SANE of Butler County

(PATIENT ID STICKER HERE)

EXAM INFORMATION:

Location of Exam (Hospital): _____ SANE RN:_____

Date /Time of Page: _____ Arrival Time:_____ Comment:_____

MD Report to: _____ RN Report to: _____ Advocates: #_____ Bedside / Waiting Rm / None

DFSA Indicated?: Yes / No **DFSA collected?:** Yes / NA / Declined

Name of personnel forensic chart given to at hospital:_____

PATIENT INFORMATION:

Patient Name:_____ DOB:_____ Gender: M / F / T Guardian Present: Y / N

Patient Phone #:_____ Patient Address:_____

SSN:_____ _____

Hospital Acct Number:_____ Inmate: Y / N Location:_____

Jane Doe ID:_____ Nursing Home: Y / N Location:_____

REPORTED PERPETRATOR INFORMATION:

Relationship to patient: **CIRCLE ONE**: Acquaintance / Partner / Student / Caregiver / Family / Parent-Guardian / Unknown

Estimated Age:_____ Gender: M / F/ Transgender / Unknown Other:_____

ASSAULT INFORMATION: *(dispatch can assist with appropriate law enforcement jurisdiction)*

Date of Assault:_____/____/_____ Time of Assault:____ : ____ AM or PM

Location / Address of Assault:_____

LE Agency for kit jurisdiction:_____ At Bedside: Y / N

Crime reported TO: _____ Time: _____

Kit Location Reported to:_____ Time:_____

CPS/APS/ODH (include agency and name of personnel)

Agency:_____ Name:_____ Time:_____

For UC exams:

Did social worker perform mandate reporting? (circle one) Yes / No

Name of SW:_____

Ohio Department of Health Consent For Exam, Photographs, and Release of Evidence

PAYMENT/BILLING OF TREATMENT

_____ I understand that I will not be charged for the antibiotics and evidence collection exam. Any other medications and medical treatment including but not limited to x-rays and blood work will be billed to me, my insurance or another named party for payment.

MEDICAL FORENSIC EXAM/EVIDENCE COLLECTION/PHOTO DOCUMENTATION

_____ I consent to the medical forensic exam. I understand that I can decline any portion of the exam or any portion of evidence collection process. I understand my choice of treatment steps during the exam will be reassessed frequently.

_____ I consent to the evidence collection during the forensic examination. I understand that I can decline any portion of the exam or any portion of evidence collection process. I understand my choice of treatment steps during the exam will be reassessed frequently.

_____ I consent to photo documentation, which may include my genitalia, body parts if injuries are present. I understand that I can decline any portion of photo documentation including photo documentation of my genitals.

_____ I consent to the medical forensic exam and photographs to be used in future educational presentations for forensic examiners.

_____ I consent to the release of all medical records and photographs to the appropriate law enforcement agency related to the sexual assault forensic examination.

REPORTING

_____I understand the hospital is legally required to report sexual assaults to law enforcement. My name and contact information will be given to law enforcement unless I choose to decline my name and contact information to be given. I understand that the hospital is legally required to report all abuse or suspected abuse of patients 17 years of age or younger to the Department of Children Services. For patients 17 years or younger, the hospital is required to send a letter to the parent or legal guardian notifying them of the exam. The sexual assault evidence collection kit and toxicology samples for drug-facilitated sexual assault will be given to law enforcement and may be tested at a crime lab.

Patients 18 years or older (Initial one)

_____ I agree to speak to law enforcement. I understand that my name and contact information will be provided to law enforcement.

_____ I **DO NOT** agree to speak with law enforcement at this time. My name and contact information will be given to law enforcement. I understand that law enforcement **may attempt to contact me**. I understand that I am not obligated to participate in the investigation of this crime, but that law enforcement may investigate it.

Signature of **PATIENT/GUARDIAN:** _____ Date:_____ Time: _____

Signature of **SANE/WITNESS:** _____ Date:_____ Time: _____

********After the consent is completed contact LE to perform mandated reporting**

Consent for Blood/Urine Collection for Testing – (Form E)

I understand that I have the right to refuse such testing. I have been informed that results from any and all testing that I consent to can be used in a court of law for the purpose of prosecution of this crime. I understand that the results of such testing may reveal prescription or illegal drug use that may not be related to the reported assault. Use of illegal substances that may constitute felonious criminal activity may result in ineligibility for Crime Victims Compensation Funding. I authorize release of my name and other identifying information to S.A.N.E. of Butler County, Inc. and to the respective law enforcement agency along with the blood and/or urine samples for use in the investigation and prosecution of the reported crime. I release S.A.N.E. of Butler County, Inc. from any and all liability that can be associated with the collection process or use of the samples obtained.

Check one and sign to confirm this information has been reviewed with you:

☐ I **CONSENT** to blood and/or urine collection ☐ I **DECLINE** blood and/or urine collection

Signature of patient

Print name of patient

Date and Time of Signature

Specimen Collector's Report

I herby certify that I collected the specimen from the patient: Circle Specimen BLOOD URINE

Signature of RN collecting specimen

Print name of RN collecting Specimen

Date and Time of specimen collected

I herby certify that I witnessed the actual blood draw or collection of urine from the above named individual:

Signature of witness

Print name of witness

Date and Time of witness

Morning After Pill (Plan B) Information and Consent

Before you give your consent be sure you understand both the pros and cons of using the "morning after pill"/ Plan B. This form outlines the possible complications that can occur with use of these pills and the danger signs to watch for. If you have any questions as you read we will be happy to discuss them. You can change your mind at any time prior to starting the medication.

