



# Sample Policies & Fillable Documents

For common issues related to the Iowa Sexual Assault Protocol

## ABSTRACT

This document includes sample policies and fillable documents that address common issues encountered by examiners and other professionals using the Iowa Sexual Assault Protocol. The forms and fillable documents reflect best practices and should be adapted as necessary for each individual healthcare organization's needs.

January 2021

## DISCLAIMER

These sample forms and fillable documents are provided solely for educational purposes. Neither the steering committee or the Iowa Attorney General's Crime Victim Assistance Division make any warranties, express or implied, regarding the legal effect of any forms or documents.

Practitioners should consult with appropriate supervisors, administrators, and/or legal counsel before adapting any of these forms for individual use. The sample policies are designed for a general audience and may require revision before use in any particular practice.

Finally, note that yellow highlighting appears in portions of the sample forms and policies where individualized information must be inserted for the forms and policies to function properly.

## A NOTE ON TECHNOLOGY

The sample documents contained in this .PDF file are also available in a more edit-friendly format via Dropbox, available at <https://www.dropbox.com/sh/09htnt0tyfqcl7m/AAAdfjgi714almQ8kPXy8dfoa?dl=0>. From that location, users can download an editable .docx file for all sample policies and forms.

## ATTRIBUTION

Practitioners and SART teams should feel free to use the sample materials contained in this document for their practice without attribution, with the exception of the Sexual Assault Examination Model Chart.

The Sexual Assault Examination Model Chart is an original creation of 5.1.5 FoReNsics, LLC, and may only be reproduced or altered with attribution. The watermarked logo contained in the footer of the Model Chart is sufficient attribution. Other requests to reproduce or alter the Model Chart should be directed to [515forensicsllc@gmail.com](mailto:515forensicsllc@gmail.com).

# TABLE OF CONTENTS

- Sample Policies & Fillable Documents .....1
- Abstract .....1
- Disclaimer .....2
- A Note on Technology .....2
- Attribution .....2
- Table of Contents.....3
- SANE Job Description.....1
- Sexual Assault Examiner Documentation.....6
- Sexual Assault Examiner Peer Review .....8
- Sexual Assault Examiner Pediatrics.....9
- Sexual Assault Examiner Documentation Storage .....12
- Sexual Assault Examiner Equipment and Supplies .....13
- Memorandum of Understanding.....1
- SANE Independent Contractor Agreement.....2
- Individual Provider Reimbursement Invoice .....1
- Sexual Assault Examination Model Chart .....1

## **SANE JOB DESCRIPTION**

**JOB TITLE:** SEXUAL ASSAULT NURSE EXAMINER (SANE)

**REPORTS TO:** SANE Program Coordinator and/or Agency of Hire

### **JOB PURPOSE:**

The Sexual Assault Nurse Examiner (SANE) will provide timely, non-judgmental, compassionate care to the sexual assault patient age 13 and older. Care may include a medical-forensic exam, prophylaxis for pregnancy and sexually transmitted diseases, photographic documentation, referrals for appropriate medical and psychological follow-up, support, and participation in legal proceedings. The SANE is expected to follow protocols established by the Medical Director and/or management of the SANE Program for which the SANE participates.

### **JOB RESPONSIBILITIES:**

#### **General:**

- Exhibit a willingness to serve persons who are affected by sexual assault, age 13 and older.
- Uphold the belief that quality services are a top priority.
- Establish and maintain a positive network of collaborative partnerships with service providers in the area to facilitate optimum access to needed services.
- Participate in team debriefings as needed to assist with quality assurance of services offered.

#### **SANE:**

- A) Participate in SANE/SART meetings as scheduled.
- B) Maintain clinical expertise as a sexual assault examiner.
- C) Maintain current Registered Nurse licensure or higher.
- D) Maintain malpractice insurance as an individual or it is provided by the practicing program. Individual should remain in good standing at all times and notify supervisor immediately if any accusations arise.

- E) Complete the initial and on-going training requirements as identified by the program. Initial training should be obtained from an internationally recognized training program.
- F) Debrief as needed to maintain emotional and physical wellness.
- G) Maintain open communication with supervisor and SART program on regular basis.
- H) Maintain equipment in proper working condition and exercise fiscal responsibility of program resources.
- I) Share individual expertise with other members of sexual assault exam team.
- J) Maintain competency through active performance of cases with no lapse of greater than six (6) months or review and discussion with SANE supervisor.
- K) Participate in quality assurance chart and photograph review process as determined by the program administration.
- L) Adhere to all administrative, clinical, and contract policies and procedures.
- M) Follows policies, procedures, and protocols for the program.
- N) Participates in documentation and evaluation process with SANE coordinators or manager.
- O) Assures all activities performed adhere to established SANE guidelines.
- P) Commit and be available to cover minimum number of shifts each month, communicating availability to supervisor in a timely manner. Maintain ability to respond within 60 minutes of notification. Must not be under the influence of drugs or alcohol while on call.
- Q) Participate in professional development as determined by the program, including staff meetings, conferences, and in-services.
- R) Maintain up-to-date familiarity of program policy and procedures in order to exercise good judgment in various situations.
- S) Perform and document sexual assault examination and forensic interview accurately.

- T) Perform a complete physical and forensic evidence-collection examination including head-to-toe assessment for trauma, detailed genital examination, forensic specimen collection and documentation, (including photography), and assess for mandatory reporting status, reporting when appropriate.
- U) Document injuries accurately with support of photographic evidence.
- V) Maintain chain of custody for each sexual assault exam and adhere to evidence protocols.
- W) Exercise professional standards that do not create conflict of interests with employment or patient care, including patient and medical record confidentiality.
- X) Responsible for fact/expert witness testimony when a subpoena is received.

**POSITION QUALIFICATIONS:**

- Registered Nurse or higher with current state licensure, prefer minimum of two (2) years experience.
- Successfully completes approved Sexual Assault Examiner training. Trainings must be approved by either local jurisdiction or International Association of Forensic Nurses.
- Completes the initial and on-going requirements as identified by the program.
- Submits and maintains paperwork to remain in compliance with program credentialing requirements.
- Ability to plan and organize work autonomously.
- Demonstrated initiative, resourcefulness, and good judgment in executing the role and responsibilities of an examiner.
- Ability to pass background checks.

**WORKING CONDITIONS:**

- Requires concentrated, complex, and variable mental efforts, with emphasis on synthesis of information, written, and oral communication.

- Documentation of updated immunizations as determined by program/facility requirements.
- Knowledge and ability to initiate lifesaving measures if required
- Awareness of occupational exposure to blood and body fluids.
- Ability to lift materials weighing up to 20 pounds.
- Independently mobile. Tasks generally performed while sitting, standing, and walking. Must have access to reliable transportation in order to meet the needs of the organization.
- Requires access to medical and personal information of a delicate nature and realizes the potentially serious consequences of improper disclosure.
- An at-will employment relationship exists between the Nurse Examiner and the organization.

