

DEPARTMENT OF THE ARMY
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Medical Services
MEDICAL FACILITY MANAGEMENT OF SEXUAL ASSAULT

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*This regulation supersedes MEDCOM Regulation 40-36, 2 February 1995.

1. HISTORY. This is the second printing of this publication and publishes a major revision.

2. PURPOSE. This regulation establishes the U.S. Army Medical Command (USAMEDCOM) policy for timely comprehensive medical management of sexual assault victims and provides implementation guidance.

3. APPLICABILITY. This regulation pertains to all USAMEDCOM personnel who are directly or indirectly involved in the provision of care to victims of sexual assault.

4. REFERENCES. References are listed in appendix A.

5. EXPLANATION OF ABBREVIATIONS AND TERMS. Abbreviations and special terms used in this regulation are provided in the glossary.

6. RESPONSIBILITIES.

a. The Director of Health Policy and Services is responsible for establishing policy and providing guidance for the timely and expected standard of care for victims of sexual assault.

b. The military treatment facility (MTF) commander will--

(1) In accordance with this regulation, ensure that all patients who present to the MTF with an allegation of sexual assault receive a uniform standard of care which is monitored and tracked until the provision of health care related to the sexual assault is completed.

(2) Ensure that the MTF's management of sexual assault victims is compassionate, sensitive, and not burdensome upon the patient.

(3) Ensure that all victims of sexual assault, upon initial encounter with the MTF, have immediate access to examination by a provider trained in performing forensic examination and evidence collection. The forensic examiner may be a member of the MTF medical staff or available outside the MTF by established memorandums of understanding (MOUs)/memorandums of agreement (MOAs).

(4) Ensure that a sexual assault clinical provider (SACP) manages each sexual assault patient's medical treatment--as directly related to the sexual assault incident--from initial presentation to completion of all follow-up visits.

(5) Ensure that initial and follow-up evaluations/treatments are clinically appropriate for each individual patient consistent with his/her clinical diagnosis and according to this regulation.

(6) Ensure that all medical providers and MTF personnel participate in annual sexual assault awareness training.

(7) Designate a representative to the Installation Sexual Assault Review Board.

(8) Ensure that each sexual assault victim is assigned to an SACP.

(9) Assign sexual assault care coordinators (SACCs) to assist SACP with the delivery of a uniformed standard of care.

(10) Ensure that resources are available to support the standards of practice outlined in this regulation.

(11) Ensure that all clinical staff respond to allegations of sexual assault with sensitivity and compassion.

(12) Ensure and maintain collaborative, supportive relationships with relevant installation agencies that have vested interests in the sexual assault victim (e.g., Criminal Investigation Division (CID), Victim Advocacy Program, and the Judge Advocate General).

c. The Deputy Commander for Clinical Services will--

(1) Ensure that MTF clinical personnel are adequately trained in the standard of care for victims of sexual assault.

(2) Ensure that those who function as forensic sexual assault examiners are trained to the standard of care as provided in this regulation, to include the procedures for the use of the evidence collection kit.

(3) Ensure that all sexual assault records are reviewed to ensure compliance with established standards of care. Corrective actions will be taken when standards of care are not met.

(4) Designate a sufficient number of privileged health care providers to be SACP in order to ensure adequate, comprehensive continuity of care and management of sexual assault patients according to this regulation.

(5) Develop, maintain, and disseminate a sexual assault standing operating procedure (SOP) for the MTF medical personnel consistent with the standards of practice as contained in this regulation.

(6) Review the MTF SOP on an annual basis and update as needed in order to meet the objectives of this regulation.

d. The Chief, Obstetrics/Gynecology will ensure that a gynecologist is available for consultation, if needed, by the provider performing the forensic examination and collecting forensic evidence.

e. The Chief, Urology will ensure that a urologist is available for consultation, if needed, by the provider performing the forensic examination and collecting forensic evidence.

f. The Chief, Pediatrics will ensure a pediatrician is available for consultation, if needed, by the provider performing the forensic examination and collecting forensic evidence.

g. The Chief, Family Practice will ensure a family practitioner is available for consultation, if needed, by the provider performing the forensic examination and collecting forensic evidence.

h. The Chief, Pathology/Laboratory Services will--

(1) Ensure that all forensic material forwarded to their service is labeled, handled, and stored according to applicable regulations.

(2) Ensure that laboratory personnel receive mandatory annual sexual assault awareness training in order to promote the standard of care requiring that sexual assault victims be treated with sensitivity and compassion.

i. The Chief, Patient Administration Division (PAD) will--

(1) Ensure that reports and records of sexual assault patients are received and processed during both duty and nonduty hours in an appropriate and timely manner.

(2) Maintain and manage a "Special Handling File" on sexual assault cases according to applicable regulations and maintain close coordination with clinical administrative staff on records management of sexual assault patients.

(3) Ensure that patients are identified with the appropriate International Classification of Disease (ICD-9) code and tracked by this code.

(4) Ensure release of records requested by the CID or civilian law enforcement agencies, in accordance with applicable regulations.

j. The Chief, Social Work Service will--

(1) Ensure that an on-call staff roster is provided to all departments where examiners are located.

(2) Ensure that a provider physically reports to the examiner location to assist the victim and their caretakers when the victim is a child.

(3) In instances of assault on an adult, the on-call provider must offer a response to the examiner when no other provision for a victim advocate is available and when the victim requests an advocate.

(4) Ensure that all sexual assault victims seen by providers are screened for traumatic stress upon initial contact.

(5) Ensure mental health follow-up care is provided to sexual assault victims, as needed. In the event that mental health resources are unavailable, the SACC will facilitate mental health care within the community.

(6) Ensure social work follow-up care is provided to sexual assault victims as needed.

k. The Sexual Assault Clinical Provider will--

(1) Be responsible for the primary medical management of all identified victims of sexual assault from initial contact to the completion of their health care related to the sexual assault according to this regulation.

(2) Ensure that the patient obtains comprehensive, timely, and appropriate medical care (including follow-up care) relevant to his/her medical conditions arising from the sexual assault incident. This includes, but is not limited to, specialty care and referrals, ancillary support services, and diagnostic testing.

(3) Coordinate and collaborate with the SACC, installation agencies (e.g., Victim Advocacy Program and CID), as needed.

(4) Be a fully privileged health care provider of the MTF medical staff, able to address the medical needs of sexual assault victims.

(5) Develop an individualized patient management care plan in collaboration with the patient and SACC.

(6) Document the patient's complete care and management according to the provisions of this regulation.

l. The Sexual Assault Care Coordinator will--

(1) According to this regulation, monitor and track the health care management of each identified victim of sexual assault who presents to the MTF.

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(2) Collaborate and coordinate with the SACP to ensure the patient's health care needs are addressed from his/her initial MTF encounter until completion of all health care related to the sexual assault.

(3) Collaborate and coordinate with the Victim Advocacy Program to facilitate resolution of related issues.

(4) Facilitate the timely completion of the patient's comprehensive individualized care plan in a timely manner to include supportive and responsive interaction with the patient.

(5) Maintain the requisite MTF commander database in order to manage sexual assault victims.

(6) Be directly responsible to the MTF commander.

(7) Explain advocacy and counseling services and assess acute stress reaction.

m. The forensic examiner will--

(1) Be a fully privileged health care provider of the MTF medical staff, able to address the medical needs of the sexual assault victim.

(2) Be qualified to evaluate, diagnose, and treat a sexually assaulted victim.

(3) Ensure continuity and follow-up care for each patient by direct contact with and referral to the SACP. The means of achieving this requirement is for the SACP to be the forensic examiner.

(4) Be trained in the performance of forensic examination and evidence collection. (Note: Most of the sexual assault research has shown that the best and most compassionate results are obtained by an individual who is trained and routinely performs these exams. Sexual assault nurse examiner training is one method of education that has been shown to accomplish the level of expertise required.)

(5) Perform the forensic examination of patients who come within the scope of this regulation. The MTF may, through established MOUs/MOAs, use an alternative provider to perform the forensic examination and collection of evidence. The SACP must ensure the patient's need for continuity of care.

n. First responders (emergency medical services/emergency department personnel) will--

(1) Assess the victim's need for treatment of potentially life-threatening or serious injuries, administer necessary first aid, and request/obtain emergency medical assistance according to jurisdictional policy.

(2) Address safety needs of the victim and others at the scene (e.g., offenders) and call for assistance/backup, if needed.

(3) Quickly assess the age, abilities, communication modality, and health condition of the victim and tailor response as appropriate (e.g., a language interpreter or child protective service worker may be needed).

(4) Respond to requests for victim assistance as quickly as possible. Understand that a victim needs immediate assistance for many reasons: he/she may not be safe, may be physically injured, and/or is experiencing trauma. Be aware that time delays in response can cause loss of evidence and increased trauma.

(5) If injuries do not appear serious, emphasize to the victim the need for medical evaluation and address related health concerns. Also, explain the purpose of the exam and what happens during the exam process, keeping in mind that the amount of information that the victim wants at this time varies.

(6) Inform the victim about exam facility options (if options exist) and seek the victim's consent for transportation to the facility of his/her choice.

(7) Ensure timely interaction among the victim and victim advocates as soon as possible after disclosure of the assault, even if the victim refuses medical care and refuses the medical forensic exam. Follow local procedures for activating an advocate.

(8) Ask the victim if he/she would like family members or friends to be contacted.

(9) Ensure preservation of crime scene evidence, including evidence on the victim. Document the victim's demeanor and statements related to the assault.

(10) Explain to the victim the reporting process and his/her participation options. The amount of information required will vary per individual.

(11) If a victim agrees to seek emergency care and/or have evidence collected--

(a) Explain to the victim how to preserve bodily evidence until it can be collected (e.g., do not wash, change clothes, urinate, defecate, smoke, drink, eat, brush hair or teeth, or rinse mouth).

(b) Explain to the victim that clothing most likely will be taken as evidence. He/she may wish to bring or have someone bring a clean change of clothes to the exam facility. If applicable, let the victim know that replacement clothing will be available at the exam site. If he/she changed clothes since the assault, clothing worn during and immediately after the assault will be needed. Follow law enforcement procedures for retrieving clothing or other items from a crime scene so that evidence is not inadvertently destroyed or contaminated.

