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

____________________________________________________________________________________________

Examining Health Practitioner:    Health Practitioner:
_________________________________________    ___________________________
Signature       Signature
_________________________________________    ___________________________
Print Name      Print Name

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