#### **COMPENSATION:**

Compensation may be provided in one of the following forms:

- **Community Based Program**
  - On call rate (to be determined by program) \$xxx/hr
  - Provider exam rate (flat rate determined by Iowa CVAD programs). As of 1/1/2021, the rate is \$200/exam.
- **Hospital/Facility/Employer Based Program**
  - Option A:
    - On-call rate (to be determined by program) \$xxx/hr; AND
    - Provider exam rate (flat rate to be determined by Iowa CVAD program) to be paid to the SANE directly \$200/exam.
  - Option B:
    - Hourly wage while working clocked in \$xxxx/hr; AND
    - Provider exam rate (flat rate to be determined by Iowa CVAD program) to be paid to the facility \$200/exam

#### **REQUIRED TRAINING:**

- **Agency/Facility Orientation (& and other training local jurisdiction requires)**

\* \* \*

The information noted herein is intended to describe the general nature and level of work being performed by the individual(s) assigned to this classification. The information is not intended to be construed as an exhaustive list of all responsibilities, duties or skills required of personnel so classified.

**Examiner:** I agree to the terms if this position as stated above. Failure to comply with these terms may lead to termination or resignation.

\_\_\_\_\_  
Examiner Signature

\_\_\_\_\_  
Date

**Attestation:** Taken together, our signatures below confirm that the undersigned employee has successfully demonstrated competence in all clinical skills delineated in this job description and performs satisfactorily in the job. The undersigned administrator has job knowledge, education, experience, and licensure that is at least equal to the person being validated.

\_\_\_\_\_  
SANE Administration

\_\_\_\_\_  
Date



# **SEXUAL ASSAULT EXAMINER DOCUMENTATION**

## **POLICY:**

The priority of the Sexual Assault Examiner is to provide appropriate medical care for any need that may be present in the sexual assault patient. After appropriate care has been rendered, a comprehensive exam will be conducted for the purpose of medical forensic evidence collection.

## **STANDARD RECOMMENDATION OF CARE:**

Documentation of the medical forensic exam and evidence collection is an essential evaluation tool. Medical forensic documentation consists of a quoted narrative from the patient as well as the nurse's evaluation. Documentation must be detailed and the examiner should recognize the significance of medicolegal implications.

## **PURPOSE:**

The purpose of this policy is to direct the Sexual Assault Examiner in the use of medicolegal forensic documentation and the proper storage of these documents.

## **EQUIPMENT:**

- Paper chart (see attached) or substantially equivalent electronic health record
- Forensic ruler
- Alternative light source
- A photography device (digital SLR camera with macro lens OR colposcope)

## **PROCEDURE:**

1. All patients should give consent in writing or verbally for the examiner to conduct an exam. If patient is unable to provide consent, the examiner should consult the facility's policy for further direction. Patient may decline any portion(s) of the exam process.
2. Minimize patient discomfort throughout examination and documentation process.
3. Patient narrative should be obtained verbatim and documented as such. This narrative should guide the exam process.

4. Any photographs taken by the examiner are considered part of the patient's medical record.
5. Injury documentation should consist of both written and digital documentation whenever possible.
6. Examiner should evaluate, address and document sexually transmitted infection concerns and risk factors, along with pregnancy if applicable.
7. Documentation should reflect any evidence collected.
8. After-visit summary should be supplied to patient and should address medications, safety, and follow-up care.
9. Involved prosecutors, law enforcement officials, examiners, and advocates should further discuss the extent of documentation they view as critical, examine any related case law, consider their concerns on this issue and how to be sensitive to victims, and, ultimately, determine what strategy is right for their community.
10. Each facility should work with their health information management department for proper storage procedures and ensuring chain of custody.
11. Original documentation should always be maintained if paper charting is utilized. No additional notes should be kept and if taken, must become part of the medical record.
12. Documentation may be utilized for team peer-review, second opinions, legal proceedings, and continuation of care.
13. Documentation should only be released when accompanied by a signed consent or court order. Chain of custody should be maintained.
14. When documentation is released, an original copy will be maintained with the medical records. Each facility should have a procedure to replicate the original documentation.

## **SEXUAL ASSAULT EXAMINER PEER REVIEW**

### **POLICY:**

It is suggested that examiners within an exam site, jurisdiction, or region devise an appropriate review process tailored to their needs.

### **STANDARD OF RECOMMENDATION:**

Consider having a clinical director or supervisor at the exam site systematically review documentation related to the exam. (In some jurisdictions or facilities, review of nonphysician examiner's documentation by a medical director/supervisor is required.)

### **PURPOSE:**

These reviews increase the overall effectiveness of the examiner program by ensuring that reports are completed according to policy. These reviews also aid in assessing staff training needs.

### **PROCEDURE:**

1. Determine and select peer-review team.
2. Understand confidentiality in relation to peer review. Patient's right to privacy and confidentiality continue to remain of utmost importance.
3. Charts should be de-identified prior to peer review team evaluation.
4. Peer-review team will determine frequency of meetings and reviews.
5. Peer-review team should communicate findings and provide any constructive feedback to the team leader/coordinator.
6. Consider the attached evaluation tool for purposes of each chart review.

## **SEXUAL ASSAULT EXAMINER PEDIATRICS**

### **POLICY:**

The priority of the Sexual Assault Examiner is to provide appropriate medical care for any need that may be present in the pediatric sexual assault patient. After appropriate medical stabilization care has been rendered, a comprehensive pediatric exam will be conducted by a trained pediatric examiner for the purpose of medical forensic evidence collection.

### **STANDARD RECOMMENDATION OF CARE:**

The pediatric medical forensic exam and evidence collection is an essential evaluation for an acute suspected pediatric sexual abuse report. If a trained pediatric examiner is not available, an appropriate transfer of care to a trained examiner should be arranged. Pediatric medical forensic exams must be detailed, trauma-orientated, and specialized. The examiner must recognize the significance of medicolegal implications.

### **PURPOSE:**

The purpose of this policy is to direct the pediatric sexual assault exam in the use of medicolegal forensic evaluation and ensure services are provided by a specially trained provider who has extensive knowledge in pediatric sexual abuse assessment.

### **PROCEDURE:**

1. All medical facilities should provide appropriate emergent and stabilization care for patients of any age who present for a sexual assault exam.
2. Regarding pediatric patients, facilities who do not have trained pediatric sexual assault examiners should collaborate with neighboring communities to identify the closest trained provider.
3. Facilities should work together to identify appropriate transfer procedures and expectations to provide services to acute pediatric sexual abuse patients.
4. The providers at all levels should work to promote minimal patient discomfort and protect the integrity of any potential evidence throughout the screening, transfer, and examination process.