(c) In suspected cases of drug-facilitated assault, the victim's first available urine sample should be sought if he/she cannot wait to urinate until arrival at the exam site. The victim may have been drugged without his/her knowledge. If the victim or his/her family, friends, or responders suspect drug-facilitated assault, a urine sample should be sought.

(d) Transport or arrange transportation for the victim to the exam site. A victim with disabilities may have equipment (e.g., wheelchairs and other assistive devices) and/or service animals that also need to be transported. Equipment should be treated with care as victims may consider equipment as extensions of themselves.

(e) Follow the MTF's SOP and applicable jurisdictional policy on alerting exam facilities about the pending arrival of patients.

(f) Ensure that suspects and victims are not in the same exam facility at the same time, if possible.

7. POLICY.

a. USAMEDCOM policy is to treat victims of sexual assault and to ensure that MTF personnel are professionally trained to intervene in sexual assault cases. Since incidents of sexual assault constitute violations of the law, Department of the Army policy also recognizes a commander's authority to take disciplinary or administrative action in appropriate cases.

b. Medical personnel will execute the requirements of this regulation (e.g., the forensic history and examination) in a nonjudgmental manner exemplifying the USAMEDCOM's commitment to establish a health care environment that is sensitive, compassionate, responsive, and supportive to sexual assault victims.

8. TRIAGE AND INTAKE.

a. Priority cases.

(1) Sexually assaulted patients, with or without overt physical injury, will receive priority medical attention.

(2) A private location within the exam facility will be used for taking histories and performing the physical examination of sexually assaulted victims. This designated area will facilitate meeting the patient's health care needs as well as maximizing his/her safety and privacy.

(3) MTF personnel will immediately notify the SACP and SACC to coordinate care of identified sexual assault victims, irrespective of when and where the patient presents for care.

(4) Sexual assault victims will be referred immediately for a sexual assault forensic examination (location to be determined by local SOP) when the sexual assault occurred within 72 hours of the patient's presentation to the MTF.

(5) If the patient is identified greater than 72 hours after the sexual assault, immediate forensic medical management will be as determined by the SACP. The sexual assault victim will be provided a same-day appointment with the SACP to assess and develop an individualized plan of care related to the sexual assault event.

b. Priority of acute care needs.

(1) Medical evaluation and treatment of acute injury, trauma care, and safety needs take precedence over the forensic examination. Medical personnel have an affirmative responsibility to preserve forensic materials and evidence in conjunction with any and all administered medical care.

(2) The medical forensic exam will be conducted (with the patient's permission) as soon as possible after the initial medical evaluation, management, and stabilization of acute problems and before treating nonacute injuries.

c. Notification of sexual assault responders.

(1) Alert the SACP and SACC of the sexual assault victim's presence and his/her status.

(2) Alert the identified sexual assault forensic examiner of the need for their services. The examiner may be an MTF staff member, such as the SACP, or may be a forensically trained provider outside the MTF per MOUs/MOAs.

(3) Examiners should be available to evaluate a sexually assaulted patient within 30 minutes of notification, or a patient should be transported to the designated site for forensic examination within 30 minutes.

(4) Contact the installation sexual assault victim advocate, if not already done.

(5) Contact the on-call social work provider. The provider will report for all child cases and as requested by the examiner for all adult cases.

d. Immediate medical and mental health interventions.

(1) Assess the patient's need for immediate medical or mental health intervention prior to the medical forensic exam.

(2) Seek the patient's informed consent before providing treatment. Also, inform the victim of their right to receive medical care regardless of whether the assault is

reported to law enforcement and if and how their reporting decision will affect payment for medical care and examinations.

9. DOCUMENTATION BY HEALTH CARE PERSONNEL.

a. Medical forensic report.

(1) Examiners are responsible for documenting forensic details of the exam in the medical forensic report, according to jurisdictional policy.

(2) This report includes the following forms which are provided at appendix B:

(a) Patient consent forms related to evidence (MEDCOM OP 29-2-R, Sexual Assault Patient Release Statement and MEDCOM OP 29-3-R, Sexual Assault Photographic Release).

(b) The medical forensic history (MEDCOM OP 29-4-R, Sexual Assault History).

(c) Documentation of exam findings (MEDCOM OP 29-5-R, Sexual Assault Physical Examination and Collection of Laboratory Specimens).

(d) Sexual assault medical examination report face sheet (MEDCOM OP 29-1-R, Sexual Assault Medical Examination Report).

(3) The only medical issues documented in this report are findings that potentially relate to the assault or preexisting medical factors that could influence interpretation of findings.

(4) If the case is reported, the criminal justice system will use the medical forensic report, along with collected evidence, photographs and video images, and victim/witness statements as a basis for investigation and possible prosecution. When custody of forensic reports and collected evidence is transferred to law enforcement officials, DA Form 4137 (Evidence/Property Custody Document) will be used in accordance with AR 195-5.

(5) If examiners are required to testify in court, they will use the report to recall the incident.

(6) Forensic examination records will be maintained separately from the outpatient treatment record to avoid inadvertent 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 personnel allowed access to these records according to the Health Insurance Portability and Accountability Act requirements.

(7) It is vital that the exam documentation be thorough, precise, and accurate.

b. Medical records.

(1) The medical record is not part of the evidence collection kit and it should not be submitted to the crime lab.

(2) SACPs and SACCs along with all health care providers shall document care within the outpatient treatment record.

10. THE MEDICAL FORENSIC HISTORY.

a. Coordination of history taking and investigative interviewing. The examiner obtains a detailed forensic and medical history by asking questions related to the assault. Such information is intended to guide the exam, evidence collection, and crime lab analysis of findings.

b. Presence of advocates during the history. Victim advocates should be able to provide support and advocacy during the history, if desired by patients.

c. Patient's needs.

(1) Consider the patient's needs before gathering the history.

(2) The facility should have procedures in place and examiners should be educated to accommodate the patient's communication skill level and preferred mode of communicating.

(3) It is important that examiners are aware of and responsive to verbal and nonverbal cues from patients.

(4) Use a private and quiet setting for information gathering.

d. Obtaining the history.

(1) The following information should be sought routinely from patients:

(a) Date and time of the sexual assault(s).

(b) Pertinent patient medical history.

(c) Recent consensual sexual activity.

(d) Post-assault activities of patients. (For example, have patients urinated, defecated, wiped genitals or the body, douched, removed/inserted a tampon/sanitary pad/diaphragm, used oral rinse/gargled, washed, brushed teeth, ate or drank, smoked, used drugs, or changed clothing?)

(e) Assault-related patient history (e.g., memory loss; lapse of consciousness; vomiting; nongenital injury, pain, and/or bleeding; and anal-genital injury, pain, and/or bleeding can direct evidence collection and medical care). Note: Collecting toxicology samples is recommended if there was either loss of memory or lapse of consciousness, according to jurisdictional policy.

(f) Suspect information (if known). Suspect information gathered during this history should be limited to that which will guide the exam and forensic evidence collection.

(g) Nature of the physical assault(s) and information about the physical surroundings of the assault(s) (e.g., indoors, outdoors, car, alley, room, rug, dirt, mud, or grass) and methods employed by suspects is crucial to the detection, collection, and analysis of physical evidence. Knowing whether suspects may have been injured during the assault may be useful when recovering evidence from patients (e.g., blood) or from suspects (e.g., bruising, fingernail marks, or bite marks).

(h) Description of the sexual assault(s) including an accurate but brief description is crucial to detecting, collecting, and analyzing physical evidence. The description should include any--

1 Penetration of genitalia (e.g., vulva, hymen, and/or vagina of female patient), however slight;

2 Penetration of the anal opening, however slight;

3 Oral contact with genitals (of patients by suspects or of suspects by patients);

4 Other contact with genitals (of patients by suspects or of suspects by patients);

5 Oral contact with the anus (of patients by suspects or of suspects by patients);

6 Nongenital act(s) (e.g., licking, kissing, suction injury, and biting);

7 Other act(s) including use of objects;

8 If known, whether ejaculation occurred and location(s) of ejaculation (e.g., mouth, vagina, genitals, anus/rectum, body surface, on clothing, on bedding, or other); and

9 Use of contraception or lubricants.

(2) The above questions require specific and sometimes detailed answers. Some may be difficult for patients to answer. Examiners should explain that these questions are asked during every sexual assault medical forensic exam. They should also explain why each question is being asked.

11. PHOTOGRAPHY.

a. Extent. Taking photographs of those parts of a patient's anatomy involved in the assault should be routine in sexual assault cases.

b. Photographers and equipment. Photographers should be familiar with equipment operation and be educated on forensic photography in sexual assault cases.

c. Patient comfort and privacy.

(1) Minimize the patient's discomfort while they are being photographed and respect their need for modesty and privacy.

(2) Drape the patient appropriately while taking photographs. Take measures to avoid allegations of impropriety when photographing patients. For instance, when a male photographer is photographing a female patient, another woman should be present.

d. Explanation of photography procedures.

(1) Photographers will explain forensic photography procedures to patients. Taking photographs of patients in the aftermath of an assault can be re-traumatizing.

(2) To help reduce the chances of re-traumatization, help patients understand the purpose of photography in forensic evidence collection, the extent to which photographs will be taken and procedures that will be used, potential uses of photographs during investigation and prosecution (especially anogenital images if taken), and the possible need to obtain additional photographs following the exam.

e. Taking photographs.

(1) Photographers shall--

(a) Take initial and follow-up photographs as appropriate.

(b) Strive to control every element in the photograph to produce a clear, powerful statement. Photographs should be taken prior to evidence collection.

(c) Link patient's identity and the date to the photographs. For example, print the patient's name, date of exam, and the photographer's name/initials on a plain sheet

of paper. Photograph this sheet at the beginning and end of the roll of film for identification. Also photograph the face of patients for identification purposes. Some cameras offer the option of imprinting the date and/or time on the negative, and some have the ability to enter a case number so the face or name of a patient is not on the film. Mechanisms should be in place (e.g., at law enforcement agencies and exam facilities) to protect the patient's privacy and confidentiality related to the photographs.

