Sexual Assault (SA) Triage Algorithm for Patients 15 Years and Above

Identified victim of SA
CONTACT ADVOCATE & SANE

If ≥ 18 yrs.
NO LE Contact Required
If 15 – 17 yrs.
CONTACT LE and/or DHS

NOT Medically Stable

Refer to medical provider for evaluation & treatment

YES Medically Stable

If > 84 hrs conduct physical exam, no SAFE Kit (unless special circumstances)

If < 84 hrs offer SAFE Kit (If ≥ 18 yrs confirm collection of anonymous or reporting kit)

YES
Obtain Consent and complete SAFE Kit

NO
Complete physical exam (No SAFE Kit)

Consent: pregnancy test, STI prophylaxis, < 5 days post assault offer EC

Stabilized

Treat & Consult with LEA re: evidence collection

Offer crisis intervention and referral resources

YES
Consent: pregnancy test, STI prophylaxis, < 5 days post assault offer EC

NO
Complete physical exam (No SAFE Kit)

Refer to medical provider for evaluation & treatment

Stabilized

If > 84 hrs conduct physical exam, no SAFE Kit (unless special circumstances)

If < 84 hrs offer SAFE Kit (If ≥ 18 yrs confirm collection of anonymous or reporting kit)

YES
Obtain Consent and complete SAFE Kit

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Stabilized

Treat & Consult with LEA re: evidence collection

Offer crisis intervention and referral resources

YES
Consent: pregnancy test, STI prophylaxis, < 5 days post assault offer EC

NO
Complete physical exam (No SAFE Kit)
State of Oregon Medical Guidelines for Sexual Assault Evaluation†

ADOLESCENT (≥ 15 years)/ ADULT

Overview

• This guideline represents the basic standards in the medical care of the sexual assault patient.
• The purpose of this guideline is to:
  o Provide direction for medical professionals in the care of the older adolescent or adult sexual assault patient;
  o Ensure that compassionate and sensitive services and care are provided in a non-judgmental manner; and to
  o Ensure that the physical and psychological well being of the sexual assault patient is given precedence over forensic needs.
• The guideline is based on current Oregon law, Centers for Disease Control and Prevention (CDC), and American College of Emergency Physicians (ACEP) recommendations for the prophylaxis of sexually transmitted infection and pregnancy, and “best practice” in the care of the sexual assault patient.

Age Considerations

• This guideline is for the care of the adolescent (age 15 years and older) and adult with a history or concern of sexual abuse or assault.
• For care of children age 14 years and younger, see the Recommended Medical Guideline: Acute Sexual Assault Emergency Medical Evaluation – Child/Young Adolescent (≤ 14 years).
• Acute triage assessment should include assessment of the specific aspects of physical and cognitive development of the individual adolescent patient to determine whether the Child or Adult Guideline should be used.

Key Points

• The guideline is not intended to include all the triage issues, medical evaluations, tests and follow-up that may be necessary for appropriate care for an individual patient.
• The timing of the exam, as well as the extent of the exam, depends on the detail and clarity of the history, as well as physical signs and symptoms. Not all the steps outlined in this guideline will be appropriate for every patient.
• Best practice recommendation by the Attorney General’s Sexual Assault Task Force is to have a sexual assault evaluation conducted by a sexual assault medical examiner or specially trained nurse (e.g. Sexual Assault Nurse Examiner).
State of Oregon Medical Guidelines for Sexual Assault Evaluation

ADOLESCENT (≥ 15 years)/ADULT

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I. GENERAL INFORMATION

### Purpose of Exam

**Medical/Forensic**
1. Identify and treat injuries
2. Evaluate and treat medical conditions
3. Assess risk of pregnancy and sexually transmitted infections
4. Provide prophylaxis for sexually transmitted infections and emergency contraception, when indicated
5. Document history of assault
6. Document medical findings
7. Collect forensic evidence

**Social/Psychological**
1. Respond to patient’s immediate mental health needs
2. Respond to patient’s family’s immediate emotional needs and concerns
3. Assess patient safety
4. Explain reporting process, Crime Victims Compensation, Sexual Assault Victims’ Emergency (SAVE) Fund and resources for advocacy and counseling

### Report/Refer

1. Refer for follow-up medical care
2. Refer for advocacy or counseling
3. In the case of minors report to Oregon Department of Human Services (DHS) and/or law enforcement agency (LEA) ASAP
4. If report is mandated, report to LEA in the jurisdiction where the crime occurred
   (See section “Mandated Reporting” below)
II. TRIAGE DECISIONS

**Initial Triage**

Medical assessment is indicated for ALL patients, regardless of reporting status, at any time following sexual assault.