5. When patient transfer is complete, the specially trained pediatric sexual assault nurse examiner should be contacted to provide medicolegal and forensic exam services.
6. The examiner should also refer pediatric patients for forensic interviewing by a trained forensic interviewer, typically at a Child Advocacy Center or Child Protection Center. Iowa's seven Centers are based in Davenport, Hiawatha, Mason City, Muscatine, Sioux City, Waterloo, and West Des Moines.
7. All evaluations for pediatric sexual abuse mandate a referral to DHS and the appropriate law enforcement jurisdiction. The initial referral should be conducted prior to any transfer of patient. The contact person's name and number should be shared with the acquiring provider and that provider will then provide exam details as necessary with the appropriate case workers assigned.
8. Local advocacy programs/services should also be consulted prior to any patient transfer.
9. Any pediatric patient who does not meet acute criteria (<72 hrs exposure to potential assailant or acute injury or severe injury) should be referred only for a forensic interview at the closest child advocacy center. This referral can be obtained through DHS and law enforcement consultation. Forensic interviews are conducted at scheduled times per the CAC/CPC.
10. Pediatric patients should be defined by each medical facility by age. At no time should age of menarche or Tanner staging be used to determine pediatric patients. The age determined should be no less than 12 years of age and no more than 18 years of age to define pediatric patients. Most commonly many facilities and examiners will define a pediatric sexual assault patient as under age 13 or 14 years old.
11. All notes of the initial complaint and throughout the transfer process should be detailed and kept with patient medical records.
12. Documentation may be utilized for team peer-review, second opinions, legal proceedings, and continuation of care.
13. Documentation should only be released when accompanied by a signed consent or court order. Chain of custody should be maintained.

14. When documentation is released, an original copy will be maintained with the medical records. Each facility should have a procedure to replicate the original documentation.

## **SEXUAL ASSAULT EXAMINER DOCUMENTATION STORAGE**

### **POLICY:**

It is vital that the exam documentation be thorough, precise, and accurate. It is essential that examiners receive education on the importance of proper documentation, protecting patient's right to privacy, and on writing reports that are relevant to their role. Every facility should ensure proper privacy of documentation to patient's.

### **STANDARD OF RECOMMENDATION:**

The complete medical forensic record of the sexual assault visit should be maintained separately from the patient's medical record to limit disclosure of unrelated information and to preserve confidentiality. The medical record is stored at the exam site. The exam site should have clear policies about who is allowed access to these records.

### **PURPOSE:**

The medical record is not part of the evidence collection kit and it should not be submitted to the crime lab or given to law enforcement. Much of the record is not relevant to case prosecution, and releasing it infringes upon patients' privacy rights. Although all or part of the medical record may be subpoenaed, if patients do not consent to its release, it is ultimately up to the court to decide whether such information is pertinent to the case and should be released.

# **SEXUAL ASSAULT EXAMINER EQUIPMENT AND SUPPLIES**

## **POLICY:**

Each facility is responsible for providing and maintaining the necessary supplies to serve patients of sexual assault. Supplies should be readily available, regularly examined for expiration, and in working condition at all times.

## **STANDARD OF RECOMMENDATION:**

Obtaining equipment and supplies that can increase the quality and quantity of evidence collected can have a significant impact on case outcomes. However, the costs of equipment and training on equipment use can be prohibitive for some jurisdictions and examiner programs.

## **PROCEDURE:**

Some ideas to address cost barriers:

1. Seek used or donated equipment or alternative, less-expensive equipment where it exists.
2. Apply for grant or foundation funding for equipment where eligible.
3. Ask for help from community groups in raising funds for one-time equipment or ongoing supply costs.
4. Consider sharing costs and equipment with other departments in an exam facility or among other near-by local health care facilities.
5. Consider the benefits of a mobile examiner program where costs of equipment, examiner education and clinical preparation, and on-call costs may be shared by multiple exam sites.
6. Because the information gathered in the exam is used to investigate and prosecute the offense, ask for assistance from local law enforcement and prosecutor's offices in obtaining equipment and supplies used specifically for forensic evidence collection.

## **SUPPLIES:**

Necessary supplies may include, but are not limited to, the following:

- Sexual assault evidence-collection kits
- Photography device (digital SLR camera with macro lens OR Colposcope)



- Documentation forms
- Examination table
- Alternate light source
- Speculums of various sized
- Urine specimen containers
- Pregnancy testing supplies
- Drapes
- Patient gowns
- Paper bags
- Prophylactic medications or agreement with local pharmacy to carry/access routine medications
- Sterile swabs and large procto swabs
- Gauze
- Gloves
- Face masks
- Appropriate PPE as indicated
- Pens
- Sharps container
- Computer for charting (if electronic charting is being utilized)
- Saline or sterile water
- Alcohol pads
- Lancets
- Band-aids

# MEMORANDUM OF UNDERSTANDING

(Provider Name Here), M.D.

and

(SART Team Name Here (SART))

NOW, on this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, this Memorandum of Understanding (hereafter "MOU") is entered into between (Provider Name), M.D. and SART Team Name (hereafter "SART") for the purpose of formally recognizing (Provider Name), M.D. as interested and committed to participating in the efforts of the SART in the role of MEDICAL ADVISOR.

THEREFORE, SART and (Provider Name), M.D. express their mutual understanding that:

## A. Medical Advisor Role and Responsibilities:

1. Establishing, reviewing, and approving, in collaboration with the Sexual Assault Examiner (SAE) Coordinator at least annually, all applicable medical and forensic policies and protocols, utilizing evidence based practices.
2. Maintaining credentials and privileges at participating health care facilities, as deemed necessary and appropriate.
3. Supporting the SAE Coordinator in training, educating, and recruiting medical professionals for SART and SAE participation.
4. Authorizing SAEs to administer medications pursuant to an approved protocol that meets or exceeds generally accepted practices.
5. Conducting education and remediation activities for SAEs and other medical professionals regarding current and approved clinical practices.
6. Educating and advising local health care facilities and physicians to support SART operations.
7. Attending SART Committee meetings and other relevant program activities, as appropriate.

## B. Additional Terms:

In addition to the responsibilities explained in Section A, (Provider Name), M.D. and SART agree to the following terms:

1. **Two Year Commitment.** (Provider Name), M.D. shall participate in SART for a minimum of two (2) years.
2. **Payment.** No payment shall be made in exchange for services. In addition, (Provider Name), M.D. shall not collect the examiner fee from the Sexual Abuse Examination Payment Program, as administered by the Iowa Attorney General's Crime Victim Assistance Division.
3. **Liability.** Each Party to this MOU is responsible for obtaining and maintaining appropriate insurance or self-insurance to protect it and its officers, employees, or agents against liabilities that may arise from that party's involvement in the activities or events that are the subject of this MOU.
4. **Mutual Indemnification.** Each party to this MOU agrees to indemnify and hold the other party harmless from and against any and all claims, judgments, costs, and liabilities for injuries, damages, and expenses, including attorney fees, arising from and to the extent attributable each party's performance of obligations under this MOU.
5. **Termination.** After the initial two-year commitment concludes, this MOU is automatically renewable for additional two-year terms unless (Provider Name), M.D. provides SART with a six-month written Notice of Termination, SART provides (Provider Name), M.D. with a six-month written Notice of Termination or the MOU is terminated by SART for cause based on performance.
6. **No Assignment.** This MOU may not be assigned or transferred by either party without the prior written consent of the other party.
7. **Governing Law.** This MOU shall be governed by the laws of the State of Iowa and any dispute shall be brought in (Name) County, Iowa.