♦ I understand that the "morning after pill" /Plan B, is a hormone or combination of hormones. These pills are taken after having unprotected vaginal intercourse. It is to be used as an emergency measure only and not as a main method of birth control.

♦I understand that the pills either keep the ovary from releasing an egg so the egg and sperm can't join or changes the lining of the uterus (womb) in such a way that if an egg is fertilized by a sperm the fertilized egg may not attach (implant) and develop in to pregnancy. The medication should be started as soon as possible after a single act of unprotected vaginal intercourse and within 72 hours of that intercourse.

♦I understand that taking these pills does not prevent pregnancy 100%. Some pregnancies do occur and these can result from (1) a fertilized egg that has already implanted: (2) too much time having gone by between unprotected vaginal intercourse and taking the "morning after pill". /Plan B: (3) failure of the drug itself in spite of this, I wish to try to prevent pregnancy at this time by using the "morning after pill"/Plan B.

♦I understand that studies have shown that some of the offspring of women who take estrogen hormones during pregnancy may have birth defects of their reproductive systems. I understand these estrogen hormones are present in the method of treatment I am seeking and understand that if the treatment fails I must accept this risk should I decide to continue the pregnancy.

♦I understand that a sensitive laboratory test for pregnancy may be done to try to rule out the presence of an already established pregnancy. I understand that the earlier the pregnancy test, the greater the chance of error. I further understand that the correctness of the results of the pregnancy test is not guaranteed whether positive or negative. I hereby release the hospital and medical staff and employees from any an all liability arising out of or connected with this pregnancy test and particularly with regard to any errors in diagnosis based on this test.

♦As a result of taking the "morning after pill" /Plan B I understand that I may have a slightly greater chance than non- pill users of developing certain serious problems. These include the following:

- Blood Clots
- Stroke
- Heart Attack (greater risk for women age 35 or older, who smoke heavily)
- Death that may occur from one of the above causes

♦I understand that I must not use the pill if I have had or now have :

- Blood Clots
- Inflammation in the veins
- Liver Disease
- Unexplained bleeding from the vagina
- Any suspicion of abnormal growth or cancer of the breast or reproductive organs.
- An already established pregnancy.

♦I understand that some of the other reactions to these pills may include :

- Nausea and/or vomiting

- Breast tenderness
- Irregular bleeding
- Headache

♦I know to watch for the following pill danger signals and to report to my physician immediately:

- Chest or arm pain
- Shortness of breath
- unusual swelling or pain in the legs
- Severe headaches
- Eye problems, such as blurred or double vision
- Pain in abdomen
- Yellowing of the skin or eyes
- Severe depression

♦I understand that if I see a physician for any reason before I get my period, I should tell him/her that I have taken the "morning after pill"/Plan B.

No guarantee or assurance has been made to me as to the results that my be obtained if I use the "morning after pill"/Plan B. I hereby request that a person authorized by the medical establishment/hospital perform a pregnancy test and that the "morning after pill"/Plan B be provided. I have given a complete and accurate history. The only unprotected intercourse since my last period started was within 72 hours.

☐Copy of this form has been given to the patient for further reference.

Signature of patient_____Date_____

Witness_____Date_____

Please sign the below section if declining the medication.

I am declining the medication, Plan B and understand the consequences of declining this medication.

Signature of patient_____Date_____

Witness_____Date_____

Place label here that includes Hospital Name, Address, Telephone and Emergency Department Contact

This form should be given to the Survivor prior to signing medical/treatment Consent

EMERGENCY CONTRACEPTIVE FACT SHEET SAMPLE

What is Emergency Contraception?

Sometimes called the "morning after pill," emergency contraception is used to prevent pregnancy immediately after unprotected sex.

What is unprotected sex?

- Sex without using birth control.
- The condom breaks or comes off.
- The diaphragm slips out of place.
- Rape or sexual assault.
- You stopped taking the birth control pills for more than a week or missed almost half of the birth control pills in the past two weeks.

Depending on when in your menstrual cycle you had unprotected sex, you could have 1 in 3 chance of becoming pregnant. Emergency contraception can reduce your risk by 75 percent.

When do you use Emergency Contraception?

It is most effective when started within 24 hours of unprotected sex but no later than 72 hours.

Is it safe?

Twenty years of study by the FDA says Emergency Contraception is safe and effective, but it isn't for everyone. Patients at _____ are screened to see if Emergency Contraception is safe for them.
Name of Hospital/Facility

How can I get Emergency Contraception?

After your sexual assault exam, you will be asked several questions to see if Emergency Contraception is right for you. You will take the first dose at the hospital. The second dose should be swallowed 12 hours later.

Are there any side effects?

You may feel nausea and have vomiting, but these symptoms go away a day or two after treatment. If you vomit within one or two hours after taking a dose call your physician, you may need to repeat a dose.

When will I have my period?

Your next period may start a few days earlier or later than usual. If you period has not started within three weeks, call your health care provider. Emergency contraceptives may not prevent an ectopic pregnancy (tubal pregnancy – the fertilized egg implants outside the uterus).