1. Patients may be evaluated at the ED, Primary Care Provider (PCP) or clinic for medical care, as appropriate

**Medical stabilization always precedes forensic examination**

1. The following history or conditions should be evaluated medically prior to the sexual assault exam:
   - History of loss of consciousness
   - Head injury
   - Altered consciousness or mental status
   - Significant facial injury
   - Possible fractures
   - Blunt injury to abdomen or back
   - Active bleeding
   - Strangulation
   - Risk or concern for any life or limb threatening injury
   - Abdominal pain

2. Psychiatric illness
   - If apparent psychiatric illness complicates assessment of alleged sexual assault, both psychiatric assessment and medical forensic exam generally will be necessary. Proceed according to patient tolerance and needs

**Forensic Exam**

**Acute:** If assault within prior 84 hours

Medical/forensic exam is appropriate on an urgent basis

1. Advise patient, if possible:
   - Do not bathe before exam
   - Bring in clothes worn at time of assault and immediately after assault, especially undergarments
   - Bring change of clothing
   - Come to hospital with support person, if possible

**Non-Acute:** If assault >84 hours prior

Forensic exam is generally not indicated on emergency basis

1. Crime lab generally does not accept evidence collected more than 84 hours after an assault
2. Individual case circumstances may warrant urgent evidence collection beyond 84 hours after assault (i.e., multiple assailants, patient was unconscious for a period of time) or when requested by LEA

**Advocacy**

Medical staff should request an advocate by contacting a local advocacy organization as soon as possible once the patient is identified as a sexual assault victim.

1. Medical staff should initiate advocacy automatically rather than asking the patient if they would like an advocate to be called.
2. Medical staff should inform the patient of their right to speak with a Sexual Assault Advocate and explain the advocate’s role. For example, advocates support the choices patients’ make and help ensure that patients have all of the information they need to make informed decisions. Some advocates can accompany the patient through the entire process (medical, legal, etc.). Advocates provide:
   - Emotional support, crisis intervention, safety planning
   - Assistance navigating multiple systems (medical, legal, social service, housing) and coordinating follow-up contacts
   - Ancillary services, including assistance with transportation, housing, child care, etc.
   - Information and referral
3. Once the advocate arrives, inform the patient that the advocate is present and offer the patient the opportunity to speak with the advocate one-on-one. Patients may then have the option to decline advocacy services. If the patient does not feel comfortable meeting the advocate in person, then medical staff should give the patient any informational materials delivered by the advocate.

### Mandated Reporting

**Serious Physical Injury / Injury from weapons**

1. Serious physical injury or injury caused by any weapon must be reported to the medical examiner or appropriate designee (per statute) irrespective of reporting the sexual assault

2. Consult with physician, intern, or resident

3. Mandated oral report of injury by telephone or otherwise, and followed soon thereafter by a written report to appropriate medical examiner

**Minors < 18 years**

1. Nursing and medical providers are mandated to report to police or DHS when they have a reasonable suspicion of child abuse

2. A report to police and/or DHS is mandatory if victim is under 18 years of age

3. Mandatory reporting applies even when minor has signed for own care

4. Mandated within 24 hours

**Adults > 18 years**

If the patient is an adult age 18 years or older and is not disabled, mentally ill or ≥ 65 years of age, notification of law enforcement is done only if the patient gives consent to report the sexual assault.

1. If the patient is age 18 years or older and is disabled or mentally ill; or 65 years and over; a report to police and to county Adult Protective Services or State Residential Care Services is mandatory

2. Mandated within 24 hours

### Consent

Informed consent for all procedures, evidence collection and treatments is obtained in all cases

1. Patients age 15 years and older may sign the consent

### Release of Information

The patient must first be informed of the reasons for the release and written consent obtained before the release of medical information or sexual assault documentation is completed.

### Cost of Evidence Collection

Patients are not charged for the cost of the medical examination, collection of forensic evidence, or STI or EC prescriptions. These costs are paid for by the Department of Justice through its Sexual Assault Victims’ Emergency Medical Response Fund. Patients do not have to report to police to access these funds or to have a SAFE Kit collected.

### Discussion with Patient

1. Discuss each step of the medical and forensic procedures

2. Discuss patient reporting and non-reporting to law enforcement

3. Discuss mandatory DHS and/or LEA report

4. Let patient know that written information and educational literature will be provided

### Patient Demographic

Document the following information if it is available and pertinent

1. Routine data: patient name, gender, age, birth date, hospital/clinic number or medical records number, home address, phone number; telephone number for parent or guardian if different

2. Date and time of arrival

3. Who accompanied patient, and their relationship

4. Interpreter name, if used, and language

5. Name of LEA assigned detective

6. Name of DHS caseworker if patient is less than 18 years old or adult
History of Assault

Interview patient and document the following:

Facts about assault
1. Source of information (patient, police, or other person)
2. Nature of concern
3. Time, place of assault, and jurisdiction/location if known
4. Hours since assault
5. Number of assailants and sexual assailants, identity if known
6. Identity and relationship of alleged offender, if known
7. Record narrative history of assault

Nature of force used
1. Patient had impaired consciousness
2. Known or suspected drug or alcohol ingestion
3. Verbal threats
4. Use of physical force
5. Use of weapon
6. Use of coercion

Physical facts of sexual assault
1. Which orifices assaulted
2. By what (finger, penis, mouth, foreign object)
3. Whether condom was used
4. Whether ejaculation was noted, and where
5. Physical injuries
6. Whether bleeding or pain was reported

Post assault activity of patient
1. Showered or bathed
2. Douched, rinsed mouth, urinated, or defecated
3. Changed clothes, gave clothes to police at scene, or brought clothes worn at time of assault to emergency department/clinic

Risk factors of assailant regarding hepatitis B/C, syphilis, and HIV, if known
1. Known or suspected IV drug use
2. Man who has had sex with men
3. From a high risk community
4. STI history or history of prostitution
5. Blood or mucous membrane exposure

Past Medical History
1. Significant medical problems, surgery, major injuries, chronic diseases, immune problems, developmental, cognitive, mental health and/or physical disabilities
2. Current medications
3. Recent ingestion of other drugs, including over-the-counter drugs, legal and illegal substances, and alcohol
4. Allergies
5. Ob-gyn history
6. Birth control method (IUD, tubal, OCP, etc.)
7. Last menstrual period
8. Last consensual intercourse
9. Patient’s history of hepatitis B vaccine or illness

IV. PHYSICAL EXAM & EVIDENCE COLLECTION

Forensic Evidence Collection
1. Standard Sexual Assault Forensic Evidence (SAFE) Kit, provided by Oregon State Police Crime Lab, is used for evidence collection in both reported cases and non-reported cases
2. Oregon State Police Sexual Assault Forensic Lab information form
3. The evidence collection exam is done by a registered nurse, nurse
The preferred examiner is one who is trained and certified as a Sexual Assault Forensic Examiner.