WHEREFORE the signatures below acknowledge our commitment to this agreement.

Dated \_\_\_\_ day of \_\_\_\_\_, 20(XX).

In effect unless revoked in writing by either of the parties.

---

(Provider Name), M.D. Medical Advisor – [x] County SART

---

Date

---

Coordinator – [x] SART

---

Date

# SANE INDEPENDENT CONTRACTOR AGREEMENT

THIS IS a contract for the provision of Sexual Assault Examination Services (SAE) between (Insert Program Name/Info Here), and\_(Contractor).

[In entering into this agreement, the Contractor agrees to the following terms:]

\_\_\_\_1. I am a licensed nursing/medical professional in (STATE). My license is in good standing. (Please attach a copy of your license-front and back.) I have not had my nursing license revoked and am not currently being investigated by the Iowa Board of Nursing or the equivalent board in any other state. I am obligated to inform the SANE Coordinator immediately if any investigation begins or if I am no longer in good standing with the Iowa Board of Nursing or the equivalent board in any other state.

\_\_\_\_2. I have completed an approved 40-hour SANE training course. (Please attached a copy of certificate of completion). The course was approved either by my location jurisdiction or by the International Association of Forensic Nurses. I must fully complete my preceptorship and be approved by a primary SANE or the SANE Coordinator in order to conduct independent sexual assault exams.

\_\_\_\_3. I do not have any preconceived biases about how sexual assault criminal charges should be resolved. I am willing to collect and identify evidence from patients and offer medical treatment, including preventative medications, without preconceived biases. I am willing to provide services to all patients, regardless of the patient's race, creed, color, sex, sexual orientation, gender identity, national origin, religion, ancestry, or disability.

\_\_\_\_4. I understand that active participation in the program means I commit to a minimum of (Insert Hours Amount Here) of on-call time per month. If I am unable to adhere to my obligation, I will notify the SANE Coordinator.

\_\_\_\_5. I also understand/agree that if I am unable to fulfill my commitment to a minimum of (XX) hours of on-call time per month for (XX) years to (program name), I will repay full or partial tuition determined by program administrators. I may also be expected to repay full or partial tuition if I am dismissed from the team due to unprofessional conduct before my (XX) year obligation is fulfilled.

\_\_\_\_6. I have reviewed the Sexual Assault Nurse Examiner job description and agree that I am qualified, capable, and willing to fulfill these duties.

\_\_\_\_7. I understand that program meetings will be held on a regular basis throughout the year and I will be expected to attend the majority of the meetings in order to be considered in good standing. I will do my best to attend these meetings.

\_\_\_\_\_8. I understand I am **mandated** to attend training for skill development and maintenance as indicated by the SANE Coordinator. If I am unable to attend, I will arrange alternative training with the SANE Coordinator.

\_\_\_\_\_9. After the initial (XX)-year commitment, this contract will remain in good standing until I otherwise notify the SANE Coordinator of any change in my status. If I choose to voluntarily leave this role after the initial (XX)-year commitment I will give a minimum of 30 days notice.

\_\_\_\_\_10. I understand that this is an “independent contract for professional services” and that it is not an employment contract.

\_\_\_\_\_11. I agree to provide the best professional services I can when performing sexual assault examinations. I will follow the protocol for the (program name here) in performing examinations.

\_\_\_\_\_12. I will keep patient information confidential.

\_\_\_\_\_13. I will abide by the rules of on-call time and facility requirements.

---

**Name**

---

**Date**

---

**SART/SANE Coordinator**

---

**Date**

# INDIVIDUAL PROVIDER REIMBURSEMENT INVOICE

INVOICE DATE \_\_\_\_\_ DATE OF EXAM \_\_\_\_\_

PATIENT NAME \_\_\_\_\_  FEMALE  MALE

TRACK KIT BARCODE \_\_\_\_\_

HOSPITAL/CLINIC

- (Name of ) MEDICAL CENTER
- (Name of ) MEDICAL CENTER
- (Name of ) MEDICAL CENTER
- (Name of ) MEDICAL CENTER

AMOUNT **\$200.00**

DIAGNOSIS CODE **V71.5**

PROVIDER NAME \_\_\_\_\_

SSN# \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_

**SEND THIS FORM TO:**

**CRIME VICTIM ASSISTANCE DIVISION**

ATTN: SAE PROGRAM –Ruth Walker / Elise Weber-Nelson

Attorney General’s Office

Lucas Bldg, Ground Fl.

321 E. 12th St.

Des Moines, IA 50319

Phone: (515) 242-6111

Fax: (515) 281-8199

Email: [ruth.walker@ag.iowa.gov](mailto:ruth.walker@ag.iowa.gov) or [elise.webernelson@ag.iowa.gov](mailto:elise.webernelson@ag.iowa.gov)

## SEXUAL ASSAULT EXAMINATION MODEL CHART

SANE Case #: \_\_\_\_\_

Law Enforcement Jurisdiction: \_\_\_\_\_

Law Enforcement Case # (if available) \_\_\_\_\_

Exam Site: \_\_\_\_\_

Date of Exam: \_\_\_\_\_

Client Name: \_\_\_\_\_

SANE: \_\_\_\_\_

Advocate Name: \_\_\_\_\_

SANE Contact Information: \_\_\_\_\_



# CONSENT FOR EVALUATION AND TREATMENT OF SEXUAL ASSAULT/ABUSE EXAMINATION

## Consent for Treatment

I, \_\_\_\_\_, consent and authorize  
(Name of Patient)  
\_\_\_\_\_ and/or the staff of (your facility name) to obtain a  
(Name of SANE)  
medical history, perform a physical exam to collect laboratory material,  
provide prophylactic treatment, and obtain other medical specimens. I further  
consent that this may be done by taking of photographs and digital imagery.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

## Authorization for Release of Information

I, \_\_\_\_\_, consent and authorize  
(Name of Patient)  
\_\_\_\_\_ to disclose the information in my record  
(Name of SANE)

to the following:

- Crime Victim Assistance Division, Iowa Attorney General's Office,  
for receiving payment of the costs of services provided.
- YOUR FACILITY HERE for peer review and litigation purposes.
- Referring Medical Providers providing continued follow up  
treatment/care.
- Any additional providers deemed necessary. Please Specify.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

*Under no circumstances will the patient's information be disclosed without prior patient authorization unless otherwise required by law.*

## PATIENT INTERVIEW/PHYSICAL EXAM/SEXUAL ASSAULT EXAM RECORD

|                         |                         |
|-------------------------|-------------------------|
| <b>Date of Assault:</b> | <b>Time of Assault:</b> |
| <b>Date of Exam:</b>    | <b>Time of Exam:</b>    |