How soon can I get pregnant after taking emergency contraception?

You can get pregnant if you have unprotected sex immediately after taking the treatment. Until you know your HIV status you should use protective measures such as not having sexual intercourse or using a male or female condom.

STEP 3	Assault History	Page 1
Assault Date	Time	Place Patient Label Here
Exam Date	Time	
Hospital	City	

Assailant Information

Name(s)	Relationship to Patient	Age	is assailant Injured or bleeding?

Which of the following occurred?					**Other--Please describe**
Vaginal penetration by assailant's...	☐ Fingers	☐ Penis	☐ Object	☐ Unsure	**Comment:**
Anal penetration by assailant's...	☐ Fingers	☐ Penis	☐ Object	☐ Unsure	**Comment:**
Oral penetration by assailant's...	☐ Fingers	☐ Penis	☐ Object	☐ Unsure	**Comment:**
Assailant mouth on patient genitals	☐ Yes	☐ No	☐ Unsure		**Comment:**
Assailant ejaculation	☐ Yes	☐ No	☐ Unsure	Where? _____	
Lubrication including saliva	☐ Yes	☐ No	☐ Unsure	Where? _____	
Strangulation if yes use strangulation assessment form	☐ Yes	☐ No	☐ Unsure	**List other body areas kissed, licked, bitten on narrative**	

Since the assault, patient has:

Douche/enema	☐ Yes	☐ No	☐ Unsure	Changed Clothes	☐ Yes	☐ No	☐ Unsure
Bowel movement	☐ Yes	☐ No	☐ Unsure	Bathed/ Showered	☐ Yes	☐ No	☐ Unsure
Urinated	☐ Yes	☐ No	☐ Unsure	Had Food or Drink	☐ Yes	☐ No	☐ Unsure
Vomited	☐ Yes	☐ No	☐ Unsure	Brushed Teeth	☐ Yes	☐ No	☐ Unsure

At time of assault, was:

Patient menstruating?	☐ Yes	☐ No	☐ Unsure	
Tampon present?	☐ Yes	☐ No	☐ Unsure	Where is tampon now? _____
Condom used?	☐ Yes	☐ No	☐ Unsure	Where is condom now? _____

At time of exam, was:			LMP Date	**Consensual sexual activity w/in 96 hours?**
Patient menstruating?	☐ Yes	☐ No		☐ Yes ⇨⇨ Date Time
Tampon present?	☐ Yes	☐ No		☐ No **Condom used: Yes / No** **Name of person: Vaginal / Anal**

Date:	**Date:**
Nurse or Physician completing form — print name	Nurse or Physician completing form — signature

Narrative History (in patient's own words—use quotes)
Please write legibly

Note General Appearance (including condition of clothing)

Rips/tears/stains on clothing?

Positive ALS on clothing?

Note Emotional Status

Alert?

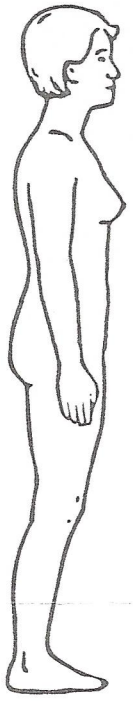
Oriented?

Record injuries on anatomical diagrams. Complete during the physical examination.

Check method used:

- ☐ Direct visualization
- ☐ Foley catheter technique
- ☐ Photography
- ☐ Speculum exam
- ☐ Toluidine blue dye
- ☐ Woods (or other) lamp
- ☐ Colposcope
- ☐ Other

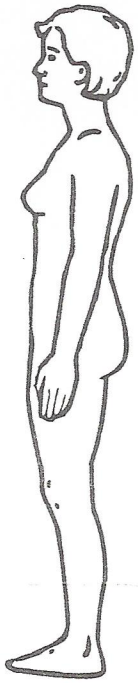
P = Pain
D = Debris
S = Swab/Dry Stain
F = Finding
O = Other



