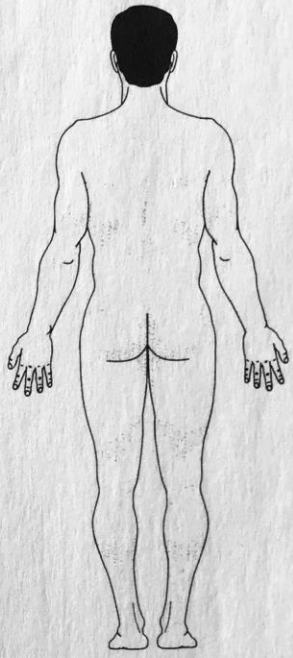
Anal

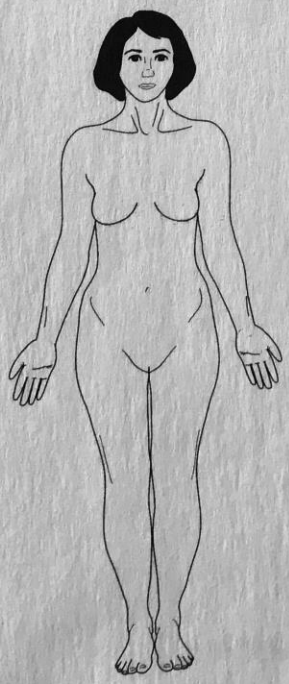


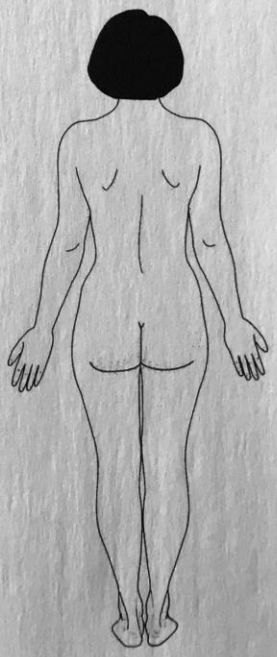
COMPREHENSIVE SEXUAL ASSAULT ASSESSMENT FORM PAGE 6 OF 7

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









NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

COMPREHENSIVE SEXUAL ASSAULT ASSESSMENT FORM PAGE 7 OF 7

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 hav described on this form.
2. I understand that my medical and/or billing information could be re-disclosed and no longer protected by federal healt information privacy regulations if the recipient(s) described on this form are not required by law to protect the privacy of th information.
3. I understand that if my medical and/or billing records contain information relating to HIV/AIDS, this information will not b 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 fro using or re-disclosing any HIV/AIDS related information without my authorization, unless permitted to do so under federal o state law. I also understand that I have a right to request a list of people who may receive or use my HIV/AIDS relate information without authorization. If I experience discrimination because of the use or disclosure of HIV/AIDS relate information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commissio 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 car 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 th 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 authorizatio form by completing a **Request for Access Form**. I also understand that I have a right to receive a copy of this form after 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 th right to revoke it at any time, except to the extent that the hospital has already taken action based on my authorization or tha the authorization was obtained as a condition for obtaining insurance coverage. To revoke this authorization, please complet 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 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 emergenc room visit, including all forensic evidence obtained, the contents of m 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 a http://lep.nychhc.org