Patient Statement of Assault:

**GENERAL APPEARANCE** (document physical injuries):

**Emotional State:**  Fidgeting  Fearful  Loud  Agitated  Listless  
 Staring  Cooperative  Trembling  Yelling  Quiet  Tearful  
 Tense  Loud  Sobbing  Other \_\_\_\_\_

|                           |              |
|---------------------------|--------------|
| <b>EXAMINER INITIALS:</b> | <b>DATE:</b> |
|---------------------------|--------------|

| During the assault, did                      | YES | NO | UNSURE |
|--|-----|----|--------|
| Assailant's penis penetrate vagina?          |     |    |        |
| Assailant's penis penetrate anus/rectum?     |     |    |        |
| Assailant's penis penetrate mouth?           |     |    |        |
| Assailant wear a condom?                     |     |    |        |
| Assailant ejaculate?                         |     |    |        |
| Digit or foreign body penetrate vagina?      |     |    |        |
| Digit or foreign body penetrate anus/rectum? |     |    |        |
| Digit or foreign body penetrate mouth?       |     |    |        |

|        |
|--------|
| Other: |
|        |
|        |

|                                |
|--------------------------------|
| Type of violence/threats used: |
| Weapons/restraints used:       |
| Forced use of alcohol/drugs:   |

**CIRCUMSTANCES SINCE ASSAULT** (Duplicate DCI Information):

| Since the assault, has the patient:         | YES | NO | UNSURE |
|---|-----|----|--------|
| Showered/Bathed?                            |     |    |        |
| Douched?                                    |     |    |        |
| Changed Clothes?                            |     |    |        |
| If clothes were changed are they available? |     |    |        |
| Eaten/Drank fluids?                         |     |    |        |
| Gargled or brushed teeth?                   |     |    |        |
| Vomited?                                    |     |    |        |
| Urinated?                                   |     |    |        |
| Defecated?                                  |     |    |        |

|   |
|---|
| Had intercourse in the last 120hr (5 days)? |
| If so, when?                                |

|                           |              |
|---------------------------|--------------|
| <b>EXAMINER INITIALS:</b> | <b>DATE:</b> |
|---------------------------|--------------|

## Medical History

|                                       |     |    |         |
|---------------------------------------|-----|----|---------|
| Medications:                          |     |    |         |
| Allergies:                            |     |    |         |
| Tetanus vaccine current:              | YES | NO | UNKNOWN |
| Hepatitis vaccine current:            | YES | NO | UNKNOWN |
| Has the patient received HPV vaccine: | YES | NO | UNKNOWN |
| Last menstrual period:                |     |    |         |
| Menstrual interval:                   |     |    |         |
| Patient's general health:             |     |    |         |

## General Examination (Include lacerations, bruises, and other findings)

|                               |
|-------------------------------|
| Individuals present for exam: |
| Vital Signs:                  |
| Pain:                         |
| Neuro:                        |
| Head/Neck:                    |
| Face/EENT:                    |
| Chest:                        |
| Breasts:                      |
| Back:                         |
| Abdomen:                      |
| Right Arm:                    |
| Left Arm:                     |
| Right Leg:                    |
| Left Leg:                     |

## Colposcope/Alternative Light Source

|                                  |     |    |           |
|----------------------------------|-----|----|-----------|
| Colposcope used:                 | YES | NO |           |
| Colposcope photos obtained:      | YES | NO | How many? |
| Alternative light source used:   | YES | NO |           |
| Photos taken by law enforcement: | YES | NO |           |

|                           |              |
|---------------------------|--------------|
| <b>EXAMINER INITIALS:</b> | <b>DATE:</b> |
|---------------------------|--------------|

**Female GU/GYN** (See drawing on page 9)

|                              |
|------------------------------|
| <b>Introitus:</b>            |
| <b>Labia majora:</b>         |
| <b>Labia minora:</b>         |
| <b>Clitoris:</b>             |
| <b>Fossa navicularis:</b>    |
| <b>Posterior fourchette:</b> |
| <b>Perineum:</b>             |
| <b>Hymen:</b>                |
| <b>Vagina:</b>               |
| <b>Cervix:</b>               |
| <b>Anus/rectum:</b>          |
| <b>Other:</b>                |

**Male GU** (See drawing on page 9)

|                 |
|-----------------|
| <b>Penis:</b>   |
| <b>Scrotum:</b> |
| <b>Anus:</b>    |
| <b>Rectum:</b>  |
| <b>Other:</b>   |

|                           |              |
|---------------------------|--------------|
| <b>EXAMINER INITIALS:</b> | <b>DATE:</b> |
|---------------------------|--------------|

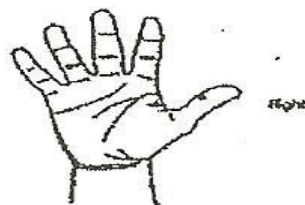
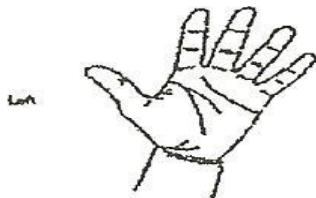
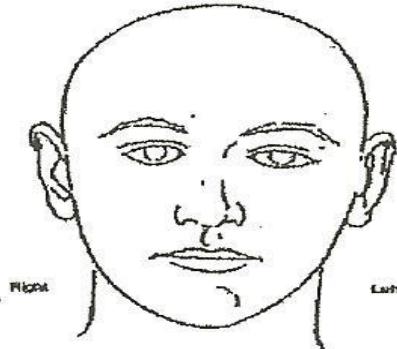
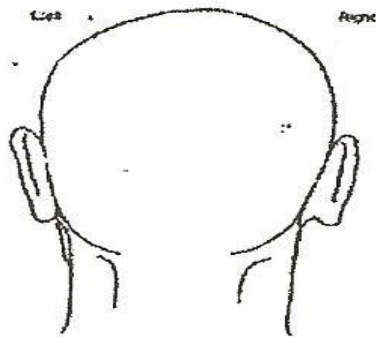
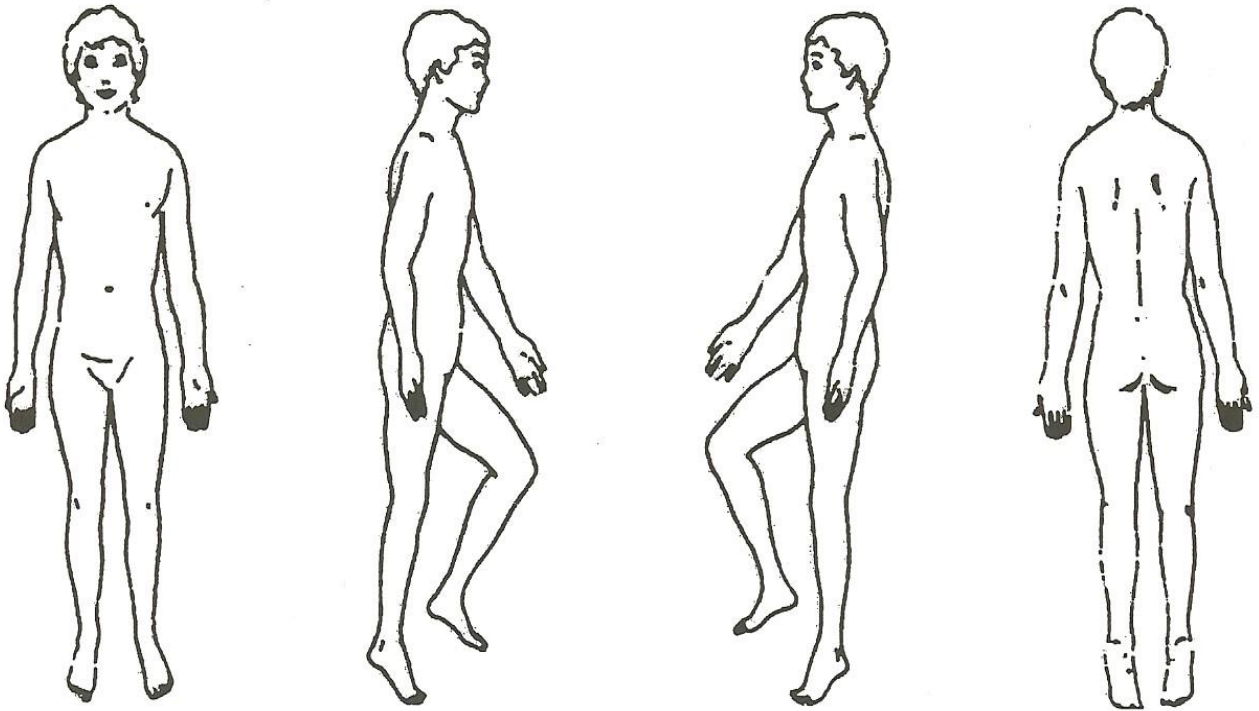
## STRANGULATION ASSESSMENT