Right

_____ **Pain**
_____ **Debris**
_____ **Swabs**
_____ **Findings**
_____ **Other**

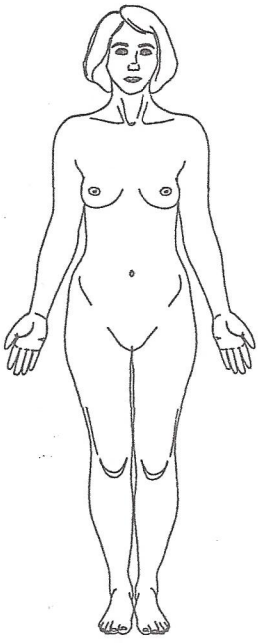
_____ **Pt Declined Assessment**



Left

_____ **Pain**
_____ **Debris**
_____ **Swabs**
_____ **Findings**
_____ **Other**

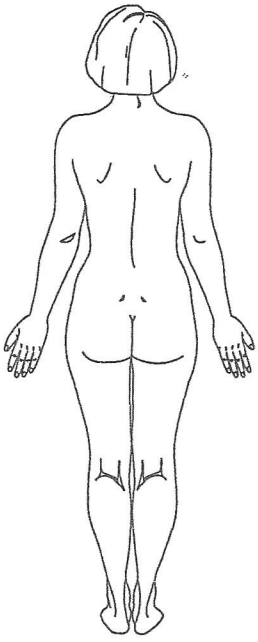
_____ **Pt Declined Assessment**



Anterior

_____ **Pain**
_____ **Debris**
_____ **Swabs**
_____ **Findings**
_____ **Other**

_____ **Pt Declined Assessment**



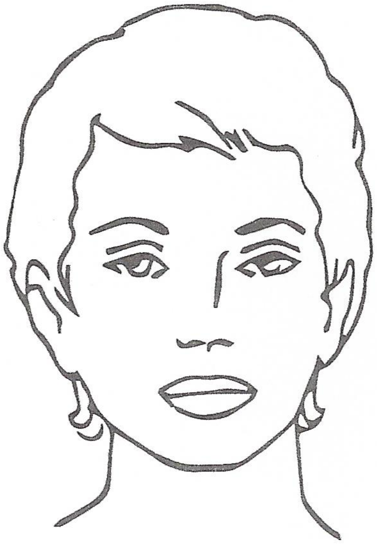
Posterior

_____ **Pain**
_____ **Debris**
_____ **Swabs**
_____ **Findings**
_____ **Other**

_____ **Pt Declined Assessment**

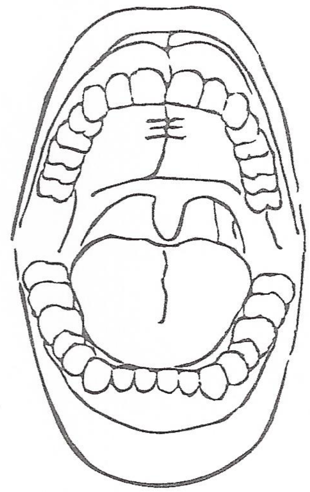
RN:_____ **Date:**_____

Indicate the location, shape and type of injury: tears (lacerations), erythema, abrasions, redness, swelling.



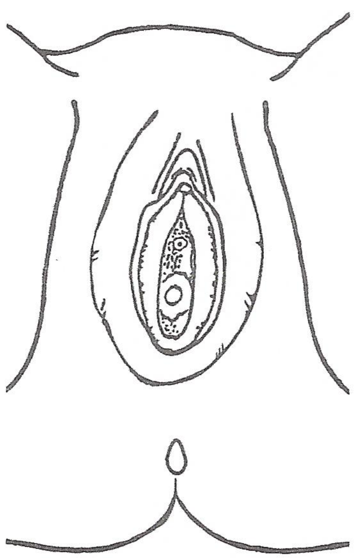
_____ Pain
_____ Debris
_____ Swabs
_____ Findings
_____ Other

_____ Pt Declined Assessment



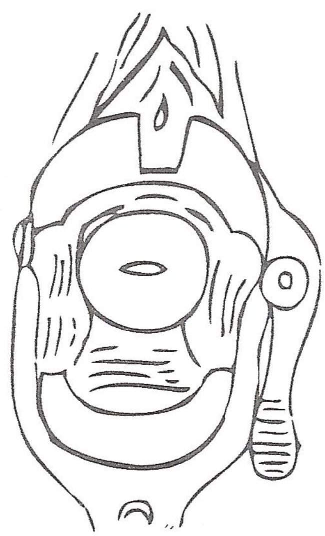
_____ Pain
_____ Debris
_____ Swabs
_____ Findings
_____ Other

_____ Pt Declined Assessment



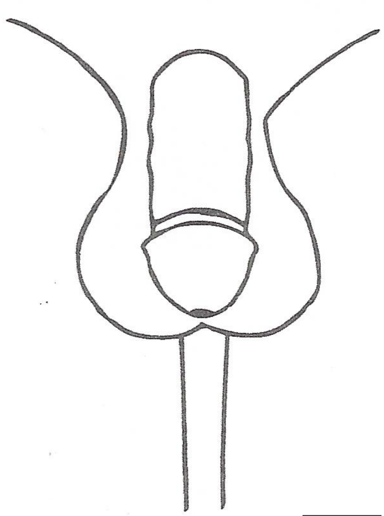
_____ Pain
_____ Debris
_____ Swabs
_____ Findings
_____ Other

_____ Pt Declined Assessment



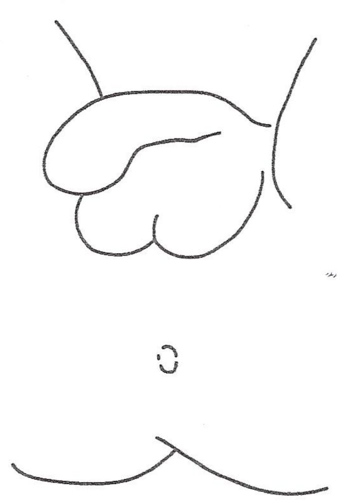
_____ Pain
_____ Debris
_____ Swabs
_____ Findings
_____ Other

_____ Pt Declined Assessment



_____ Pain
_____ Debris
_____ Swabs
_____ Findings
_____ Other

_____ Pt Declined Assessment



_____ Pain
_____ Debris
_____ Swabs
_____ Findings
_____ Other

_____ Pt Declined Assessment

RN:____________________ Date:_____________

Indicate the location, shape and type of injury: lacerations, erythema, abrasions, redness, swelling.