(d) Take clear and accurate photographs by using the shutter speed and lens aperture to control exposure (automated cameras and flash units can give incorrect exposures). Use adequate lighting whether the source is natural, flood, or flash. Use of flashes and lighting in the exam room can change the color of evidence; a filter may help adjust lighting so that the photograph is truer to color (noting in records any alternations to the environment to enhance photographs). Include a color bar in the photograph to ensure accurate color reproduction.

(e) Strive for undistorted photographs with good perspective (whenever possible, use a normal focal length lens, keep the camera level, and photograph the subject at eye level). Maintain sharp focus (keep the camera steady, focus carefully, use maximum depth of field, and look at the frame of the scene). A good quality macros lens with a ring strobe flash offers the best quality and most flexibility for forensic photography involving sexual assault.

(f) Use an inch scale or ruler for size reference in photographs. In addition to those photographs that identify patients and anatomical locations being photographed, take at least two photographs of each area—one with and one without scale. Taking two photographs in this manner demonstrates that the scale was not concealing anything important. Photograph evidence in place before moving it or collecting it. Do not alter or move evidence when photographing, and make every effort to minimize distraction in photographs while maintaining the focus of areas being photographed.

(g) Photograph bite marks.

(h) Take at least two shots at three orientations--

1 Take full-body images (anterior, posterior, and lateral) with the patient's face visible and clearly identifiable. Position patients approximately two feet from the corner of the room, using walls to reflect and diffuse flash illumination. When photographing the backs of patients, turn their faces toward the camera so that they can be recognized.

2 Take medium-range photographs of each separate injury, including cuts, bruises, swelling, lacerations, and abrasions. Work from one side to the other and then top to bottom or design a workable method. Be consistent. Take "regional" shots to show injuries in the context and orientation of a body region; these photographs should include easily identifiable anatomical landmarks.

3 Take close-up images of particular injuries, using the scale. When photographing a wound, show its relationship to another part of the body. Take at least three photographs involving a wound area. Shield uninvolved breast or genital areas when possible; highly graphic photos may be deemed inadmissible in court and make the case less credible. All injuries should be recorded with a close-up attachment. Try to capture subtleties in texture and color. Document pattern injuries caused by an object. Do not use an external light source around an injured eye as it can cause retinal damage.

(2) Close-up photographs of hands and fingernails may show traces of blood, skin, or hair. Be sure to look for damage to nails or missing nails. Photograph marks of restraint or bondage around wrists, ankles, or neck; they may be compared later with the object in question that made the marks. Photograph transfer evidence present on the body or clothing, such as dirt, gravel, or vegetation.

(3) All photographs should be clearly labeled and the chain of custody maintained. Follow jurisdictional policy for development of film, transfer, duplication or additional prints, and storage of photographs. Do not include photographs in the evidence collection kit sent to the crime lab.

(4) Follow-up photographs may be necessary. Photography should be repeated as new or different evidence on the patient's body is found following the exam (e.g., bruising may appear days later). Create procedures that examiners, law enforcement investigators, and patients follow to ensure this evidence is documented. In addition to documenting emerging or evolving injuries, follow-up photographs provide documentation of healing or resolving injuries and clarify findings of stable, normal variants in anatomy that could be confused with acute injuries.

12. EXAM AND EVIDENCE COLLECTION PROCEDURES.

a. Forensic exam.

(1) Purpose of the forensic exam.

(a) Patient health care needs and concerns discovered in the course of the exam should be addressed prior to discharge. However, patients must understand that the exam does not provide routine medical care. For example, a pap smear will not be done during the female pelvic exam.

(b) Every precaution should be taken by all first responders to reduce outside contamination and dilution of evidence. For example, examiners should wear nonlubricated gloves and change them throughout the exam/evidence collection whenever cross-contamination could occur.

(c) Examiners should--

1 Collect as much evidence as possible.

2 Be aware of evidence that may pertain to whether or not the patient consented to the sexual contact with the suspect.

3 Modify the exam and evidence collection to address the patient's needs and concerns.

4 Explain exam and evidence collection procedures to patients.

(2) Procedures.

(a) In addition to instructions included in the evidence collection kit, the exam should be guided by the scope of informed consent and the medical forensic history. In the course of the exam, examiners may question patients about trauma related to the assault. These questions should be specific enough to yield clinically relevant information. For example, simply asking patients if they are injured or hurt anywhere is not as specific as asking if they hurt in specific body locations.

(b) During the general physical examination--

1 Obtain the patient's vital signs.

2 Note the date and time of the exam, physical appearance; general demeanor, behavior, and orientation; and condition of clothing on arrival.

3 Record all physical findings (which include observable or palpable tissue injuries; physiologic changes; and foreign materials such as grass, sand, stains, dried or moist secretions, or positive fluorescence) on body diagram forms.

4 Use an alternate light source to assist in identifying findings.

(c) During the female genital exam, evaluate--

1 The external genitalia and perineal area for injury, foreign materials, and other findings in the following areas: abdomen, thighs, perineum, labia majora, labia minora, clitoral hood and surrounding area, perurethral tissue/urethral meatus, hymen, fossa navicularis, and posterior fourchette. The use of a colposcope during the external genital exam enhances viewing microscopic trauma and may provide photographic documentation.

2 The vagina and cervix for injury, foreign materials, and foreign bodies. Use a colposcope or other magnifying device if available. In some jurisdictions, toluidine blue dye may be used to detect trauma, either with or without the use of a colposcope.

3 The buttocks, perianal skin, and anal folds for injury, foreign materials, and other findings. If rectal injury is suspected, an anoscope can be used as a tool to identify and evaluate trauma (it may also be used to help obtain anal swabs and trace evidence).

(d) For male patients, examine the external and perineal area for injury, foreign materials, and other findings, including the abdomen, buttocks, thighs, foreskin, urethral meatus, shaft, scrotum, perineum, glans, and testes. Document whether or not the patient is circumcised.

(e) Record findings from the general physical and anogenital exam on appropriate body diagram forms. Detailed descriptions of findings should be provided as required. During the exam, collect evidence as specified in the evidence collection kit and photograph anatomy involved in the assault.

b. Collection of biological evidence.

(1) Collect clothing evidence. This paragraph provides procedures for collecting clothing, underwear, and foreign material dislodged while undressing.

(a) Place a clean hospital sheet on the floor as a barrier. Then place the collection paper on the barrier sheet. Be careful to prevent evidence transfer. Document all findings. Ask patients to disrobe (assisting them as requested and then draping them appropriately). When disrobing, have patients remove shoes and then undress over the collection paper to catch any foreign material that is dislodged. If someone assists, he/she should wear gloves. If patients are concerned about privacy while disrobing, advocates and/or support personnel can turn around, hold up a sheet to shield patients, or leave the room.

(b) Collect clothing pertinent to the assault. First, determine if patients are wearing the same clothes worn during or immediately following the assault. If so, the clothing should be examined for any apparent foreign material, stains, or damage. When the determination has been made that items may contain possible evidence, those items should be collected. If it is determined that patients are not wearing the same clothing, examiners should inquire as to the location of the original clothing. If original clothing has not been brought to the exam site, information on clothing location should be provided to law enforcement personnel (if involved) so that clothing can be retrieved before any potential evidence is destroyed. In addition to collecting underwear worn at the time of or immediately after the assault, collect underwear patients are wearing at the time of the exam (if relevant to the case).

(c) Be sensitive about how much clothing to take as evidence. For example, take the patient's coat or shoes only if it is determined that there may be evidence on them. Exam site personnel can coordinate with advocacy programs to ensure that replacement clothing is available for patients in a range of sizes. This clothing is critical in some instances (e.g., a patient may own only the clothing that is being collected).

(d) If female patients are menstruating, collect tampons and sanitary napkins. Air-dry them as much as possible and then place them in a separate paper collection bag.

(e) Follow jurisdictional policy for handling and transporting wet evidence that cannot be dried thoroughly at the exam site (e.g., wet clothing, tampons, and sanitary napkins).

(f) Ensure wet evidence is packaged in leak-proof containers and separated from other evidence when being transported. It is critical to alert involved law enforcement representatives and crime lab personnel about the presence of wet evidence and the need for immediate analysis or further drying. After drying items according to jurisdictional policy, place each piece of clothing and collection paper in a separate paper bag, label, seal, and initial seal. If additional bags are needed, use new grocery-style paper bags only. The barrier sheet is not submitted as evidence.

(g) Package evidence in bags, label, seal, and initial the seal.

(2) Collect debris.

(a) Collect obvious debris on the patient's body (e.g., dirt, leaves, fibers, and hair) on a collection sheet, package, label, seal, and initial seal.

(b) For fingernail evidence, ask patients whether or not they scratched the suspect's face, body, or clothing. If so, or if fibers of other materials are observed under the patient's fingernails, collect fingernail clippings, scrapings, and/or swabbings. If fingernail scrapings are collected, package fingernail scrapings and tools used to obtain the sample, label, seal, and initial seal. Cut broken fingernails at the remaining jagged edge for later comparison. Collect a fake nail as a known sample if one is missing. Package, label, seal, and initial the seals.

(c) If requested, assist patients in putting on exam gowns after clothing and debris are collected.

(d) Collect foreign materials and swabs from the surface of the body.

1 Carefully inspect the body, including head, hair, and scalp, for dried or moist secretions and stains (e.g., blood, seminal fluid, sweat, and saliva) and other foreign material.

2 Use an alternate light source to assist in identifying evidence. Obtain swabs from any suspicious area that may be a dry secretion or stain, any moist secretion, any area that fluoresces with longwave ultraviolet light, and any area for which patients relate a history or suspicion of bodily fluid transfer (e.g., licking, kissing, biting, splashed semen, or suction injury).

3 Also collect swabs from potentially high-yield areas (e.g., neck, breasts, or external genitalia) if the history is absent or incomplete.

4 Flake off dried secretions and/or swab dried secretions with a swab moistened with one drop of water. Swab moist secretions with a dry swab. Separate swabs should be used for every sample area collected. Follow local policies regarding the number of swabs required to collect each specimen.