**Chain of Custody of Forensic Specimens**

One staff member must be responsible for maintaining chain of evidence at all times. That staff member

1. Observes specimens OR
2. Designates another staff member to watch specimens OR
3. Secures specimens in freezer, refrigerator, cabinet or specific area

**General Information**

1. All patients should receive a complete head-to-toe physical examination
2. It is the patient’s right to consent or refuse any aspect of the exam and evidence collection
3. The patient may have a support person (relative, friend, or advocate) present during the exam
4. If suspected or known oral sodomy, it is preferable that the patient does not eat or drink before the exam, but the patient’s comfort should not be compromised to achieve this
   - Oral swabs, for example, should be obtained immediately if patient is thirsty or wishes to rinse mouth
5. Use powder free gloves and change gloves frequently during exam and evidence collection
6. General exam findings:
   - Document developmental level, emotional status, mental status and general appearance
   - Document objective observations: “patient avoids eye contact and is teary-eyed” is preferable to “patient is sad”
   - Vital signs, height and weight

**Exam Procedures**

1. Because a patient may not initially report all aspects of the assault, collect evidence routinely from the mouth and vagina. Collect swabs from the rectum if there is any possibility that evidence may be found there.
2. If the patient has bathed or showered, specific steps of evidence collection should be omitted. These steps are indicated in the following sections
3. The following sections outline the steps for the medical exam and the collection of evidence. The order of these steps may vary by examiner preference or patient need

**Clothing, Trace Evidence, and Skin Exam**

**Clothing Collection**

If assault occurred out of doors, or clothing was stained or damaged during assault, collection is particularly important. Do not collect the clothes if the patient is wearing clothing other than what was worn during or immediately after the assault. Wet clothing should be dried in a secure room or area, or transferred to law enforcement ASAP. Do not cut through any existing holes, rips, or stains. Do not shake out victim’s clothing or trace evidence may be lost

1. Place each item of clothing in a separate paper bag
2. Place patient label on each bag. Tape each bag closed, and sign over tape
3. Maintain chain of evidence for clothing bags. Place in secured area when not directly observed

If applicable to pt. history consider photo documentation (see below) on all 4 sides of the body and the patient’s hands prior to being undressed.

**Underpants**

Collect patient’s underpants routinely, even if changed after assault

1. Pooled secretions may leak onto underwear
2. Package patient’s underpants in a small paper bag. Seal, label, sign over label, and store securely in a clean paper bag
Trace Evidence Collection

To collect foreign material which may fall when patient undresses.

Omit if patient has bathed or changed clothes since assault

1. Place bed sheet or large paper sheet on floor. This is to prevent floor debris from adhering to evidence collection paper
2. Unfold and place evidence collection paper sheet over the bottom sheet
3. Instruct patient to stand in the center of paper and remove clothing
4. Bindle paper (using a square or rectangular piece of paper, fold all edges inward so that there are no open edges) where patient stood, retaining any foreign material, and place in paper envelope and process as forensic evidence: seal in envelope, label, sign over seal and place in the Evidence Kit

Photo Documentation

General

1. Medical provider may take photographs or may assist law enforcement. Medical provider may take photos for law enforcement using law enforcement camera. Only medical provider should photograph ano-genital injuries.
2. Digital photography is the recommended means of photo documentation, but 35mm film is acceptable alternatives when digital is unavailable. If film is used, only one patient must be photographed on each roll and film must be developed at a secure facility.
3. Ensure that the correct date and time are set on any camera that is used.
4. Body maps are always encouraged in conjunction with photographs, narrative notes, and detailed charting.
5. Patient comfort, dignity, and privacy must be a priority at all times. Drape sheet over body whenever possible.
6. Prints of photographs should be labeled individually with patient label and examiner initials on the back of the print. Note each photograph taken in the chart and type of camera used.
7. Consider use of photo log to document the date, time, camera, photographer, and number of photographs.

Technique

1. Photograph each item/injury as found, and then again after any alteration, such as cleaning or suturing.
2. Take one distance photograph of clothed body prior to exam.
3. Take one photograph of face if the patient consents.
4. Photograph injuries at 90 degree angle to (directly above) the plane of the wound.
5. Multiple photographs, from multiple angles, may be required to adequately document a finding.
6. Each finding should be photographed a minimum of three times. Once from a distance adequate to provide anatomical orientation. Once from close-up to show detail (using macro setting on digital cameras). Once more with a standard sized measuring device such as a ruler (or any other object that is of standard size, such as a coin).
7. Photograph findings both with and without flash to determine which provides best representation of color and documentation of detail.
8. Keep extraneous and distracting items out of photographs. Fill the screen with the item(s) of interest.
9. DO NOT delete any digital photographs, regardless of the quality. DO NOT dispose of any film prints or negatives.