SANE of Butler County

(PATIENT ID STICKER HERE)

DEBRIS FINDINGS:

Complete this form if your patient to indicate if you found any debris during your physical assessment.
*Use a separate charting box for each debris finding

ID Label _____ Body Location: _____ ☐ CHECK IF PHOTO OBTAINED

Debris Description: _____

PATIENT Statement: _____

_____

EXAMINER Comment: _____

_____

ID Label _____ Body Location: _____ ☐ CHECK IF PHOTO OBTAINED

Debris Description: _____

PATIENT Statement: _____

_____

EXAMINER Comment: _____

_____

ID Label _____ Body Location: _____ ☐ CHECK IF PHOTO OBTAINED

Debris Description: _____

PATIENT Statement: _____

_____

EXAMINER Comment: _____

_____

SANE of Butler County

(PATIENT ID STICKER HERE)

OTHER FINDINGS: **(note: measurements are for generalized findings and not tattoos or piercings)**

☐ CHECK IF PHOTO OBTAINED

ID Label __________ Body Location: ______________________________

Measurement ________ X _________ Unit of Measurement (Circle one): inches centimeters millimeters

Type: ____________________ Description: ______________________________

PATIENT Statement: ______________________________

____

EXAMINER Comment: ______________________________

____

☐ CHECK IF PHOTO OBTAINED

ID Label __________ Body Location: ______________________________

Measurement ________ X _________ Unit of Measurement (Circle one): inches centimeters millimeters

Type: ____________________ Description: ______________________________

PATIENT Statement: ______________________________

____

EXAMINER Comment: ______________________________

____

☐ CHECK IF PHOTO OBTAINED

ID Label __________ Body Location: ______________________________

Measurement ________ X _________ Unit of Measurement (Circle one): inches centimeters millimeters

Type: ____________________ Description: ______________________________

PATIENT Statement: ______________________________

____

EXAMINER Comment: ______________________________

____

SANE of Butler County

(PATIENT ID STICKER HERE)

PAIN FINDINGS:

Complete this form if your patient indicated pain to any location during the examination.
*Use a separate charting box for each pain notation

ID Label _____ Pain Scale (0-10): _____ Body Location: _____

Pain Description: _____

PATIENT Statement: _____

_____

EXAMINER Comment: _____

_____ ☐ CHECK IF PHOTO OBTAINED

ID Label _____ Pain Scale (0-10): _____ Body Location: _____

Pain Description: _____

PATIENT Statement: _____

_____

EXAMINER Comment: _____

_____ ☐ CHECK IF PHOTO OBTAINED

ID Label _____ Pain Scale (0-10): _____ Body Location: _____

Pain Description: _____

PATIENT Statement: _____

_____

EXAMINER Comment: _____

_____ ☐ CHECK IF PHOTO OBTAINED

SANE of Butler County

(PATIENT ID STICKER HERE)

PHYSICAL FINDINGS: Complete this form for any abnormal findings during the examination.

ID Label ________ Body Location: ____

Measurement ______ X ______ Unit of Measurement (Circle one): inches centimeters millimeters

Wound Type: ______________________________ Description: ______________________

PATIENT Statement: ____

____

EXAMINER Comment: _______________________________________ ☐ CHECK IF PHOTO OBTAINED

____

ID Label ________ Body Location: ____

Measurement ______ X ______ Unit of Measurement (Circle one): inches centimeters millimeters

Wound Type: ______________________________ Description: ______________________

PATIENT Statement: ____

____

EXAMINER Comment: _______________________________________ ☐ CHECK IF PHOTO OBTAINED

____

ID Label ________ Body Location: ____

Measurement ______ X ______ Unit of Measurement (Circle one): inches centimeters millimeters

Wound Type: ______________________________ Description: ______________________

PATIENT Statement: ____

____

EXAMINER Comment: _______________________________________ ☐ CHECK IF PHOTO OBTAINED

____

SANE of Butler County

(PATIENT ID STICKER HERE)

SWABS OBTAINED:

Complete this form to indicate where your swabs/dry stains were obtained from.
*Use a separate charting box for each swab collected

ID Label _____ Body Location: _____

ALS (Circle one) Negative Positive Description : _____

PATIENT Statement: _____

_____

EXAMINER Comment: _____

_____ ☐ CHECK IF PHOTO OBTAINED

ID Label _____ Body Location: _____

ALS (Circle one) Negative Positive Description : _____

PATIENT Statement: _____

_____

EXAMINER Comment: _____

_____ ☐ CHECK IF PHOTO OBTAINED

ID Label _____ Body Location: _____

ALS (Circle one) Negative Positive Description : _____

PATIENT Statement: _____

_____

EXAMINER Comment: _____

_____ ☐ CHECK IF PHOTO OBTAINED

SANE of Butler County

Attempted Strangulation Cases
Documentation Worksheet

Symptoms and / or Internal Injury:

Breathing Changes	Voice Changes	Swallowing Changes	Behavioral Changes	Other
☐ Difficulty Breathing ☐ Hyperventilation ☐ Unable to Breathe ☐ Other: _____**None Noted**	☐ Raspy Voice ☐ Hoarse Voice ☐ Coughing ☐ Unable to Speak ☐ Other: _____**None Noted**	☐ Trouble Swallowing ☐ Painful to Swallow ☐ Neck Pain ☐ Nausea ☐ Vomiting ☐ Other: _____**None Noted**	☐ Agitation ☐ Amnesia ☐ PTSD ☐ Hallucinations ☐ Combativeness _____**None Noted**	☐ Dizzy ☐ Headaches ☐ Fainted ☐ Involuntary Urination ☐ Involuntary Defecation _____**None Noted**