5 Swab bite marks.

6 Optional: Smear swabs onto microscope slides, according to local policy.

7 Cut matted head, facial, or pubic hairs bearing crusted material (or flake off material if possible) and place in an envelope.

8 According to local policy, air-dry all specimens, package swabs and slides separately, label, seal, and initial seals. Note that coding of evidence must allow the crime lab to know which swab was used to prepare which slide.

9 If teeth are flossed prior to oral swab collection, package used floss, label, seal, and initial the seal.

(3) Collect hair combings.

(a) The purpose of this procedure is to collect hair shed by suspects that may have been transferred to the patient's hair. Hair combings may also reveal other foreign materials. Some jurisdictions collect head hair combings only if indicated. Whether or not head combings are collected, it is important to examine head, facial, and pubic hair for secretions, foreign materials, and/or debris and collect as appropriate. Pubic hair combings are typically collected if the assault involved the genital area of patients.

1 Head and hair combings. Use the comb and collection paper provided for this procedure. Place the unfolded paper under patient's head. Comb head hair towards paper (patients may comb). Fold comb with debris/hair into paper. Package paper, label, seal, and initial the seal.

2 Pubic hair combings. Use the comb and collection paper provided for this procedure. Place the unfolded paper under patient's buttocks and comb hair toward paper (patients may comb). Fold comb with debris/hair into paper. Package paper, label, seal, and initial the seal.

(b) Collect hair reference samples as needed. Follow local policy for collection of hair reference samples. Many jurisdictions do not collect pubic hair reference samples routinely. In other jurisdictions, both samples are collected routinely unless otherwise indicated or declined by patients. Whatever the jurisdictional policy,

patients should always be informed about the purpose of collection, procedures used to collect samples, discomfort that may be involved, and how these samples may be used during the investigation and prosecution. If hair reference samples are not collected at the initial exam, it is important to inform patients that there might be a need to collect these samples for crime lab analysis at a later date. They should be aware that hair evidence collected at a later date may not be as conclusive as it is if collected at the time of the initial exam due to the fact that hair characteristics can change over time.

(c) When these samples are collected, the indications, timing, and techniques vary. Jurisdictional policies should be in place and followed. Give patients the option of collecting samples themselves.

(4) Collect oral and anogenital swabs and smears.

(a) With the patient's consent, the medical forensic history, and exam findings should guide collection of oral and anogenital specimens. In general, specimens should be collected only from orifices and areas surrounding the orifices that patients report to be involved in the assault. Keep in mind that some patients may be vague about the type(s) of sexual contact that occurred. Examiners can help clarify which orifices were involved by asking appropriate questions. If there is uncertainty about involved orifices (e.g., because patients have little memory of the assault, were unconscious or incoherent, or do not understand what occurred), collection from oral, vaginal, and anal orifices (with the patient's permission) may be appropriate. In some jurisdictions, policy calls for collection from all three orifices. Again, the patient's consent is needed to collect these samples.

(b) When collecting these swabs and smears, remember the following:

1 Caution patients who use a bathroom prior to the exam that evidence may be present in pubic, genital, and anal areas and urge them not to wash or wipe away secretions until after evidence collection.

2 When taking a swab, examiners should take care to not contaminate the collection with secretions or materials from other areas, such as vaginal to rectal or penile to rectal.

3 Follow jurisdictional policy for collecting swabs (and the number of swabs used to collect a sample), smearing swabs on slides, and drying and packaging swabs and slides. Also, follow local policy for timeframes in which samples should be collected (e.g., oral and penile samples are only collected within 24 hours of the assault in one jurisdiction) unless otherwise indicated.

4 Do not stain or chemically fix swabs or smears.

5 When preparing slides, note that coding of evidence material must allow the crime lab to know which swab was used to prepare which slide.

6 Document any foreign substance or material introduced by health care providers (e.g., lubricating jelly on a speculum or betadine prior to introduction of a catheter).

(c) Oral sample.

1 Place swabs together to collect specimen from oral cavity between gums and cheeks and under tongue. Remove dentures and swab with same swabs.

2 Optional: Smear swabs onto two microscopic slides.

3 Air-dry swabs and slides.

4 Package slides and swabs, place in envelope, label, seal, and initial the seal.

(d) External genital sample.

1 Swab external genital dry-skin areas with swabs (blind swabbing by protocol or history), at least one dry and one moistened with a drop of sterile, distilled, or deionized water, according to jurisdictional policy.

2 Optional: Smear swabs on two microscope slides.

3 Air-dry swabs and slides.

4 Package slides and swabs, place in envelope, label, seal, and initial the seal.

(e) Vaginal/cervical sample

1 Use swabs together to collect a sample from vaginal pool. It is prudent to collect swabs from both the vagina and cervix, regardless of time between assault and exam.

2 Optional: Smear swabs onto microscope slides.

3 Air-dry swabs and slides.

4 Package slides and swabs, place in envelope, label (specifically indicating sampling site), seal, and initial the seal.

(5) Wet-mount examinations.

(a) Some jurisdictions require examiners to conduct wet-mount examinations of vaginal/cervical secretions for motile and nonmotile sperm when a male suspect may have ejaculated in a patient's vagina.

(b) Because sperm motility decreases quickly with time and removal from the vagina/cervix, wet-mount evaluation during the exam can provide the only opportunity to see sperm motility.

(c) The presence of motile sperm may help define the timeframe in which the crime occurred. In other jurisdictions, however, the crime lab is responsible for all analysis of evidence and examiners do not do the wet-mount evaluation for sperm.

(d) Follow jurisdictional policy on whether wet-mount evaluation for sperm is needed and methods of evaluation. If it is required, examiners should be educated on use of the microscope, identification of sperm, and reporting their findings.

1 Prepare a wet-mount slide according to jurisdictional policy. Smear one swab collected from the vaginal pool on a slide. Typically, the slide is prepared by placing one drop of normal saline onto the slide. Roll the swab into the drop and place a cover slip on the slide.

2 View for presence of sperm under a microscope at 400x or by using a phase contrast or other optically staining microscope (within 10 minutes of preparing slide).

3 Air-dry this swab and slide (not removing the cover slip).

4 Package swab and slide, place in envelope, label as "wet mount" (specifically indicating sampling site), seal, and initial the seal. Immediately following collection of vaginal/cervical samples and any necessary wet-mount evaluation, the pelvic examination should be performed and any necessary medical cultures taken.

(e) Penile sample.

1 Slightly moisten swabs with distilled water and thoroughly swab the external surface of the penile shaft and glans. Swab all outer areas of the penis and scrotum where contact is suspected.

2 Gently roll the swabs over one of the microscope slides, according to jurisdictional policy.

3 Air-dry swabs and slides.

4 Package slides and swabs, place in envelope, label, seal, and initial the seals.

5 Immediately following this procedure, any necessary medical cultures should be taken.

(f) Perineal area sample.

1 If there was vaginal/anal contact, there may be leakage of semen in the perineal area. Use an alternate light source on the anal area and flake off or swab areas of dried secretions.

2 Optional: Smear swabs on microscopic slides, according to jurisdictional policy.

3 Flaked dried secretions should be placed into the provided container. Air-dry swabs and slides and package them separately. Place in envelope, label, seal, and initial the seal.

4 Avoid contaminating anal/rectal samples by cleansing the perianal area after external secretions and foreign materials have been collected.

(g) Anal/rectal sample.

1 Collect swab from the anal cavity. Avoid contact with external skin surfaces.

2 Optional: Smear swabs on microscopic slides, according to jurisdictional policy.

3 Air-dry swabs and slides.

4 Package swabs and slides, place in envelope, label, seal, and initial the seal.

5 At this time, any additional examinations or tests involving the anus should be conducted.

(6) Buccal swabs, saliva, and blood for deoxyribonucleic acid (DNA) analysis and comparison.

(a) Many samples collected during the exam contain a mixture of secretions. To interpret genetic typing results obtained from these swabs, it is essential to know the genetic profile of patients. The patient's DNA reference samples are used for this purpose. Follow jurisdictional policy regarding the type of samples accepted by the

crime lab. Collection of a buccal swab or saliva sample is encouraged unless it is medically or forensically necessary to take blood. If a blood sample is collected, the most noninvasive method of collection should be used.

(b) Buccal swabs.

1 On a case-by-case basis, decide whether it is appropriate to collect a buccal (inner cheek) swab reference sample for DNA typing rather than a blood sample. For example, a blood sample may not be needed or patients might not allow blood to be drawn. A saliva sample is an alternative to the buccal swab. (Note that buccal swabs and saliva samples are not suitable for blood typing and serology.) If oral copulation is asserted or suspected, a buccal swab or saliva sample for the patient's DNA reference may be contaminated. In those cases, blood is usually the better reference sample.

2 To collect, have patients rinse their mouths with tap water and then expose the inner cheek area. Swab this area with gentle pressure. Air-dry the swab. Package, place in envelope, label, seal, and initial the seal.

(c) Saliva sample.

1 Have patients saturate with saliva the inner circle of a folded piece of absorbent paper (e.g., filter paper).

2 Allow the paper to air-dry according to jurisdictional policy.

3 Without touching the inner circle, package the paper, place in envelope, label, seal, and initial the seal. (Patients should not eat, drink, or smoke for at least 15 minutes prior to the saliva sample collection.)

(d) Dry blood.

1 If drawn blood is not being collected for medical or toxicological purposes, consider dry blood collection because it is a less invasive method of blood collection.

2 Using a betadine swab, wipe the tip of the left or right ring finger.

3 Using a sterile lancet, prick the finger.

4 While holding the finger over one of four circles on the blood collection card, milk the finger, allowing two drops of blood to fall in a circle. Repeat procedure for the remaining circles as required by jurisdictional policy (it may not be necessary to fill all four circles).

5 Allow blood to air-dry according to jurisdictional policy. Fill out the patient's name on the first line. Package according to jurisdictional policy, then place in envelope, label, seal, and initial the seal.

(e) Drawn blood.

1 In order to minimize the patient's discomfort, collect drawn blood needed for the reference sample at the same time blood is collected for medical or toxicological purposes.