Ano-Genital Photographs

1. Due to the extremely sensitive nature of these photographs, they are to be kept with the medical record.
2. They are released only in response to a subpoena and are then released directly to the medical expert who is reviewing them.

Head Hair

Collect standard head hair samples on all patients.

1. Pre-fold blank sheet of paper in thirds, both horizontally and vertically
Skin Exam

Document

**Bruises, petechiae, abrasions, lacerations, and bite marks, and suction ecchymoses, tenderness**

1. Describe traumatic lesions and mark on traumagram
2. Ask patient how each injury occurred and document patient's statements
3. Confirm that photos have been taken and a drawing completed of acute traumatic skin lesions (see photo documentation section)
4. Using an alternate light source with room lights dimmed: scan patient's skin surface, including breasts, abdomen, perineum, hair, face, buttocks, and thighs
   - Semen may fluoresce
   - Document presence/absence and location of fluorescence

Fingernail Debris/ Swabbing

Collect if patient reports scratching assailant or examiner believes nail debris may be related to assault. Obtain when visible debris or blood under nails, nails broken during assault and/or history suggests patient scratched offender

1. Place small paper sheet labeled “Left hand” or “Right hand” on flat surface
2. Using disposable plastic scraper or clean, disposable blunt metal scissors, or sterile clipper/scissors, scrape under all five fingernails of each hand, allowing any debris to fall onto paper
3. Alternatively, with patient's permission, cut fingernails
4. Patient may be able to do this with direct supervision
5. Bindle paper (using a square or rectangular piece of paper, fold all edges inward so that there are no open edges) to retain debris and scraper
6. Fold scraper in paper, place each paper in a separate labeled envelope
7. Seal envelope (do not LICK), place patient label over seal, sign over seal and store securely in the Evidence Kit

Skin and Hair Debris

Collect when foreign material is visible on patient's skin or hair and patient reports, or examiner believes, debris is related to assault. Collect grass, fibers, paint flecks, etc., which may adhere to patient’s skin. **Omit this step if patient bathed or if no debris visible**

1. Place small paper sheet on flat surface
2. Collect any foreign debris (dirt, leaves, fiber, hair, etc.), place in center of paper
3. Bindle paper (using a square or rectangular piece of paper, fold all edges inward so that there are no open edges) to retain debris
4. Place each folded sheet in an envelope and label with site
5. Seal envelope (do not LICK), place patient label over seal, sign over seal and store securely in Evidence Kit

Forensic Swabs

Collect when assault occurred within last 84 hours and the patient has not bathed:

1. Patient reports alleged assailant's blood, semen, or saliva may be deposited on skin or
2. Assailant's blood or dried secretions are visible or
3. Assailant’s bite marks or suction ecchymosis are visible or
4. Alternate light source scan is positive

Swab and Slide Technique

1. Use 4 cotton swabs
2. Use 2 swabs at a time if possible to save time
3. Lightly moisten swabs with tap water if secretions are dried
4. Swab areas of possible dried secretions, follow moist swabbing with two dry swabs
5. Label swabs with site where collected, number 1-4 in order obtained

**Slides are made only when the presence of semen is suspected**

6. Using swab #1, rub cotton tip on dime-size area on center of the slide.
   Retain this swab for labeling and processing with the other 3 swabs from this site.
7. Process slide as forensic evidence
8. Process swabs as forensic evidence

### Oral Exam

**Document**

Lacerations, abrasions, petechiae, and bruises. Check mucosa, palate, upper/lower frenula, and tongue

**Forensic Swabs**

Collect when

1. Abuse/assault occurred within prior 12 hours or
2. Visible oral injury or
3. History of oral/genital contact in prior 12 hours

**Reference Swabs**

Collect reference oral standard swabs to establish patient DNA

1. Use 4 swabs
2. Vigorously swab inside of cheek of the mouth
3. Process as forensic swab

### Genital Exam – Female

**Document**

Genital lacerations, abrasions, bruises, petechiae, erythema, inflammation, bleeding, edema, and discharge; Tanner Stage

**Forensic Swabs**

Collect when

1. Assault occurred within prior 84 hours and
2. History of penile-genital or oral-genital contact or
3. Report of contact to genitalia, perineum, or anus by any part of assailant’s body or
4. Ejaculation occurred near anogenital area or
5. Visible acute genital or anal injury or
6. Alternate light source scan is positive

**External Genital Area Swabs**

Collect routinely when report of contact to genitalia, perineum, or anus by any part of assailant’s body.

