NEW YORK STATE | Division of Criminal Justice Services

ATTACH PATIENT LABEL

Or Enter Patient Name: _____

MEDICAL RECORD SEXUAL ASSAULT FORM

I. HISTORY **DATE OF VISIT**_____ **TIME** _____

Significant past medical history:

_____

_____

Approximate Time of Attack _____ Is patient pregnant? _____ LMP _____ Medications _____Allergies _____

Date of Attack _____ Usual form of birth control_____

Is patient bleeding from an injury? Yes _____ No _____

Is yes, describe location

_____

_____

II. PHYSICAL EXAMINATION (Note all evidence/details of trauma):

_____

_____

III. PELVIC/GENITOURINARY EXAM

Ext/BUS/Hymen ____ Cervix ____ Adnexae ____ Vagina ____ Uterus ____ Rectal ____ Penis ____ Scrotum ____

IV. DIAGNOSTIC TESTS

Pregnancy test ____ GC Cultures ____ (Pharyngeal ____ Cervical ____ Urethral ____ Rectal ____) VDRL___

Chlamydia ____ Hepatitis B ____ Other ____

V. TREATMENT

Tetanus Toxoid ____ Pregnancy Prevention ____ STD Prophylaxis ____ Other _____

VI. EVIDENCE COLLECTION:

Evidence collected? Y ____ N ____ Evidence kit released to law enforcement Y ____ N ____

Written consent? Y ____ N ____

VII. FOLLOW UP APPPOINTMENT

1. Medical: (Adults should be seen within 2 weeks) 2. Counseling:

_____

_____

Examining Health Practitioner:

_____
Signature

_____
Print Name

Health Practitioner:

_____
Signature

_____
Print Name

Distribution: Original in patient medical record; Copy in Part A Kit box;
Copy to OVS if Provider is applying for direct reimbursement