2 Blood for the reference sample may be collected in lavender-top and/or yellow-top blood drawing tubes. These colored tubes contain preservatives suitable for forensic blood typing. The color to use is typically specified by the designated crime lab. If tubes are included in the evidence collection kit, check expiration dates and replace if expired. Mix according to jurisdictional policy.

3 Write the patient's name, date and time of collection, and the collector's initial on the tube. Package according to jurisdictional policy, then place in envelope, label, seal, and initial the seal.

(f) Collect other evidence. Other evidence may be collected beyond what is needed for the sexual assault evidence collection kit.

c. Toxicology samples.

(1) Make the decision about whether to collect toxicology samples for forensic purposes, what to collect, and collection methods according to jurisdictional policy.

(2) Do not put toxicology samples in the sexual assault evidence collection kit, unless otherwise indicated. Identify which forensic labs the jurisdiction has selected to analyze these samples, choose a lab, and follow transfer policies.

(3) Keep medical specimens separate from forensic specimens obtained during the exam. Specimens collected for medical purposes should be kept and processed at the medical facility, and specimens collected for forensic analysis should be transferred to the crime laboratory or other specified laboratories for analysis (with the patient's consent).

(4) It is not necessary to maintain the chain of custody on medical specimens; instead, follow exam facility policy for documenting medical care and storing medical records.

13. DRUG-FACILITATED SEXUAL ASSAULT.

a. Training and development of policies.

(1) MTF providers must recognize that sexual assault assailants may use numerous drugs (including alcohol) to facilitate sexual assault and also understand the urgency of collecting toxicology samples, if medically necessary, or if a drug-facilitated sexual assault is suspected.

(2) MTF providers should also be aware that collection of toxicology samples is typically separate from the sexual assault forensic evidence collection kit, and procedures for toxicology analysis may be different from that of other evidence analysis.

(3) Ideally, the first available urine sample should be collected in suspected drug-facilitated sexual assault cases.

(4) Law enforcement agencies and emergency medical services should develop procedures and staff training for collection in cases where patients must urinate before arriving at the exam site. Advocates and other professionals who may have contact with patients prior to their arrival at the exam site should also be educated to provide those who suspect that drugs were used to facilitate the assault with information on how to collect a sample if they cannot wait to urinate until they get to the site.

b. Response to voluntary use of drugs and/or alcohol.

(1) It may be revealed during the exam process or through toxicological analysis that patients voluntarily used drugs and/or alcohol just prior to the assault.

(2) Voluntary drug and/or alcohol use by patients during this period should not diminish the perceived seriousness of the assault. Law enforcement officers and prosecutors should guard against disqualifying cases in which patients voluntarily used illegal drugs or illegally used alcohol.

(3) Patients should understand that information related to voluntary alcohol or drug use may be used against them in court, but also that in some instances it might be helpful in prosecuting a case (see para d below on explanation of procedures). Also, before pursuing charges related to illegal drug or alcohol use by patients, prosecutors should give great weight to the impact that the threat of such charges may have on the patient's willingness to report the sexual assault and be involved in subsequent criminal justice proceedings.

(4) It is important to document patient voluntary use of drugs and alcohol between the time of the assault and the exam.

(5) Some patients may self-medicate to cope with post-assault trauma and require immediate medical treatment. In addition, ingestion of drugs and/or alcohol during this

period may affect the quality of evidence and impede the patient's ability to make informed decisions about treatment and evidence collection.

c. Circumstances in which testing may be indicated.

(1) Routine toxicology testing is not recommended. However, in any of the following situations, the collection of a urine and/or blood sample may be indicated:

(a) If a patient's medical condition appears to warrant toxicology screening for optimal care (e.g., the patient presents with drowsiness, fatigue, light-headedness, dizziness, decreased blood pressure, memory loss, impaired motor skills, or severe intoxication);

(b) If a patient or accompanying persons (e.g., family member, friend, or law enforcement representative) states the patient was or may have been drugged; and/or

(c) If a patient suspects drug involvement because of a lack of recollection of event(s).

(2) Patients should be questioned about involuntary drug/alcohol use only if determined to be medically necessary or if there is a suspicion the assault was drug-facilitated.

d. Explanation of testing procedures.

(1) Seek informed consent from patients to collect toxicology samples. Patients should understand the following before agreeing to toxicology testing:

(a) The purposes of toxicology testing and the scope of confidentiality of results;

(b) The ability to detect and identify drugs and alcohol depends on collection of urine and/or blood within a limited time period following ingestion;

(c) There is no guarantee that testing will reveal that drugs were used to facilitate the assault;

(d) Testing may or may not be limited to drugs commonly used to facilitate sexual assault and may reveal other drugs or alcohol that patients may have ingested voluntarily;

(e) Whether any follow-up treatment is necessary if testing reveals the presence of drugs used to facilitate sexual assault;

(f) Test results showing voluntary use of drugs and/or alcohol may be discoverable by the defense and used to attempt to discredit patients or to question their ability to accurately perceive the events in question (however, these results could also help substantiate that voluntary drug and/or alcohol use sufficiently impaired the patient's consent and prevented legal consent);

(g) Whether there is a local prosecution practice of charging sexual assault victims for illegal voluntary drug and/or alcohol use revealed through toxicology screening;

(h) Failure or refusal to undergo testing when indicated by circumstances as described above may negatively impact the investigation and/or prosecution;

(i) When and how to obtain information on the results from toxicology testing;

(j) Who will pay for toxicology testing; and

(k) Whether patients have the opportunity to revoke their consent to toxicology testing.

(2) Care should be taken when providing the above information to patients. In particular, they may need to hear repeatedly from examiners that voluntary use of drugs and/or alcohol, if any, does not reduce the seriousness of the assault. Under no circumstances should the medical forensic exam and treatment be conditioned upon patient consent to toxicology testing.

e. Collecting samples.

(1) Toxicology samples should be collected as soon as possible after a suspected drug-facilitated case is identified and informed consent is obtained, even if patients are undecided about reporting to law enforcement.

(2) The length of time that drugs used for drug-facilitated assault remain in urine or blood depends on a number of variables (e.g., the type and amount of drug ingested, the patient's body size and rate of metabolism, whether patients had a full stomach, and whether they previously urinated).

(3) Collect a urine sample.

(a) Urine allows a longer window for detection of drugs commonly used in these cases than does blood. The sooner a urine specimen is obtained after the assault, the greater the chances of detecting drugs that are quickly eliminated from the body.

(b) Immediately collect a urine sample when appropriate. If patients may have ingested a drug used for facilitating sexual assault within 96 hours prior to the exam, a urine specimen of at least 30 milliliters but preferably 100 milliliters (about 3 ounces) should be collected in a clean plastic or glass container (follow jurisdictional policy).

(c) The urine sample does not have to be a clean catch (e.g., blood in the urine will not compromise test results). If patients cannot wait to urinate until their arrival at the exam facility, first responders should ask them to provide a sample and bring it to the facility, documenting the chain of custody. It is suggested that law enforcement officers and emergency medical technicians keep toxicology screening kits readily available, according to local agency policy.

(d) Ideally, patients should not urinate until after evidence is collected. However, the number of times that patients urinated prior to collection of the sample should be documented.

(4) Collect a blood sample when appropriate.

(a) If ingestion of drugs used to facilitate sexual assault may have occurred within 24 hours prior to the exam, a blood sample of at least 20 milliliters should be collected in a gray-top tube (contains preservatives sodium fluoride and potassium oxalate) according to jurisdictional policy.

(b) A blood sample taken within this time period may pinpoint the time when drugs were ingested. If a blood sample is collected for toxicology screening, it should be accompanied by a urine sample.

(c) If blood alcohol determination is needed, collect blood within 24 hours of alcohol ingestion, according to jurisdictional policy. (If blood has already been taken due to suspected drug ingestion, that sample can be used to determine blood-alcohol level. An additional sample usually is not needed.)

(5) Occasionally, patients of drug-facilitated sexual assault vomit. The analysis of the vomit may also be useful to an investigation. Collect and preserve according to jurisdictional policy.

(6) Package all samples as appropriate, but pay particular attention to toxicology samples and package according to the policy of the lab doing the analysis, place in envelope, label, seal, and initial the seal.

f. Toxicology labs.

(1) Exam facility laboratories should not analyze toxicology samples in suspected drug-facilitated sexual assault cases. Instead, involved criminal justice

agencies should identify forensic laboratories that can analyze these toxicology samples (they should have the capacity to detect drugs in very small quantities). Information about these labs (e.g., contact information, evidence collection and packaging procedures, and transfer procedures) should be provided to law enforcement representatives investigating these cases, exam facilities, and examiner programs.

(2) If toxicology tests are needed purely for the medical evaluation of patients, the exam facility lab typically performs these tests. Lab results are recorded in the patient's medical record, according to facility policy. If toxicology samples are needed for both clinical and forensic purposes, one sample can be collected for immediate evaluation by the exam facility lab and another for analysis by the identified forensic lab. Take samples at the same time to minimize patient discomfort.

g. Preservation of evidence and chain of custody.

(1) Involved health care personnel should be aware of the toxicology lab's requirements on collection, packaging, labeling, storage, handling, transportation, and delivery of specimens.

(2) Policies should be in place for storage of these samples when patients are undecided about reporting. As with any forensic evidence, the chain of custody must be maintained.

14. SEXUALLY TRANSMITTED INFECTIONS: EVALUATION AND CARE.

a. Information on sexually transmitted infections (STIs).

(1) Offer patients information to include the risks of STIs, symptoms and the need for immediate examination if symptoms occur, testing and treatment options (and the need for abstinence from sexual intercourse until treatment is completed), follow-up care, and referrals as needed.

(2) Patients should be aware of the scope of confidentiality related to STI information in their medical records. The level of detail needed when providing this information verbally varies (e.g., some patients may be aware of risks and want treatment, while others may not be as knowledgeable of risks or their options).

b. STI testing.

(1) The medical forensic exam presents an opportunity to identify preexisting STIs, regardless of when they were acquired, and for examiners to make recommendations for specific treatment. Testing for STIs at the time of the exam also gives examiners and patients the option of deferring treatment until it is needed.

(2) Trichomoniasis, bacterial vaginosis, gonorrhea, and chlamydial infections are the most frequently diagnosed infections among sexually assaulted women.