|   |     |    |
|---|-----|----|
| <i>Did strangulation occur?</i>   | YES | NO |
| <i>If yes, method:</i> ONE HAND TWO HANDS FOREARM LIGATURE BODY OTHER _____ |     |    |
| <i>Angle of approach:</i> APPROACHED FROM FRONT APPROACHED FROM BEHIND      |     |    |
| <i>Was patient's mouth/nose obstructed during?</i>                          | YES | NO |
| <i>Loss of consciousness during?</i>  | YES | NO |
| <i>Loss of urine during?</i>  | YES | NO |
| <i>Loss of bowel during?</i>  | YES | NO |
| <i>Head or neck shaken?</i>   | YES | NO |

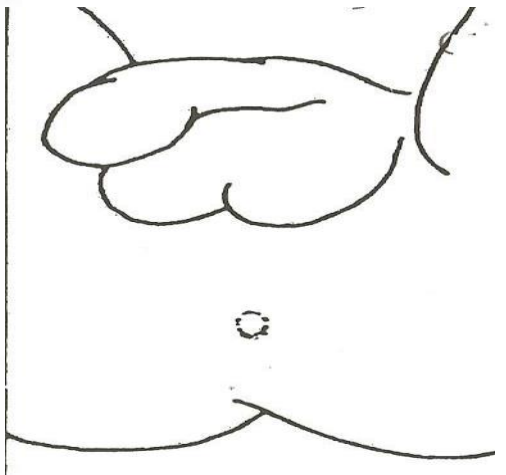
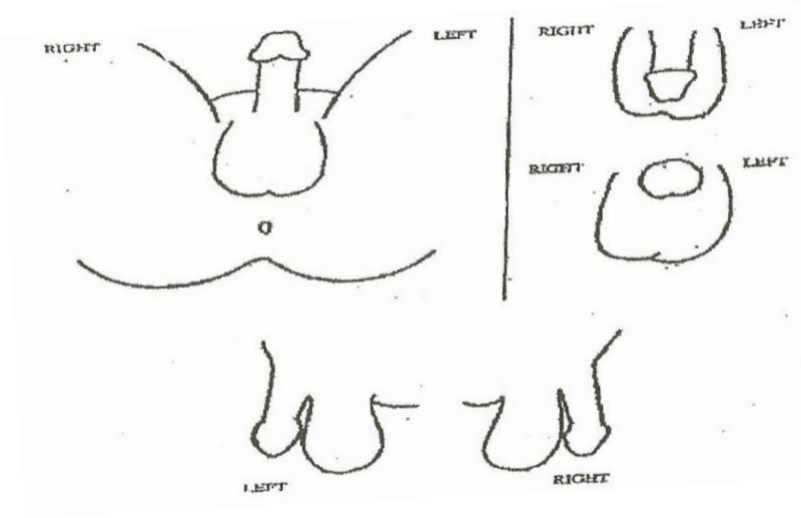
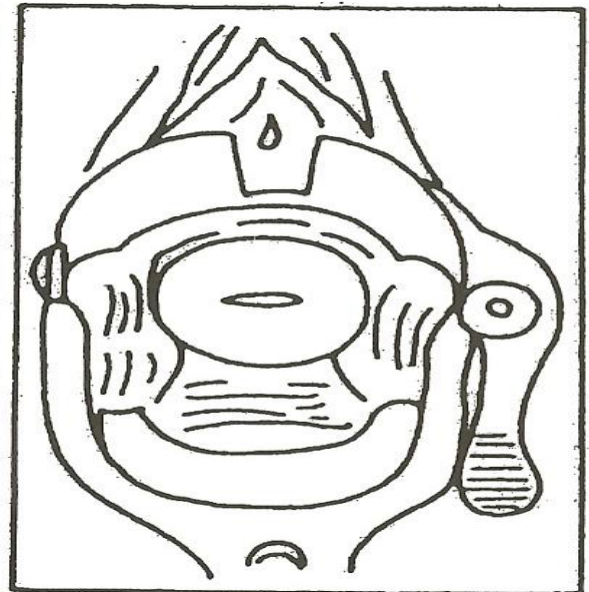
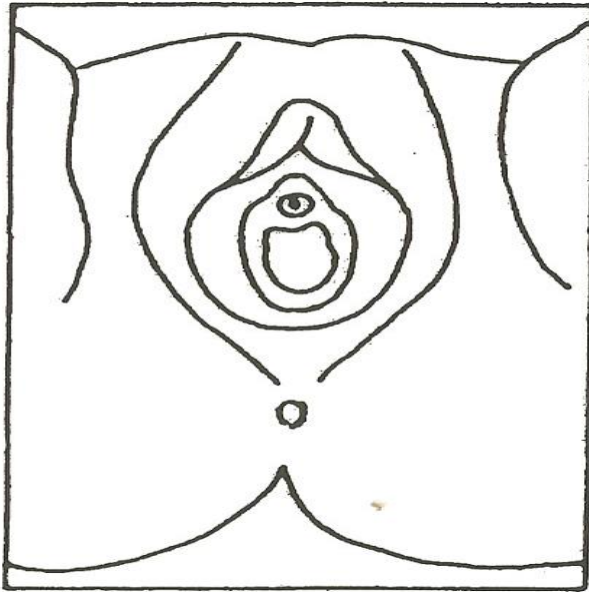
| Since the strangulation occurred:   | YES | NO |
|---|-----|----|
| <i>Difficulty breathing?</i>  |     |    |
| <i>Voice changes?</i>   |     |    |
| <i>Difficulty swallowing?</i>   |     |    |
| <i>Tongue swelling?</i>   |     |    |
| <i>Throat swelling?</i>   |     |    |
| <i>Neck swelling?</i>   |     |    |
| <i>Nose bleed?</i>  |     |    |
| <i>Persistent coughing?</i>   |     |    |
| <i>Coughing up blood?</i>   |     |    |
| <i>Persistent vomiting?</i>   |     |    |
| <i>Weakness, numbness, or tingling of body?</i>   |     |    |
| <i>Headache not relieved by Tylenol or Motrin?</i>  |     |    |
| <i>If pregnant: vaginal bleeding, decreased fetal movement, contractions or leakage of fluid?</i> |     |    |