1. Use 4 cotton swabs
2. Use 2 swabs at a time if possible to save time
3. Lightly moisten swabs with tap water if secretions are dried
4. Swab labial folds, clitoral hood and perineum
5. Label swabs with site where collected

**Slides are made only when the presence of semen is suspected**

6. Using swab #1, rub cotton tip on dime-size area on center of the slide.
   Retain this swab for labeling and processing with the other 3 swabs from this site.
7. Process slide as forensic evidence
8. Process swabs as forensic evidence

**Internal Genital Area Swabs**

Collect routinely when report of contact to genitalia, perineum, or anus by any part of assailant’s body. For young adolescents who have not had a prior pelvic exam, or any patient who cannot tolerate a speculum exam, forensic swabs may be collected by directly inserting swabs 2-3 inches into the vagina

1. Use vaginal speculum to visualize vagina and cervix, and note lacerations, abrasions, petechiae, and bruising
2. Rinse speculum in warm water for patient’s comfort.
3. If lubricant is needed use minimum amount, water based and document type used.
4. Sites to consider swabbing
   - Inner labial folds
   - Posterior fossa
   - Vagina (particularly posterior vaginal pool)
   - Endocervix
   - Cervical os
5. Use 4 swabs total for each site (e.g. collect 4 swabs for the cervical os, collect 4 swabs for the posterior vaginal pool, etc.)
6. Use 1 or 2 swabs at a time. Do not moisten swabs for areas that are moist

**Slides are made only when the presence of semen is suspected**

1. Using swab #1, rub cotton tip on dime-size area on center of the slide. Retain this swab for labeling and processing as other 3 swabs from the same genital area
2. Process as forensic slide evidence
3. Process as forensic swab

**Pubic Hair Combing, Plucking and Cutting**

If pubic hair is present comb onto a paper and bindle

**CONSIDER:** Plucking pubic hairs when one or more of the following conditions apply:

1. Stranger or unknown assailant or multiple assailants
2. Foreign pubic hair is collected in the pubic combing
3. Assailant is an acquaintance that has not previously been in the environment where the assault(s) occurred.
4. Matted pubic hair should be cut in addition to plucking.

If plucking is necessary ASK THE VICTIM IF SHE/HE WANTS TO PLUCK HER/ HIS OWN. Pluck 24 hairs from all around the pubic area.

**Genital Exam - Male**

Penile, scrotal or perineal abrasions, bruises, lacerations, petechiae, bleeding, edema, discharge, erythema, and inflammation, tenderness, Tanner Stage

**Forensic Swabs**

Collect if report of assailant saliva or secretions on victim's genital/perineal area.

1. Retract foreskin to examine glans penis
2. Areas to consider swabbing
   - Mons pubis
   - Inner thighs
   - Inguinal folds
   - External surface of glans/penis
   - Under foreskin (collect swabs even if patient has bathed or showered)
   - Scrotum
   - Perineal body
3. Swab surface of specific area with 2 swabs lightly moistened with tap water
4. Repeat with 2 dry swabs
5. For each specific site, dry swabs, label site
6. Using swab #1, rub cotton tip on dime-size area on center of the slide. Retain this swab for labeling and processing as other 3 swabs from the same genital area
7. Process as forensic slide evidence
8. Process as forensic swab
Pubic Hair Combing, Plucking and Cutting

**CONSIDER:** Plucking pubic hairs when one or more of the following conditions apply:

5. Stranger or unknown assailant or multiple assailants
6. Foreign pubic hair is collected in the pubic combing
7. Assailant is an acquaintance that has not previously been in the environment where the assault(s) occurred.
8. Matted pubic hair should be cut in addition to plucking.

If plucking is necessary ASK THE VICTIM IF SHE/HE WANTS TO PLUCK HER/HIS OWN. Pluck 24 hairs from all around the pubic area.

**Perianal and Anal Exam-**
**Male and Female**

### Document

- Perianal bruising, petechiae, edema, discharge, bleeding, tenderness, abrasions, lacerations, erythema, inflammation, and visible anal laxity

### Exam Technique

1. Use good light source
2. Use magnification with otoscope, visor, or colposcope
3. Separate anal folds to visualize injuries
4. Digital exam is not indicated, except if concern for foreign body retention
5. Anoscopy is indicated only if there is active rectal bleeding or rectal pain
6. Lubricant should be used for anoscopy. To avoid contamination by lubricant, perform anoscopy only AFTER FORENSIC SWAB COLLECTION. When applicable, document if lubricant used during the exam
7. If used, apply Toluidine blue to identify abrasions on skin surface only AFTER FORENSIC SWAB COLLECTION

### Forensic Swabs

**Collect when**

1. Assault occurred within prior 84 hours and
2. History of penile-genital or penile-anal contact or
3. Report of contact to genitalia, perineum, or anus with any parts of assailant’s body or
4. Visible acute anal trauma or
5. Alternate light source scan is positive

**External Anal/ Perianal Swabs**

1. Sites to consider swabbing
   - Perianal area (external to anal sphincter)
   - Anus
   - Gluteal cleft
2. Lightly moisten swabs with tap water before using
3. First 2 swabs: using 2 swabs at a time, swab external anal rugal area. Repeat with second 2 swabs

**Slides are made only when the presence of semen is suspected**

4. Using swab #1, rub cotton tip on dime-size area on center of the slide. Retain this swab for labeling and processing as other 3 swabs from the same area
5. Process as forensic slide evidence
6. Process as forensic swab

**Anorectal Swabs**

**Consider collecting rectal swabs with reported penetration and ejaculation when indicated by patient history.**

1. Use 4 cotton swabs total
2. Slowly insert 1-2 swabs past anal sphincter (approximately 2 cm) Slowly withdraw swabs. Repeat with remaining swabs
3. Using swab #1, rub cotton tip on dime-size area on center of the slide. Retain this swab for labeling and processing with other swab from the same area
4. Process as forensic slide evidence
5. Process as forensic swab
Collect items which may contain forensic evidence, such as tampon or pad, and condom. These should be collected on a case-by-case basis

1. Place in plastic bag and freeze or refrigerate until pick-up by LEA.
2. If freezer/refrigerator is not available, air dry the item if possible. If unable to air dry, package the item in a non-air tight container, such as a urine cup with holes in the lid to allow the item to dry. Contact LEA for transport ASAP.
3. Place patient label over seal, sign over seal, and store with Evidence Kit or in separate paper bag.