(3) Seek the informed consent of patients for testing, if indicated, following Center for Disease Control (CDC) guidelines.

(4) The identification of STIs after an assault is usually more important for psychological and medical management than for forensic purposes.

c. STI prophylaxis.

(1) Encourage patients to accept STI prophylaxis, if indicated.

(2) Routine preventive therapy after a sexual assault is often recommended because follow up with these patients can be difficult. It also may reduce the need for more expensive/extensive treatment if an STI is discovered at a later time.

(3) Meet or exceed current CDC guidelines for STI preventive therapy.

(4) If prophylaxis is declined at the time of the initial exam, it is medically prudent to obtain cultures and arrange for a follow-up examination and testing (it is recommended that all patients are reexamined (see para d below on follow-up activities)).

(5) Document, in their medical record, the patient's decision and rationale for declining prophylaxis.

(6) For nonsexually active patients, taking a prophylaxis may prevent development of STIs that could be used as evidence if the suspect had an STI. In all cases, the patient's medical needs take priority over collection of forensic evidence. However, patients should be aware of this consequence of taking the STI prophylaxis and be able to make their own decisions about treatment.

(7) If the patient's clinical presentation suggests a preexisting ascending STI, such as fever, abdominal or pelvic pain, and/or vaginal discharge, they should be evaluated and treated for the ascending infection. This treatment may differ from suggested STI prophylaxis.

(8) Hepatitis B virus (HBV) and postexposure prophylaxis.

(a) See CDC recommendations related to HBV diagnosis, treatment, prevention, postexposure immunizations, prevaccination antibody screening, postexposure prophylaxis, and special considerations.

(b) Patients who have completed a full hepatitis B vaccination regimen prior to the assault are protected from HBV infection and do not need further doses. For those who were not fully vaccinated prior to the assault, the vaccine should be completed as scheduled.

(c) Patients unvaccinated prior to the assault or unsure of whether they have been vaccinated should receive active post-exposure prophylaxis (e.g., hepatitis B vaccine alone) upon the initial clinical evaluation. Follow-up doses should be given 1 to 2 and 4 to 6 months after the first dose. Unless suspects are known to have acute hepatitis B, hepatitis B immune globulin (HBIG) is not required. (When HBIG is needed, use CDC recommended doses.)

(d) Examiners must stress to patients receiving the HBV vaccine the importance of following up for administration of doses as scheduled for full protection. Advocates should also be educated about the possibility of patients receiving HBV prophylaxis and encourage those who start the vaccine regimen to follow up for required additional doses.

(e) Obtain informed consent from patients for treatment. Patients should be aware of the benefits and toxicity associated with recommended regimens.

d. Follow-up care.

(1) Encourage follow-up STI exams, testing, immunizations, counseling, and treatment as directed. Although patients may be reluctant to go for STI follow-up exams, such exams are essential because they provide an opportunity to detect new infections acquired during or after the assault, complete hepatitis B immunization, if indicated, and complete counseling and treatment for other STIs. STI examinations for all patients should be repeated according to exam facility policy. The CDC recommends a follow-up appointment within 1 to 2 weeks of the assault. If patients tested negative at the time of the medical forensic exam and chose not to receive prophylaxis, follow-up testing should be conducted. The CDC recommends that in this case the follow-up exam be done within a week to ensure that positive test results are discussed promptly with patients and treatment is offered. The CDC recommends follow-up testing for patients who received treatment only if they report having symptoms consistent with an STI. (However, patients who were treated should be informed of the option of follow-up testing to confirm the presence or lack of infection.) The CDC recommends that testing for syphilis and human immunodeficiency virus (HIV) infection should be repeated 6, 12, and 24 weeks after the assault if initial test results were negative and if these infections are likely to be present in assailants.

(2) It is important that follow-up communication with patients (particularly by examiners and advocates) include a reminder to go to follow-up exams and receive STI-related testing, immunizations, and treatment as directed. Advocates and health care personnel may be able to assist patients in making follow-up appointments, obtaining transportation to and from appointments, and determining how to pay for expenses involved with follow-up testing and care. Some jurisdictions may cover follow-up treatment as part of initial care through funds such as crime victims' compensation. In such instances, patients may be more apt to seek follow-up

treatment. Advocates may also be able to accompany patients to these follow-up appointments.

e. Concerns about HIV infection.

(1) Although the risk of HIV infection from a sexual assault appears to be low, it is typically of grave concern for sexual assault patients.

(2) Provide information and referrals. Examiners should talk with patients about their concerns regarding the possibility of contracting HIV. As with other STIs, offer patients information about HIV risks, symptoms and the need for immediate examination if symptoms occur, testing and treatment options, and the need for abstinence from sexual intercourse until any treatment received is completed. Include local referrals for testing/counseling and comprehensive HIV services in the community and region. This information can help patients make decisions about testing and treatment based on facts rather than fear.

(3) Discuss testing options. Baseline HIV testing is not typically an exam component. However, if the assault is considered at high risk for HIV exposure, patients should establish their baseline HIV status within 72 hours after the assault and then be tested periodically as directed by health care personnel. However, even if the assault is not considered at high risk for HIV exposure, some patients may still wish to be tested.

(4) HIV testing should occur in settings where counseling can be offered to explain results and implications. When providing testing referrals, let patients know whether testing services are free, anonymous, and/or confidential. Confidential and anonymous testing is recommended.

(5) Assess the need to offer HIV post-exposure prophylaxis. In certain circumstances, the likelihood of HIV transmission may be reduced by post-exposure therapy for HIV with antiretroviral agents. Post-exposure therapy with zidovudine has been associated with a reduced risk for HIV infection and has become the standard of care for health workers who have percutaneous (e.g., needle stick) exposure to HIV, but whether these findings can be extrapolated to other exposure situations, including sexual assault, is unknown.

(6) The use of antiretroviral agents after possible exposure through sexual assault must balance potential benefits of treatment with its possible adverse side effects. Health care personnel must evaluate the patient's risk of HIV exposure and consider whether to offer treatment based on their perceived risk. Examiners unfamiliar with known risks associated with exposure or side effects of postexposure therapeutic agents should consult with an HIV treatment specialist. Numerous factors may influence the decision to offer treatment, such as the time since the exposure occurred, the probability that the assailant is infected with HIV, the likelihood that transmission

could occur from the assault, and the prevalence of HIV in the geographic area or institutional setting (e.g., a prison) where the assault occurred.

(7) Offer post-exposure HIV prophylaxis to patients at high risk for exposure, particularly when it is known that suspects have HIV/AIDS. If offered, the following information should be discussed with patients:

- (a) The unknown efficacy of postexposure prophylaxis for HIV in cases of sexual assault;
- (b) The known side effects and toxicity of antiretroviral medications;
- (c) The need for frequent dosing of medication and the follow-up care necessary;
- (d) The importance of compliance with the recommended therapy;
- (e) The necessity for immediate initiation of treatment for maximum effectiveness; and
- (f) The estimated costs of the medication and monitoring.

(8) When given following a sexual assault, post-exposure prophylaxis is the same as for occupational exposure to HIV. Refer to CDC recommendations for post-exposure antiretroviral therapy and consult with an HIV specialist where possible. Careful monitoring and follow up by a health care provider or agency experienced in HIV issues is required. Patients should be alerted to symptoms of primary HIV infection (e.g., fever, fatigue, sore throat, lymphadenopathy, and rash) and seek care if these symptoms arise.

(9) Seek informed consent of patients to administer treatment. The decision to begin or withhold treatment should be made by patients and health care personnel after patients have been adequately informed of the risks and benefits of treatment options.

15. PREGNANCY.

a. Patients of different ages, social, cultural, and religious/spiritual backgrounds may have varying feelings regarding acceptable treatment options. Examiners and other involved health care personnel must be careful not to influence the patient's choices of treatment.

b. Discuss the probability of pregnancy with female patients. The risk of pregnancy from sexual assault is estimated to be 2 to 5 percent. However, pregnancy resulting from sexual assault often is a cause of great concern and significant additional trauma to the victim; victims' fears, therefore, should be taken seriously. Discussion with patients should include treatment options and reproductive health services.

c. Conduct a pregnancy test for all patients with reproductive capability (with their consent). An exception is if a patient clearly is pregnant. If a patient is pregnant, the pregnancy may affect what medications can be administered or prescribed in the course of or after the exam.

16. DISCHARGE AND FOLLOW UP. This paragraph discusses discharge and follow up of sexual assault victims following the initial presentation at the MTF.

a. Medical discharge and follow-up care. Health care personnel have important tasks to accomplish prior to discharging patients, as do advocates and law enforcement representatives (if involved). Medical personnel should coordinate their activities with all vested parties (e.g., CID) to minimize repetitive actions and to avoid overwhelming the patient.

(1) Forensic examiner. The forensic examiner (preferably an SACP) will address the following issues with patients prior to discharge:

(a) Ensure that the patient's medical and mental health needs related to the assault have been addressed.

(b) Provide the patient with oral and written medical discharge instructions. Include a summary of the exam (e.g., evidence collected, tests conducted, medication prescribed or provided, information provided, and treatment received), medication doses to be taken, follow-up appointments needed or scheduled, and referrals.

(c) Provide the patient with the name and contact information, as well as date and time of a follow-up appointment with the SACP and SACC. Follow-up appointments must be made within 2 duty days of discharge. The patient's immediate follow-up care should be done with the provider who performed the forensic evidence collection.

(2) Offer patients clear and concise information, both orally and in writing. Information should be tailored to the patient's communication skill level/modality and language.

b. Coordination among responders.

(1) The SACP.

(a) At the initial visit, the SACP will develop an individualized plan of care for the victim. The SACP will work in collaboration with the SACC and patient to schedule necessary appointments as indicated by the individualized plan of care. The SACP will ensure that the patient understands his/her right to confidentiality and nondisclosure and that he/she does not have to disclose the assault to additional providers in order to receive follow-up medical care.

(b) For those with evidence of acute trauma, a short-term follow-up appointment will be scheduled to reexamine and document the development of visible findings and photograph areas of injury. An exam will be scheduled 2 to 4 weeks later to document resolution of findings or healing of injuries.