| Recommendations/Treatments:  | YES | NO |
|--|-----|----|
| <i>Refer to emergency provider for further evaluation?</i>                                 |     |    |
| <i>Evaluated/cleared for strangulation by emergency provider prior to SANE evaluation?</i> |     |    |
| <i>Strangulation discharge instructions provided?</i>                                      |     |    |

|                           |              |
|---------------------------|--------------|
| <b>EXAMINER INITIALS:</b> | <b>DATE:</b> |
|---------------------------|--------------|



|                           |              |
|---------------------------|--------------|
| <b>EXAMINER INITIALS:</b> | <b>DATE:</b> |
|---------------------------|--------------|



**EXAMINER INITIALS:** \_\_\_\_\_ **DATE:** \_\_\_\_\_



## STANDING ORDERS FOR SEXUAL ASSAULT EXAM

\*May complete vaginal, speculum, and colposcopic exam if indicated.

\*\*May do rectal exam if indicated.

\*\*\*May do lab work as indicated: (check if completed)

- Urine Pregnancy Test (baseline)
- Urine screen for drug facilitated assault

Patient Allergies:

---

Current Medications:

---

|                           |              |
|---------------------------|--------------|
| <b>EXAMINER INITIALS:</b> | <b>DATE:</b> |
|---------------------------|--------------|

**May prescribe medications as indicated:**

1.  **Rocephin** 500 mg. Single Dose IM (Gonorrhea)

Lot # \_\_\_\_\_ Exp Date \_\_\_\_\_ (Rocephin)

Lot # \_\_\_\_\_ Exp Date \_\_\_\_\_ (Lidocaine)

Site Given \_\_\_\_\_ Time Given \_\_\_\_\_ Reaction Y/N

**OR**

- Cefixime (Suprax)** 400 mg. Single Dose PO

**PLUS**

2.  **Azithromycin** 1 gm. Single Dose PO (Chlamydia)

**OR** (in case of allergy)

- Doxycycline** 100 mg. BID x 7 day

**(DO NOT USE DOXYCYCLINE IF PREGNANT)**

**PLUS**

3.  **Metronidazole** 2 gm. Single Dose PO (Vaginosis or Trichomoniasis)

**PLUS**

4.  For pregnancy prophylaxis:

- Ella** 1 tab PO single dose

**OR**

- Plan B**

**PLUS**

5.  **Zofran (Ondansetron)** 4 mg. ODT #1 (nausea prophylaxis)

**Immunizations:** Evaluation and referral as indicated to healthcare provider for:

1.  Hepatitis B
2.  Tetanus
3.  HPV

\*If no treatment is given patient should be referred to healthcare provider for appropriate evaluation and follow up 4-6 weeks post assault. No follow-up appointment is indicated if prophylactic medication is given and no symptoms develop in 4-6 weeks.

**PLEASE REMIND PATIENT THAT CVAD (Crime Victim Assistance Division) PAYS FOR THE EXAM AND MEDICATIONS!**

SANE SIGNATURE: \_\_\_\_\_ Date \_\_\_\_\_

PHYSICIAN SIGNATURE: \_\_\_\_\_ Date \_\_\_\_\_

## STANDING ORDERS FOR HIV PROPHYLAXIS

1-800-PEP-LINE (available 24/7)

OR

Monday-Friday 9am-8pm EST – Warmline (1-800-933-3413)

(See Algorithm for evaluation and treatment of possible non-occupational HIV exposure on next page.)

1.  **72 hour HIV nPEP:**

Raltegravir and Truvada combination per collaborating provider recommendations.

2.  **One Refill if indicated:**

Raltegravir and Truvada combination per collaborating provider recommendations.