Visible Injuries: *Photograph any visible injury

Face	Eye & Eyelids	Nose	Ear	Mouth
☐ Red or Flushed ☐ Petechiae ☐ Scratch Marks _____**None Noted**	☐ Petechiae to Eyeball ☐ R and / or ☐ L ☐ Petechiae to Eyelid ☐ R and / or ☐ L ☐ Bloody Red Eyeball(s) _____**None Noted**	☐ Bloody Nose ☐ Broken Nose ☐ Petechiae _____**None Noted**	☐ Bruising behind Ear ☐ R and / or ☐ L ☐ Bleeding from Ear Canal ☐ Petechiae _____**None Noted**	☐ Bruising ☐ Swollen Tongue ☐ Swollen Lips ☐ Cuts / Abrasions _____**None Noted**
Under Chin	**Chest**	**Shoulders**	**Neck**	**Head**
☐ Redness ☐ Scratch Marks ☐ Bruise(s) ☐ Abrasions _____**None Noted**	☐ Redness ☐ Scratch Marks ☐ Bruise(s) ☐ Abrasions _____**None Noted**	☐ Redness ☐ Scratch Marks ☐ Bruise(s) ☐ Abrasions _____**None Noted**	☐ Redness ☐ Scratch Marks ☐ Bruising ☐ Fingernail Impressions ☐ Swelling ☐ Ligature Mark _____**None Noted**	☐ Petechiae (on scalp) **Ancillary findings**: ☐ Hair Pulled ☐ Bump(s) ☐ Skull Fracture ☐ Concussion _____**None Noted**

Use the below questions as a guide for the strangulation assessment. Transfer answers onto a nursing note:

Forensic Narrative Investigation/Assessment Questions:

1. How and where was the patient strangled? List the position and mechanism
2. Was a ligature used? Assess for ligature marks
3. How long did the strangulation event occur? _____ seconds _____ minutes
4. Did the patient lose consciousness? If so how long: _____ seconds _____ minutes
5. Describe amount of force or pressure being used during strangulation?
6. Did the reported perpetrator use their left or right hand?
7. Is the reported perpetrator left or right handed (if known)?
8. Was the patient shaken simultaneously? Straddled or against a wall?
9. Was the patient's head forced or hit against the wall, ground or object during event?
10. Any statements made during the strangulation?
11. SANE should also consider positional strangulation/attempted asphyxiation

SANE of Butler County

(Place Patient ID Sticker Here)

Physician Report Information

Items To Review:

- Brief description of assault circumstance
- Reported assailant (stranger, acquaintance, etc)

Patient Allergies:	Pertinent Medical History: Date of last tetanus shot:

DFSA Information:

DFSA Indicated? No / Yes If yes, was a DFSA collected? Yes / No (reason):_____

Last intake of alcohol (if applicable): _____

Emergency Contraception Screening:

Current contraception method:_____ # missed doses in 2 weeks:_____

If patient requests emergency contraception:

1. Has the patient reviewed and signed the EC consent form? Yes / No
2. If yes, then suggest a baseline pregnancy test

Hepatitis B Vaccination Screening:

Hepatitis B Vaccination Series:

Has the patient ever received the hepatitis B vaccination series? Yes / No If yes, date of series:_____

HPV Vaccination Screening:

HPV Vaccination Series:

Has the patient ever received the HPV vaccination series? Yes / No If yes, date of series:_____

HIV Prophylaxis Screening:

HIV Prophylaxis:

Body part/area exposed:_____ Fluid exposed to:_____

Is perpetrator HIV status known? Yes / No

SANE of Butler County

Discharge Instructions

(Place Patient ID Sticker Here)

SANE of Butler County has completed a forensic examination at your request. As indicated by the forensic examiner the kit possession is given to the law enforcement entity where the crime was reported to have occurred. Law enforcement submits the forensic kit to be tested at the criminal laboratory. **Results of the kit are sent directly to law enforcement and are not shared with SANE of Butler County or the hospital you are being treated at.**

The Law enforcement agency that received your forensic kit is:_____

Emergency Department treatment provided:

Your emergency medical provider has indicated you will be receiving the following treatment during your visit.