(c) Repeat exams for STIs according to established documented guidelines and protocols.

(d) SACP's or other nonacute care providers can provide longer-term care as needed (e.g., for HIV testing, STI testing, and administering doses of Hepatitis B vaccine).

(e) The SACP will work in collaboration with the Installation Victim Advocacy Program.

(2) SACCs.

(a) The SACC will monitor the provision of care for victims of sexual assault until the completion of care related to the sexual assault or up to 6 months at which time the plan will be reassessed by the SACP. Upon completion of all sexual assault related care, the SACP will document in the outpatient treatment record the resolution and/or the need for the continuation of care related to the sexual assault.

(b) Personnel following up with patients should be familiar with the case, confidentiality issues, and potential medical needs. Explain follow-up contact procedures of all responders involved. Coordinate follow-up contact of involved agencies as much as possible, keeping the number of responders contacting patients to a minimum. Explain if contact procedures are different for non-English-speaking patients.

(c) After the exam is finished, address the patient's physical comfort needs. Help patients plan for their safety and well being. Jurisdictional and exam site policies should be in place to facilitate this process. Assist patients in developing a post-exam plan that addresses their physical safety and emotional well being. Screen for domestic and dating violence and other forms of abuse. Assist patients in considering things such as--

1 Where are they going after being discharged? With whom? Will these individuals provide them with adequate support? Is there anyone else they would like to contact? (Provide information about available community resources for obtaining support and help in making the contact if needed.)

2 Will their living arrangements expose them to the threat of continued violence or harassment? Is there a need for emergency shelter or alternative housing options? (Provide options and help obtain if needed.)

3 Are they eligible for protective orders? (Provide information and help obtain if desired.)

4 Is there a need for enhanced security measures? (Discuss options and help obtain if desired.)

5 If they feel unsafe, what will they do to get help? (Discuss options and help them develop a plan.)

(d) Planning must take into account the needs and concerns of specific populations. For example, if patients with physical disabilities require shelter, the shelter must be accessible and staff able to meet their needs for personal assistance with activities of daily living. If patients living in institutional settings have been assaulted by another resident, a staff person, or person who has easy access to residents, the institution should offer alternative living arrangements and reduce the likelihood that patients have to come into contact with the assailant again. It should also ensure them access to services designed to promote their recovery.

(e) Review and explain available supportive services. The SACP and SACC will explain to the patient the role of the Victim Advocacy Program in his/her health care. The SACC can describe and offer patients, their family members, and friends these services, as well as explain options for counseling in the community and offer referrals. The SACP and SACC will explain/reinforce the patient's role and responsibilities in the continued care and management of his/her health care related to the sexual assault. Before being discharged, the SACC should ask patients if they can follow up with them. If they agree, they can determine optimal methods and times for the contacts. During follow-up contacts, the SACP and SACC can help patients reassess their safety, offer support and crisis counseling, answer their questions and provide additional referrals and information, and help coordinate other advocacy services and counseling based upon identified needs.

(f) The SACC will work in collaboration with the SACP and patient to schedule necessary appointments as indicated by the individualized plan of care.

(g) The SACC will work in collaboration with the Installation Victim Advocacy Program.

APPENDIX A

References

Section I

Required Publications

There are no entries in this section.

Section II

Related Publications

AR 40-66
Medical Record Administration and Health Care Documentation.

AR 195-5
Evidence Procedures.

AR 600-20
Army Command Policy.

AR 608-18
The Army Family Advocacy Program.

Joint Commission on Accreditation of Healthcare Organizations Accreditation Manual for Hospitals, current edition.

Office of The Surgeon General Memorandum
Sexual Assault Victims: Army Medical Department Sexual Assault Response Program
ICD-9 Clinical Modification Coding Guidance, 4 Nov 04.

TB MED 293
Procedures for Medicolegal Examinations in Alleged Sex Crimes, 30 May 75.

U.S. Department of Justice, Office on Violence Against Women, September 2004,
Protocol for Sexual Assault Medical Forensic Examinations.

Section III
Prescribed Forms

MEDCOM OP 29-1-R, Sexual Assault Medical Examination Report

MEDCOM OP 29-2-R, Sexual Assault Patient Release Statement

MEDCOM OP 29-3-R, Sexual Assault Photographic Release

MEDCOM OP 29-4-R, Sexual Assault History

MEDCOM OP 29-5-R, Sexual Assault Physical Examination and Collection of
Laboratory Specimens

Section IV
Referenced Forms

DA Form 4137
Evidence/Property Custody Document

APPENDIX B

Forms Implemented by This Regulation

Forms are provided on the following pages and include--

MEDCOM OP 29-1-R, Sexual Assault Medical Examination Report

MEDCOM OP 29-2-R, Sexual Assault Patient Release Statement

MEDCOM OP 29-3-R, Sexual Assault Photographic Release

MEDCOM OP 29-4-R, Sexual Assault History

MEDCOM OP 29-5-R, Sexual Assault Physical Examination and Collection of
Laboratory Specimens

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE **SEXUAL ASSAULT MEDICAL EXAMINATION REPORT** OTSG APPROVED (Date)
For use of this overprint see MEDCOM Regulation 40-36.

Name and Location of Examining Facility: _____

Date of Admission: _____ Time: _____

Hospital ID Number/SSAN: _____

Name of Patient: _____ Gender: _____

Date of Birth: _____ Place of Birth: _____

Address: _____

Brought In By: _____

Agency or Relationship of Escort: _____

Investigator(s) Present: _____

Others Present: _____

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC

DATE

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)

HISTORY/PHYSICAL

FLOW CHART

OTHER EXAMINATION OR EVALUATION

OTHER (Specify)

DIAGNOSTIC STUDIES

TREATMENT

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE

SEXUAL ASSAULT PATIENT RELEASE STATEMENT

For use of this overprint see MEDCOM Regulation 40-36.

OTSG APPROVED *(Date)*

I, _____ hereby request and authorize the staff of _____ to conduct such medicolegal examinations and clinical procedures, including the collection and examinations of specimens as are necessary for diagnosis, and treatment, as well as investigation. Furthermore, I hereby authorize and request the medical staff to supply all items of evidence and copies of medical and laboratory reports to the appropriate investigative agency for use in the investigation and any resulting legal proceedings.

(Person Examined)

(Parent or Guardian (if patient is a minor dependent))

Date: _____

Witness: _____

PREPARED BY *(Signature & Title)*

DEPARTMENT/SERVICE/CLINIC

DATE

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

HISTORY/PHYSICAL

FLOW CHART

OTHER EXAMINATION OR EVALUATION

OTHER (Specify)

DIAGNOSTIC STUDIES

TREATMENT

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE

SEXUAL ASSAULT PHOTOGRAPHIC RELEASE

OTSG APPROVED (Date)

For use of this overprint see MEDCOM Regulation 40-36.

I, _____ hereby request and authorize the staff
of _____ to take and reproduce

photographs of evidence relating to the assault which occurred (date and time) _____.
I authorize the criminal investigative agency to assume and maintain custody of these photographs. The release of
these photographs is conditioned upon them being viewed only by those persons officially involved in the investigation
or legal proceedings which may be initiated as a result of this assault.

(Person Examined)

(Parent or Guardian (if patient is a minor))

Date: _____

Witness: _____

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC

DATE

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last,
first, middle; grade; date; hospital or medical facility)

- HISTORY/PHYSICAL
- OTHER EXAMINATION OR EVALUATION
- DIAGNOSTIC STUDIES
- TREATMENT
- FLOW CHART
- OTHER (Specify)

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE

SEXUAL ASSAULT HISTORY

For use of this overprint see MEDCOM Regulation 40-36.

OTSG APPROVED (Date)

1. Summary of patient's description of assault: _____

2. Age: _____ 3. Gravidity: _____ 4. Parity: _____

5. List prior admissions to hospital: _____

6. When did last period begin? _____ Normal ? Yes No

When did period end? _____

7. When did last pregnancy end? _____ 8. How did last pregnancy end? _____

9. Most recent coitus prior to alleged assault: Date: _____ Time: _____

Where did activity take place? _____

Condom used? Yes No

10. Current mode of contraception used by patient, if any: _____

11. Vaginal tampons used? Yes No

Age begun? _____

a. Used at time of assault? (advise investigator) Yes No

b. Used subsequent to assault? Yes No

c. Other sanitary devices used? Yes No

d. Collect sanitary device if present during Step 7 of examination.

(Continued on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC

DATE

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)

HISTORY/PHYSICAL

FLOW CHART

OTHER EXAMINATION OR EVALUATION

OTHER (Specify)

DIAGNOSTIC STUDIES

TREATMENT

SEXUAL ASSUALT HISTORY (Continued)

12. Douching practiced?

Yes No

Most recent: _____

13. During reported assault:

Did penis penetrate vulva?

Yes No Don't know

Assailant experience orgasm?

Yes No Don't know

If so, where? _____

Did assailant wear a condom?

Yes No Don't know

Did assailant attempt/consumate: fellatio anal intercourse cunnilingus Not applicable

14. Since reported assault has patient:

Douched?

Yes No

Bathed or showered?

Yes No

Defecated?

Yes No

Urinated?

Yes No

Brushed teeth/gargled, etc.?

Yes No

15. Has patient knowledge of:

Any present medical problems?

Yes No

Any current medications?

Yes No

Any allergy (penicillin or other)?

Yes No

16. In 24 hours immediately prior to the exam, did patient use alcohol or other drugs?

Yes No

If so, type of drug, as well as time and amount of ingestion:

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE **SEXUAL ASSAULT PHYSICAL EXAMINATION AND COLLECTION OF LABORATORY SPECIMENS**

OTSG APPROVED (Date)

For use of this overprint see MEDCOM Regulation 40-36.

The examination outline has been designed to facilitate evidence collection by minimizing the potential for cross contamination of anatomical sites and loss of trace evidence, while at the same time providing a tool to access medical and psychological needs of the patient. Variations should be well considered. The investigator will ask for an explanation of "no" responses.