V. EVIDENCE PACKAGING & STORAGE

Evidence Collection & Storage

Processing Forensic Swabs

Obtain forensic swabs (saliva, seminal fluid & perspiration)

1. Use sterile cotton swabs
2. To obtain swabs from dry areas (e.g., skin, fingertips, rectum, and any areas that fluoresce) lightly moisten swabs with tap water (soaking in water will prolong drying time and increase likelihood of specimen molding)
3. To obtain swabs from wet areas (e.g., mouth, vagina) use dry sterile cotton swabs

As each swab is obtained

1. Affix label on the shaft
2. Write on each label the site of specimen (e.g., “skin,” or “oral,” “vaginal,” “anal”).
3. At conclusion of patient exam, place swabs in drying rack or drying box in secure area
4. Allow swabs to dry

When swabs are dry

1. Place all swabs from same site in one envelope (i.e., only one site per envelope)
2. Label envelope with specimen site (e.g., “oral,” “vaginal,” “skin”)
3. Affix patient label to envelope
4. Seal envelope with tape or patient label. Do not LICK envelope to seal
5. Place patient label over seal, sign over seal, and store securely in Evidence Kit

Prepare forensic slides from swabs collected

1. Before drying swabs, use first obtained swab, rub cotton tip in dime-size area on center of slide. Do NOT throw away swab. Process this swab with other swabs from same site
2. In pencil, label frosted end of slide with location swab was obtained from
3. Place slide in open cardboard sleeve and air dry for 5 minutes
4. Close cardboard sleeve, seal with patient label, sign over seal and store securely in Evidence Kit

Processing Forensic Slides

Processing Evidence Collection Kit

1. Once all evidence has been placed inside the kit
   - Complete the Forensic Laboratory Information Form found inside the kit
   - Complete the information requested on the front of the kit
   - Place a patient label over the envelope, seal and initial
   - Give the kit to the LEA representative and have him/her sign the Forensic Laboratory Information Form. A copy of this form should be filed in the patient’s chart
2. If no LEA representative is available, store the kit in a secure area, then contact LEA immediately and give them the location of the completed kit so LEA can pick it up ASAP
**Drying Box**

1. Clean drying box with antimicrobial cleaning solution per institution protocol.

**Evidence Storage**

**Temperature**

1. Dry or dried evidence may be kept at room temperature.
2. Damp or wet evidence or specimens must be kept at cool temperature (refrigerated or frozen) until transfer to avoid molding.

**Clothing**

1. Dry clothing should be placed in paper bags, sealed with tape, signed over seal, and labeled with patient ID label.
2. Clothing should be stored in a secure area until transfer to law enforcement.
3. Wet clothing must either be dried in a secure area, refrigerated or frozen and transferred ASAP to law enforcement.

**Photo documentation**

1. Photographs are part of the medical record and are subject to the same protection and confidentiality.
2. Photos may be stored outside of the medical records department. (Just as x-rays films may be stored in the radiology department.)
3. Photos can be stored on a hard drive with limited access or on CD-R (non-rewritable).
4. No alterations should ever be made to the original downloaded image. Copies can be enhanced (contrast, brightness, size, rotation and color temperature only). Document any enhancements made to the copies.
5. Compact flash cards are reused once the patient data is deleted from it.
6. If photos are stored only on disk, two copies should be made and kept in two separate locations.
7. Photos, negatives, or CDs should be stored in an area protected from temperature extremes, with limited access, and which can be locked when not in use.

**Release**

1. Ensure HIPAA compliance when releasing photographs.
2. If copies are made or released, document the date, time and person receiving the items.

The documentation released should be specific to the dates indicated on the request. Do not copy or release non-related medical information.

**To process as Forensic Evidence/Evidence Kit**

1. Place all evidence in paper bag, kit, or envelope.
2. Seal envelope (do not LICK), place patient label over seal, sign over seal, and place in Evidence Kit.
3. All evidence in the Evidence Kit should be dry.
4. Any wet evidence should be refrigerated or frozen and kept with the kit.
5. Store entire, sealed Evidence Kit in room temperature secure area, refrigerator, or freezer until transfer to law enforcement.
6. Entire Evidence Kit may be refrigerated to keep all items together.
7. Blood tubes and urine samples should be packaged to protect from breakage or leakage.
8. Biological specimens (swabs, slides) should be labeled with site obtained from.
   - Swabs from each specific site should be numbered in order obtained for suspect kits (i.e., 1-4).
   - Swabs should be dried in a secure drying box or area before transfer or freezing.
   - Biological specimens should be placed in a secure area until transfer to law enforcement.

**Processing Non-Reporting/Anonymous Kits**

**To process a non-reporting/anonymous exam:**

1. Patient signs consent for a non-reporting/anonymous exam.
2. Label all evidence and package as instructed to do above. The envelope
should be sealed the same as for a reporting exam. When the kit is sealed in place of the patients' name, non-reporting exam is put on that line. No patient name or label should be on the outside of the kit.

3. Clothing is placed in separate paper bags, sealed the nurses name through the tape. The bag is identified by the kit and case number, date, time, contents, facility where ceased and nurses name.