"X" ALL APPLICABLE ITEMS PROVIDED DURING INTITIAL TREATMENT

	Antibiotic Administration		**HIV Baseline Testing**
	Serum/Urine Pregnancy Baseline		**HIV Post Exposure Medication** (for NEGATIVE baseline test ONLY)
	Emergency Contraception (for NEGATIVE baseline test ONLY)		**TDAP if injuries presents** (if not received within past 5-7 years)
	Hepatitis B / C Serum Baseline Testing		**HPV Vaccine** (for patients 26 or YOUNGER)
	Hepatitis B Immune Globulin (HBIG)		Other:

You are strongly encouraged to seek follow up care for the below listed items:

It is recommended that you visit your physician, or OB/GYN for repeat testing for potential sexually transmitted diseases within 7-10 days from your initial forensic exam. Additional testing should include:

"X" ALL APPLICABLE ITEMS RECOMMENDED FOR FOLLOW UP TESTING

	STD testing/re-evaluation		**Pregnancy Screening**
	Injury Evaluation (if injuries found on initial treatment)		**HPV Vaccine:** for patients 26 or younger *Can receive three doses post sexual assault HPV exposure Shot 1: during initial treatment or at follow up Shot 2: 2 months after assault Shot 3: 6 months after assault
	Hepatitis C serum re-testing		**HIV Medication Evaluation** (if initiated during initial treatment)
	Hepatitis B Series Vaccination (if initial series started on initial treatment) **Hepatitis B vaccine series is THREE shots Shot 1: At hospital Shot 2: 4 weeks after first dose Shot 3: 8 weeks after second dose		**HIV Serum re-testing** *HIV testing should be performed at different time intervals Test 1: during initial medical treatment if ordered by physician Test 2: 6 weeks after assault Test 3: 3 months after assault Test 4: 6 months after assault

BILLING PROCEDURES FROM YOUR EXAM:

Billing Procedures are in accordance with ORC 2907.28. You will not be charged for your forensic exam or the cost of antibiotics administered at the hospital. However, you may receive a bill for other procedures or tests performed at the hospitals during your treatment.

Additional charges may include (but not limited to):

-Physician examination (if injuries are present or treatment is provided in addition to the forensic exam)
-Emergency contraception medication
-Serum or urine blood testing
-Post exposure emergency medications and baseline testing (Hepatitis B/HBIG/HIV baseline testing)
-Medications administered during treatment (anti-emetics, pain medication, etc)
-Additional testing provided during treatment

To assist with the cost of any additional billing charges for your hospital visit, it is suggested to apply for the Crime Victim Compensation Fund through the Ohio Attorney Generals Office. ***For additional information regarding the Crime Victims Compensation Program please call 1-800-582-2877***

If you believe there is an error with your hospital billing charges, you may contact SANE of Butler County at 513-889-5435 during 9:00am – 5:00pm, Monday – Friday to assist you.

Follow Up Resources:

Provides free crisis intervention counseling and advocacy for the child and adult sexual assault victims and their families/co-survivors of sexual violence:

Ohio Sexual Violence 24/7 Crisis Hotline	**1-844-OHIO-HELP**
Butler County Residents	(937) 267-3349 or (513) 887-3430
Brown County Residents	(513) 378-4151
Clermont County Residents	(513) 732-7979 24/7 Crisis Line: (513) 248-0241
Darke County Residents	(937) 547-7380
Fayette County Residents	(740) 335-8033
Greene County Residents	(937) 562-5087 (937) 376-5111 after hours/holidays
Hamilton County Residents	(513) 381-5610
Miami County Residents	(937) 603-8643
Montgomery County Residents	(937) 225-5623
Preble County Residents:	(937) 456-8156
Shelby County Residents	(937) 498-7400
Warren County Residents	(513) 267-3349

Rape Abuse and Incest National Network **(RAINN)** 1-800-656-HOPE
24 hour computer system that will relay your call to the nearest rape crisis center 1-800-656-HOPE http://www.rainn.org

Ohio AIDS Hotline – 1-800-332-2437
Information about confidential free testing for HIV, STD, and Hepatitis http://ohiv.org

Attorney General's Crime Victim Compensation Program 1-800-582-2877 http://www.ohioattorneygeneral.gov/ (click on services menu)

Patient Signature **Examiner Signature** **Date**

STEP 16 Chain of Custody Form

Patient Name, Label or ID

Items **Do NOT count any clothing placed inside the kit**

☐ Sexual Assault Evidence Collection Kit

☐ Clothing Bag _____
what type of clothing?

☐ Clothing Bag _____
what type of clothing?

Do NOT count any clothing placed inside the kit

☐ Clothing Bag _____
what type of clothing?

☐ Other _____

☐ DFSA _____
circle type collected: **Blood / Urine / Both**

Items Sealed by: **When did you seal the kit in preparation for handoff?**

_____ _____
Nurse/Physician—sign Hospital and City

_____ _____
Print Date and Time

Items Released by: **(Examiner)**

_____ **SANE of Butler County / Forensic Examiner**
Nurse/Physician—signature

_____ _____
Print Date and Time ****Times Must Match**

Items Released to: **(Agency receiving possession of the kit)**

_____ _____
Law Enforcement—sign Badge/Agency

_____ _____
Print Date and Time ****Times Must Match**

SANE of Butler County
www.saneofbutlercounty.org
7182 Liberty Centre Dr, Suite N West Chester, Ohio 45069 Office: 513.889.5435 Fax: 1.866.444.7263 Answering Service: 1.800.642.9961

Crime Lab / Detective Notes for Forensic Examination

(Patient ID Sticker Here)

SANE RN Subpoena Address:
SANE RN Name
c/o Butler County Sheriff's Office
7162 Liberty Centre Drive, Suite A
West Chester, Ohio 45069

or fax to 1-866-444-7263 for same day delivery

Injury Photography

Photographs obtained during forensic examination for this patient? (circle one) **Yes / Patient Declined. / N/A**

"X" if patient DECLINED collection or Examiner unable to collect. Must indicate WHY not collected