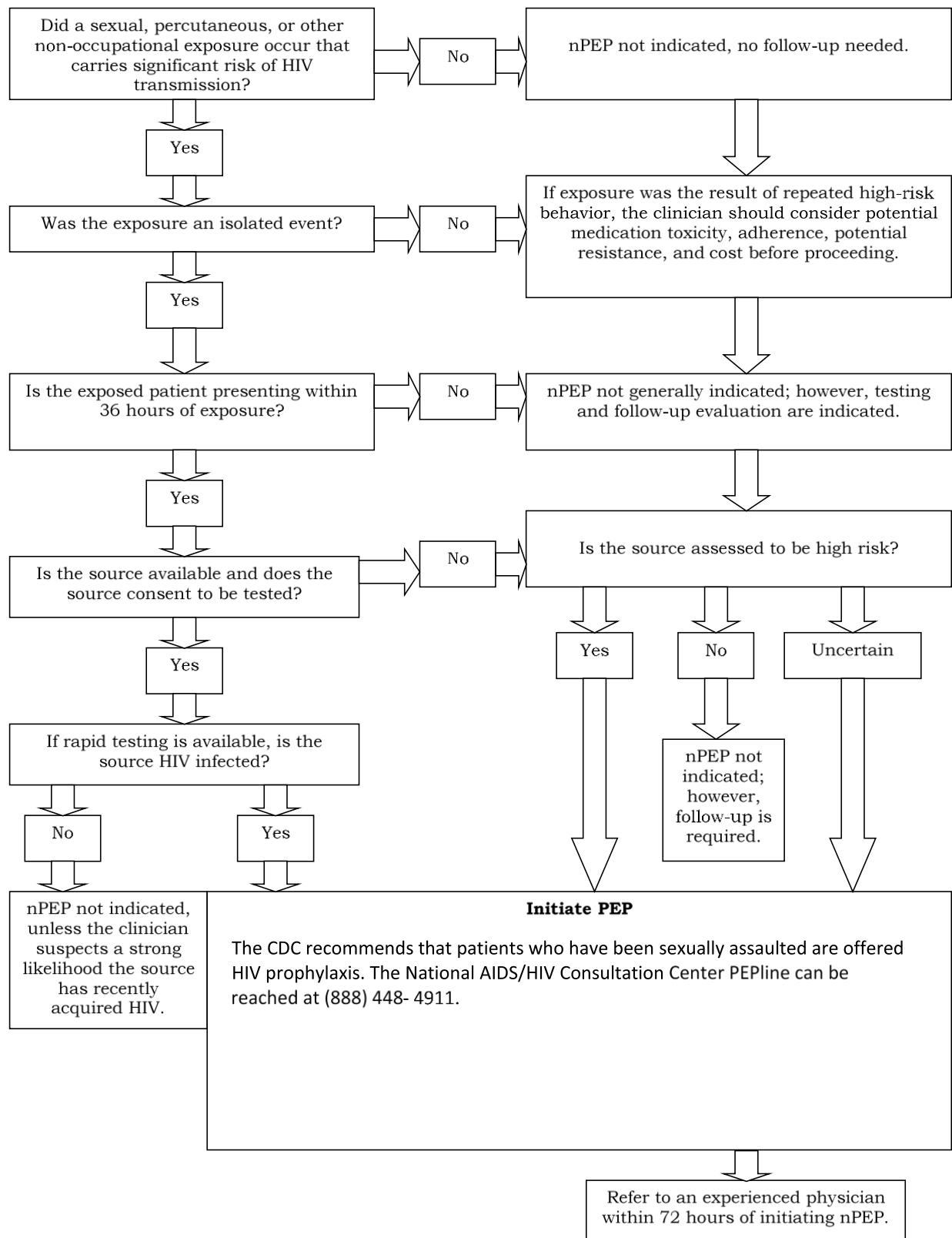
### Contact infectious disease specialist for further follow-up.

Discussed treatment options with patient. Patient declines treatment.

Authorized SANE \_\_\_\_\_ Date \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

*\*\*\*All baseline labs will be done with the Infectious Disease physician. A person with prior liver or kidney issues could be affected by taking these medications. I understand I am responsible for making and attending an appointment with the infectious disease physician within 24-72hours. Patient initials \_\_\_\_\_*



## POST EXAM INFORMATION FORM

Patient Name: \_\_\_\_\_ Hospital/Clinic Name: \_\_\_\_\_

Examining SANE: \_\_\_\_\_ Date: \_\_\_\_\_

**If you need further medical attention, please return to the emergency department. The following is a list of medical services you received. Please bring this form to any follow up appointments.**

You were informed that the State of Iowa will pay the cost of the sexual assault examination and follow-up exams for treatment of sexually-transmitted infections **in addition to** medications from the pharmacy.

### **Medications to prevent sexually transmitted infections**

- You were given Rocephin 500 mg intramuscular to prevent gonorrhea at the time of your exam.
- You were prescribed medication(s) to prevent gonorrhea, chlamydia, vaginosis, and/or trichomoniasis:
- Cefixime 400 mg (Recommend follow up gonorrhea testing in 4-6 weeks)
- Doxycycline 100 mg #14
- Azithromycin 1 gm
- Metronidazole 2 gm
- Zofran (Ondansetron) was prescribed for nausea prevention
- Recommend a blood test for syphilis in 4-6 weeks
- You **were not** prescribed treatment to prevent gonorrhea, chlamydia, or any other venereal disease because: \_\_\_\_\_
- You were prescribed medications to try to prevent HIV (post exposure prophylaxis, ("nPEP"). **72hr nPEP One refill**
- You are responsible for making and attending an appointment with a referring Infectious Disease provider within 24-72hours. *Use code "XXXT" when making this appointment. You were informed that these referring providers will provide necessary HIV counseling, medication management, and all lab testing for HIV management and follow up.*
- You were not prescribed medications to try to prevent HIV (post exposure prophylaxis, ("PEP"))

### **Pregnancy**

- You were prescribed and given information about pregnancy prophylaxis **Ella/Plan B**
- You declined pregnancy prophylaxis (Plan B)
- Follow up pregnancy test in 4-6 weeks with no menses after Plan B use

### **Immunizations**

- Referral to Planned Parenthood/Health Department/Primary Care Provider for update on immunizations.

### **Additional Information**

You were given a list of Sexual Assault Service Programs in Iowa.

Your advocate today was \_\_\_\_\_. **No appointment was made for follow-up treatment. You are responsible for on-going care. If you need further medical attention, please return to the emergency department.**

**I have received the patient information form and understand the contents:** \_\_\_\_\_

(Patient Signature)

Provided by \_\_\_\_\_  
(SANE Signature)

Date/Time \_\_\_\_\_

## TAKE HOME INSTRUCTIONS FOR PATIENTS

*BE SURE TO COPY FOR THE CHART*

### Important Metronidazole Instructions to Patient:

If you drink or are exposed to alcohol in ANY FORM during this treatment, you may expect to have severe nausea, reddening of your skin or low blood pressure.

- **NO ALCOHOL** while you are taking metronidazole
- **NO ALCOHOL for 48 hours after** you take the LAST metronidazole dose
- **NO ALCOHOL** can be used in other forms while you are taking metronidazole. These products may include items like: OVER THE COUNTER liquid cough medicines and products like Nyquil OR even topical “on the skin” items that containing alcohol—such as hand sanitizer, disinfectant products
- The **first dose** of metronidazole CANNOT be taken until you are completely sober—at least **12 hours after your last drink!**

**\*\*\*TAKE ALL MEDICATIONS AS  
DIRECTED\*\*\***

**Summary:**

DCI Sexual Assault Kit used:  Yes  No  
Lab(s) in addition to DCI sex assault exam kit:

Materials Collected:

- Underwear
- Debris
- Vaginal swabs
- Oral/rectal swabs
- Known buccal swabs
- Known blood sample

Other: \_\_\_\_\_

**Follow-up Concerns:**

\*Pt should return to ER or PCP if change signs/symptoms or concerns of infection such as: fever, vaginal/rectal bleeding, abdominal/pelvic/or back pain, nausea or vomiting, unusual vaginal discharge.

|                           |              |
|---------------------------|--------------|
| <b>EXAMINER INITIALS:</b> | <b>DATE:</b> |
|---------------------------|--------------|

## Law Enforcement Authorization for Release of Information

I, \_\_\_\_\_, consent and authorize  
(Name of Patient)

\_\_\_\_\_ and/or \_\_\_\_\_  
(Name of SANE) (Name of facility)

**to disclose the information in my record to the following:**

Law Enforcement Officials of \_\_\_\_\_ County,

Case #: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

*Under no circumstances will the patient's information be disclosed without prior patient authorization unless otherwise required by law.*

Pt. declines consent for release of information to law enforcement at time of acute exam services.