4. The laboratory information form should not be separated but rather left complete and inserted into the kit prior to sealing.

5. The patient is provided the kit # if available, name of the hospital and date kit will be held until.

6. After the patient leaves the appropriate LEA is called to pick up kit.

### VI. INITIAL LAB TESTS

<table>
<thead>
<tr>
<th>Pregnancy Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obtain urine or serum pregnancy test on all patients at risk of pregnancy (post menarchal patients, and all premenarchal girls Tanner Stage 3 and above or age 12 years or older)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Toxicology Tests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obtain toxicology and/or alcohol level when:</td>
</tr>
<tr>
<td>1. Patient appears impaired, intoxicated, or has altered mental status</td>
</tr>
<tr>
<td>2. Patient reports blackout, memory lapse, or partial or total amnesia for event</td>
</tr>
<tr>
<td>3. Patient or other is concerned that he or she may have been drugged</td>
</tr>
<tr>
<td>4. Separate consents for toxicology specimens need not be obtained, but patient should be informed that specimens are obtained</td>
</tr>
</tbody>
</table>

**Hospital/clinic toxicology**

1. If toxicology and/or alcohol results are needed for patient care, stat hospital/clinic toxicology tests must be done

**Crime lab toxicology**

1. Drug and alcohol testing may be done for legal purposes; legal specimens follow a chain of custody and generally are given to LEA (not processed through hospital/clinic lab).
2. In some circumstances examiner may order tests to be run at “any detectible level,” rather than the standard cut off. Talk with the lab toxicologist to determine how to order
3. When it is deemed necessary to collect samples for toxicology purposes, collect blood for alcohol testing and urine for drug testing. Urine must be obtained as soon as possible.

### VII. DIAGNOSTIC TESTS FOR MEDICAL TREATMENT

The following tests and procedures are not recommended for forensic purposes but may be done for patient care at the patient’s expense (Crime Victims’ Compensation and Sexual Assault Victims’ Emergency Fund may be available)

**Pregnancy Test**

Obtain urine or serum pregnancy test on all patients at risk of pregnancy (post menarchal patients, and all premenarchal girls Tanner Stage 3 and above or age 12 years or older) prior to administration of emergency contraception

**Toxicology Tests**

(Refer to Section VI “Initial Lab Tests”)

**Vaginal Wet Mount**

1. Not recommended to examine for sperm, due to lack of reproducibility and standardization
2. May be used to assess vaginitis if signs or symptoms are present
STI Tests for Gonorrhea and Chlamydia

Routine sexually transmitted screening for chlamydia and gonorrhea at the time of an acute sexual assault exam is not recommended.

1. STI testing, if done at time of acute assault, should be repeated at follow-up visit
2. Specimens for STI testing go to hospital/clinic lab NOT to crime lab
3. Inform patient that these tests are related to health issues and are not exclusively for forensic purposes
4. Positive tests may indicate pre-existing infection. Highly sensitive tests such as Nucleic Acid Amplification Test (NAAT) may also indicate infection in assailant
5. For vaginal or penile infection
   • Urine NAAT test or vaginal or penile culture for gonorrhea and chlamydia
6. For anal infection
   • Culture for gonorrhea and chlamydia
   • NAAT test cannot be done
7. For pharyngeal infection
   • Culture for gonorrhea
   • Do not culture for chlamydia

STI Tests for Syphilis and Syphilis Serology

1. Syphilis baseline test may be offered with knowledge of community epidemiology
2. Syphilis serology is best done 3 months after last contact

HIV Testing

1. Baseline HIV testing is generally NOT recommended in the emergency department
2. Baseline HIV testing may be performed up to 2 weeks after assault, and may be performed in follow-up visit or preferably by the primary care provider
   • If patient wishes HIV serology testing in the emergency department, pre-test counseling must be done and post-test counseling arranged
   • Patient must exhibit understanding that testing does not reflect acquisition of HIV from the assault, but related to possible exposure 2 months or more prior
3. If testing is done, arrangements must be made for follow-up visit to discuss results

Hepatitis Serology

1. Indicated if patient is unsure of hepatitis B immune status
2. Hepatitis B/C serology is best done 3 months after last contact

VIII TREATMENT

Pregnancy Prevention

Hospitals/clinics must inform victims of sexual assault about emergency contraception and provide emergency contraception upon request. If the patient declines emergency contraception, a refusal of consent must be obtained.

Since the effectiveness of emergency contraception is time dependent, if possible the patient should obtain medications prior to discharge or as soon as possible

When taken within 72 hours of unprotected sexual contact, EC reduces the risk of pregnancy by 89 percent; taken with 24 hours, it reduces the risk by 95 percent. Additionally, evidence suggests that emergency contraception MAY be effective as far as 120 hours after unprotected sex. (Rodrigues, et al., Am J Obstet Gynecol 2001; 184:531)

Medications for patients who have a negative pregnancy test and are at risk for conception may be given as follows:

"Plan B" (progestin only medication)
SIG: 100 mg tab (0.75 mg levonorgestrel)
Take 2 tabs immediately (Von Hertzen, et al., The Journal of Family Practice, April 2003, Vol. 52, No. 4)

Quantity: 2

“Plan B” is more effective and with fewer side effects than combined estrogen/progestin oral contraceptive; anti-emetics are not generally needed

**Alternative Regimens:**

**Anti-emetics**
Offer an anti-emetic medication if indicated.

**STI Prophylaxis**
Every patient will be offered prophylactic treatment for sexually transmitted infections per current CDC guidelines.