____Oral swabs: _____
____Fingernail swabs: _____
____Dry stain swabs: _____
____Pubic hair combings: _____
____Rectal swabs: _____
____Photography: _____
____Underwear: _____
____Clothing: _____
____Genitalia Swabs: _____
____Other: _____

Exam collection articles:

____Clothing bags (indicate number of clothing bags NOT including items inside the SA kit)

____ Blood/Urine (DFSA Kit)

Law Enforcement Contact Information:

____Patient does wish to speak with law enforcement at this time regarding reported sexual assault

____ Patient does NOT wish to speak with law enforcement at this time but is aware law enforcement may be in contact with him/her

Notes to crime lab / detective:

_____

_____

_____

_____

_____

_____

_____

_____

_____

SANE of Butler County
Progress Notes – Form B

SANE RN: _____ Date: _____
(Print Name) (Date of Exam)

(Place Patient ID Sticker Here)

Step 16 Pack Up the Evidence Kit

- ☐ Collection envelopes filled out
- ☐ Assault History form completed and in kit
- ☐ STEP 8 Underwear bag in kit
- ☐ Top of kit lid filled out
- ☐ DO NOT place DFSA samples in kit
- ☐ Close kit and use two seals on long edges of kit as shown
- ☐ Seal clothing collection bags using additional seals
- ☐ Initial along one edge of each seal
- ☐ Refrigerate or freeze DFSA samples for extended storage

- ☐ **Optional** Chain of custody templates are provided on the back of this page and on the kit lid.

FREE / LOW INCOME CLINICS

Butler County Comm Hlth Consort.
2 North Main Street Middletown, OH 45042
Phone: 513-425-8330

Cincinnati Health Network
400 Oak Street, Suite M-2
Cincinnati, OH 45219
Phone: 513-961-0600

Family Health Services of Darke County
5735 Meeker Road
Greenville, OH 45331
Phone: 937-547-2304

Lincoln Heights Health Center
1401 Steffen Avenue
Lincoln Heights, OH 45215
Phone: 513-483-3076

Neighborhood Health Care
2415 Auburn Avenue
Cincinnati, OH 45219
Phone: 513-221-4949

Samaritan Homeless Clinic
41 Catherine Street
Dayton, OH 45406-1891
Phone: 937-461-1376

Southern Ohio Health Services Network
400 Technecenter Drive, Suite 402
Milford, OH 45150
Phone: 513-576-7700

Winton Hills Medical and Health Center
5275 Winneste Avenue
Cincinnati, OH 45232
Phone: 513-242-1033

Planned Parenthood®
Southwest Ohio Region

www.ppswo.org
800.230.PLAN

STI testing and treatment
(Repeat testing recommended after 1-2 weeks)

Pregnancy testing + all options counseling
(Post 2 weeks)

Emergency contraception
(If within 5 days)

Other services include:

- Annual exam and pap test
- Breast cancer screening
- Birth control services
- HIV testing
  (Recommended retest at 6 weeks, 3 months, and 6 months)
- HPV vaccine
- UTI, vaginal and yeast infection testing and treatment
- Colposcopy*
- Abortion services*

*Denotes services provided at only some of our health centers

Center Locations

Cincinnati Surgical Center
513.287.6488
2314 Auburn Avenue | Cincinnati, Ohio 45219

Dayton Health Center
937.226.0780
224 N. Wilkinson Street | Dayton, Ohio 45402

Hamilton Health Center
513.856.8332
11 Ludlow Street | Hamilton, Ohio 45011

Mt. Auburn Health Center
513.287.6484
2314 Auburn Avenue | Cincinnati, Ohio 45219

Springdale Health Center
513.772.2207
290 Northland Boulevard | CIncinnati, Ohio 45246

Springfield Health Center
937.325.7349
1061 North Bechtle Avenue | Springfield, Ohio 45504

Western Hills Center
513.574.4348
2016 Ferguson Road | Cincinnati, Ohio 4523

For a full list of center location hours visit: https://www.plannedparenthood.org

Ohio Rape Crisis Centers and Abuse Shelters

County	Shelter	Phone
Adams	*Reach Out	800-448-2273
Brown	*YWCA House of Peace	513-753-7281
Butler	*YWCA Dove House	800-618-6523
	*Angel Place Shelter	877-952-6435 513-422-4433
	*Women Helping Women – Butler County	513-381-5610
Clermont	YWCA House of Peace	513-753-7281
	*West Side Catholic Shelter	216-631-4141
	*Jewish Family Services Association Project Chai	216-691-7233
Darke	*Shelter from Violence, Inc.	937-548-2020
Fayette	My Sister's House	740-636-9300
Greene	*Family Violence Prevention Center of Greene County	937-372-4552
	*Greene County Victims Witness Division	937-562-5087
Hamilton	*YWCA Battered Women's Shelter	800-872-9259
	*Rape Crisis & Abuse Center of Hamilton County	
Miami	*Family Abuse Shelter of Miami County	937-335-7148 800-351-7347
Montgomery	*YWCA of Dayton Shelter & Housing Services	937-222-7233
	Montgomery County Victims Witness Division	937-225-5623
Preble	*Preble County DV Shelter	937-456-6891
Shelby	*New Choices	937-498-7261
Warren	*Warren County Abuse & Rape Crisis Shelter	888-860-4084