The following recommended antimicrobial regimen for treatment of chlamydia, gonorrhea, trichomonas, and BV may be administered to pregnant and non-pregnant adolescent and adult patients of acute sexual assault (MMWR, August 4, 2006 and http://www.cdc.gov/STI/treatment):

- **Ceftriaxone** (Rocephin) 125 mg IM in a single dose (GC)¹
- **Metronidazole** 2 g orally in a single dose (trich/BV)
- **Azithromycin** 1 g orally in a single dose (chlamydia)

**Alternative Medication Regimens**

1. **Chlamydia**
   - Erythromycin base 500 mg PO QID x 7 days
   - Erythromycin ethylsuccinate 800 mg PO QID x 7 days
   - **In non-pregnant patients:**
     - Doxycycline 100 mg PO BID x 7 days
     - Ofloxacin 300 mg PO BID x 7 days
     - Levofloxacin 500 mg PO x 7 days

2. **Gonorrhea**
   - **In non-pregnant patients:**
     - Cefpodoxime (Vantin)* 400 mg PO in a single dose

* Cipro no longer recommended due to the prevalence of fluoroquinolone resistant gonorrhea

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¹ If oral-pharyngeal exposure to gonorrhea is of significant concern, Ceftriaxone is recommended over Cefixime.
Hepatitis B Vaccine

**Offer when**

1. Patient has not been previously fully immunized for hepatitis B and
2. Patient has negative history for hepatitis B and
3. Secretion-mucosal contact occurred during assault and
4. Patient signs consent for immunization
5. Inform patient that repeat vaccine doses are necessary at one month and six months after initial vaccine
6. If the patient is unsure of their immunization status or has been partially immunized, a Hepatitis B titer may be drawn. At the time of discharge, provide the patient with instructions for appropriate follow up of titer results and completion of vaccine series

**Tetanus Prophylaxis**

**Offer when**

1. Skin wounds occurred during assault and
2. Patient not up-to-date for tetanus immunization (no immunization in past five years)
3. Patient signs consent for immunization

**HIV Prophylaxis**

All patients will have a risk assessment for Postexposure Prophylaxis (PEP) completed. Prophylaxis for HIV may be initiated in the acute care setting if it is deemed necessary upon appropriate consultation.

See [HIV Postexposure Prophylaxis (PEP) after Sexual Assault Guidelines and algorithm on the Attorney General’s Sexual Assault Task Force website](#).

**HIV Prophylaxis continued**

Assistance with postexposure prophylaxis decisions can be obtained by first calling the National Clinician’s Post-Exposure Prophylaxis Hotline (PEPLine), telephone: 888-448-4911.

If additional consultation is needed, contact the OHSU Infectious Disease Department through the OHSU Consult Service, telephone: 503 494-4567 or toll free 800-245-OHSU (6478) 24 hours a day, 7 days a week

**IX. DISCHARGE AND FOLLOW UP MEDICAL VISIT**

**Discharge**

1. Discuss safety issues/plan
2. Appropriate medical follow up will be identified for the patient with respect to the evaluation of possible sexually transmitted diseases, pregnancy and any physical injuries sustained during the assault
3. Explain follow-up for test results
4. Offer patient education materials
5. Confirm plans for medical and counseling follow-up
6. Give phone number for sexual assault victim advocate and other support services
7. Follow up counseling information will be provided to the patient by the sexual assault advocate or the forensic examiner
8. Give written discharge instructions for all treatment and follow up
9. Information on area resources concerning: medical follow up, crisis intervention phone numbers, sexual assault crisis centers, shelters, DHS Child Welfare, Crime Victims Compensation Program, law enforcement and the district attorney’s office will be given to the patient at the time of discharge
10. Per community protocol, refer minor patients to local child abuse intervention center for medical and forensic follow-up

**Follow Up**

**Recommended within two weeks of the initial exam**
**Medical Visit**

Review with patient or guardian

1. Emergency department/clinic record
2. Lab results
3. Current physical symptoms
4. Emotional reactions (sleep disorders, anxiety, depressive symptoms, flashbacks, other)
5. Concerns for safety
6. Concerns regarding STIs and HIV
7. Assess social support (family, friends)
8. Additional history or any new information regarding the assault
9. If patient is a minor or a disabled, mentally ill, or elderly adult, report any new allegations to LEA and appropriate protective services agency

**Physical Exam**

Depending on history and symptoms

1. Evaluate for resolution and healing of injury
2. Evaluate current symptoms

**Laboratory Tests**

Depending on risk and patient concerns

1. Obtain urine pregnancy test. Let patient know that this is only a screening test and should be repeated if patient does not have a regular menstrual period
2. Nucleic Acid Amplification Test (NAAT) or culture for gonorrhea and chlamydia if single dose prophylaxis was not given in hospital/clinic
3. HIV: pre-test and post-test counseling required after exposure
   - Baseline
   - Three months
   - Six months
4. Hepatitis B/C serology--three months after exposure
5. Syphilis serology--three months after exposure

**Treatment**

1. Prophylaxis with Hepatitis B vaccine may be initiated up to 14 days post assault; indicated if there has been secretion-to-mucosal contact and if patient has not been fully immunized; counsel regarding completion of series.

**Referral**

Refer for further medical follow-up, mental health and social services