Indicate if procedure was done

1. **Blood Pressure:** _____ Yes No

Pulse: _____ Yes No

Respiration: _____ Yes No

Temperature: _____ Yes No

2. **Mental Status:** (Describe) Yes No

3. **General appearance of patient and clothing.** (Describe, then photograph using color negative film)

4. **Collection of Clothing:** Was this worn at time of assault? Yes No

If no advise Investigator.

- a. Have patient disrobe while standing on the large paper sheet.
- b. Place each clothing item in a separate paper bag. Don't use plastic, clothing will mold.
- c. Label each bag.
- d. Fold paper sheet; tape it shut and place it in the appropriately labeled envelope.

5. **Body Surface Examination:** Yes No

Locate, describe and photograph (with and without a scale) any evidence of injury or adherent foreign matter. (Examine with the aid of a Wood's lamp [UV light] as well as normal room lighting.)

a. Annotate any such evidence on body diagram chart (attached, pp. 6 and 7).

b. **Bite Marks:** Yes No

If found or suspected, seek the assistance of a dentist, preferably one with forensic training and discuss documentation requirements with the investigator.

Note: If numerous swabbings under this step are required, use the two sterile swabs provided in this kit and if necessary, from hospital supplies. Place these swabs in containers as indicated in Step 5b(4) below. Always ensure that at least 4 swab tubes will be available for steps 6 and 7.

- (1) Photograph with and without scale.
- (2) Remove a swab from the cap of the swab tubes, and moisten with 2-3 drops of sterile water. Swab area inside dental arch marks. Remove the second swab from the cap and return the used swab to the cap. Return cap to tube and label tube.

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC

DATE

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)

- HISTORY/PHYSICAL FLOW CHART
- OTHER EXAMINATION OR EVALUATION OTHER (Specify)
- DIAGNOSTIC STUDIES
- TREATMENT

- (3) Using the second swab from the above tube, prepare a control swab by swabbing the area adjacent to the bitten area with a swab moistened in sterile water.
 - (4) Remove the top from a "red top" tube (vacutainer). Place the control swab in the tube and press top back into place. If screw top plastic tubes are available, they may be used instead. Label tube.
 - (5) Ensure that castings are made of any impressions.
- c. Blood or Semen Stains: Yes No
Collect suspected stains as follows: (Semen will normally fluoresce under UV light.)
- (1) On skin, if stained area is caked. scrape the dried material with edge of slide into a coin envelope. Label envelope.
 - (2) If insufficient caked material is present, or material is not caked, swab stain. Follow procedures used in 5b(2)-through 5b(4) above.
 - (3) In hair, clip the entire area of stain and place in a coin envelope after air drying. Label envelope.
- d. Other Stains or Debris: Yes No
Depending on the matter involved, pick with tweezers, scrape, or swab as necessary to remove. (If solvent must be used try water, alcohol, or acetone in that order, providing control samples of whatever is used.)
- (1) Place in appropriate containers (see methods for similar specimens).
 - (2) Label containers.
- e. Breast and Other Anatomic Swabbings: Yes No
If the patient reports oral contact with the breasts or other parts of the body, swab those areas where such contact was reported. Follow procedures used in 5b(2) through 5b(4) above.

6. Head Examination and Specimen Collection:

- a. Head hair combings: Yes No
- (1) Place a small paper sheet under the patient's head.
 - (2) Comb the head to collect all possible debris and foreign hairs.
 - (3) Place the comb, retrieved hair and any collected debris on the sheet.
 - (4) Fold up the sheet, tape (seal) it shut and place it in the appropriately labeled paper envelope.
- b. Oral Specimens:
- (1) Oral Swab: Yes No
 - (a) Remove swabs from the cap of one of the swab tubes. Using one swab at a time, swab gum area and in between teeth. Return swabs to cap.
 - (b) Return cap with swabs to tube and label tube.
 - (2) Culture for gonorrhea Yes No
herpes Yes No
 - (3) Secretor Status: Yes No
 - (a) Ensure patient has not eaten anything for at least 30 minutes. Have patient rinse mouth with water – wait 5 minutes.
 - (b) Have patient thoroughly moisten (without chewing) with saliva, half of a sterile gauze pad. (Pad should be handled with tweezers only.)
 - (c) Place 2nd (unused) portion of gauze pad in a coin envelope marked "Control".
 - (d) Have patient place moistened portion of gauze pad in a ziplock bag provided for "saliva specimen."

7. **Pelvic Examination and Specimen Collection:** If reasonable, avoid having patient urinate at this point. Collect urine specimens after the pelvic exam. (See 12 below) If collection of urine specimens cannot be avoided at this time, follow item 12 instructions.

NOTE: All specimens should be collected before disturbing and manipulating anatomical sites. Speculum should be lubricated with water only.

a. Pubic Hair Combing: Yes No

- (1) Place a small paper sheet under the buttocks.
- (2) Comb the pubic area to collect all possible debris and foreign hairs.
- (3) Place comb, retrieved hair and any collected debris on the paper sheet.
- (4) Fold up sheet, tape (seal) it shut, and place it in the appropriately labeled envelope.

b. Documentation: Describe and document as appropriate findings in the following areas. (Use photographs and attached anatomical chart to facilitate documentation.)

Vulva/Foreskin: _____

Introitus/Glans: _____

Vagina/Penile Shaft: _____

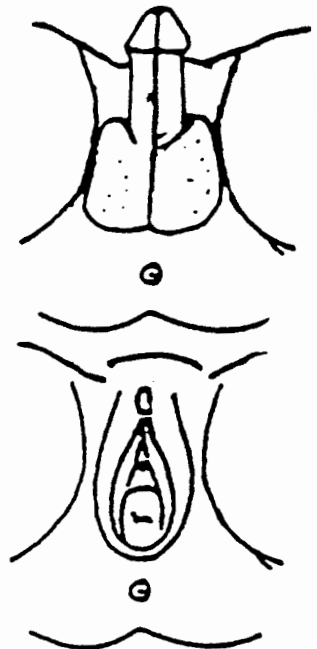
Cervix/Testes: _____

Uterus: _____

Adnexa: _____

Hymen: _____

Rectum: _____



c. Sperm Motility: Yes No

- (1) Remove one of the swabs from the cap of a swab tube. Avoiding cervix, swab vaginal canal.
- (2) Prepare a slide using the vaginal swab to make a smear. Return the swab to cap and moisten smear with one drop of normal saline.
- (3) Examine slide microscopically for presence of sperm.

Motile Non-Motile None Observed

- (4) Air Dry
- (5) Mark slide with identifying data and place in mailer marked "Vaginal Slides".

d. Vaginal/Penile Swab: Yes No

- (1) Avoiding cervix, use the second swab from step 7c(1) above to swab the vaginal canal. If the patient is male, moisten both swabs with 2-3 drops of sterile water and swab the glans penis.
- (2) Return swab(s) to cap, return cap with swabs to tube, and label.

e. Cervical Specimen: Yes No

Repeat steps 7c, 7d, using swabs from cervix or penile shaft.

f. Culture for gonorrhea: Yes No
herpes Yes No

g. Vaginal Aspirate:

- (1) Preferably, aspirate without saline. If saline is necessary, use 1-2 ml.
- (2) Prepare a slide using a drop of vaginal aspirate.
- (3) Place remaining aspirate in a red-top tube. Replace stopper and label tube.
- (4) Examine slide microscopically for presence of sperm.
 Motile Non-Motile None Observed
- (5) Air dry slide.
- (6) Seal and label tube.
- (7) Label slide and place in mailer.

h. Rectal Swab:

Yes No

- (1) Remove both swabs from the cap of a swab tube. Use the swabs one at a time. Swab rectum. (Avoid perianal area).
- (2) Replace swabs in cap and return cap to tube. Label tube.

i. Rectal culture for gonorrhea
herpes

Yes No
 Yes No

8. **Hair standards** (pubic, head and other as appropriate): As a minimum plucked specimens should be obtained from the head and pubic areas.

a. Pubic hair standards:

Yes No

- (1) Pluck a representative sample of pubic hair. Do not use tweezers. (Usually a total of 20 individual hairs from various places in the pubic area is sufficient.)
- (2) Place in appropriately labeled envelope and seal.

b. Head hair standards:

Yes No

- (1) Pluck a representative sample in terms of color, length, and texture of head hair. Do not use tweezers. (Usually about 20 individual hairs selected from various areas of the head will be sufficient.)
- (2) Place in appropriately labeled envelope and seal.

9. **Fingernails**

a. Scrapings:

Yes No

- (1) Place 3" piece of cellophane type tape, adhesive upwards, on a "zip-lock" plastic bag. Using the tip of the nail file on the fingernail clippers, scrape the underside of all nails on one hand, depositing scraping on the tape.
- (2) Stick tape to the inside of bag and seal.
- (3) Label the bag to include "R" or "L" hand as appropriate.
- (4) Repeat the procedure for the other hand.

b. Clippings/Cuttings:

Yes No

- (1) If freshly broken nails are noted, attempt to cut (clip) the broken part off, preserving the broken edge.
- (2) Place specimen(s) in a paper coin envelope. Label envelope.

c. Place nail clippers in appropriately labeled envelope and seal.

10. **Serology and Hematology:** (Four [4] vacutainers [7 ml] of blood)

DO NOT USE ALCOHOL AS A PREP

- a. Typing: Red top and Purple top (EDTA) tubes to Forensic Lab Yes No
- b. Control STD and HIV Red top tube Yes No
- c. Blood Alcohol: Tube type per hospital Yes No
(Initiate chain of custody on DD Form 1323)

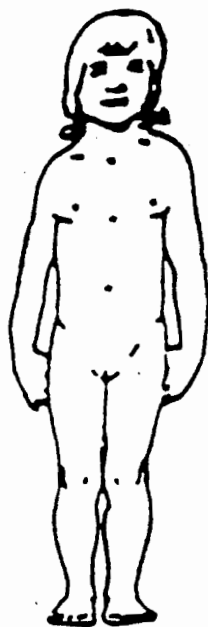
11. **Urinalysis and Toxicology:** (two [2] urine specimens)

- a. Toxicology: Urine drug screen to include THC. Yes No
(Initiate chain of custody on DD Form 1323).
- b. Urinalysis:
 - (1) Examine urine for hematuria Yes No
 - (2) Pregnancy Yes No

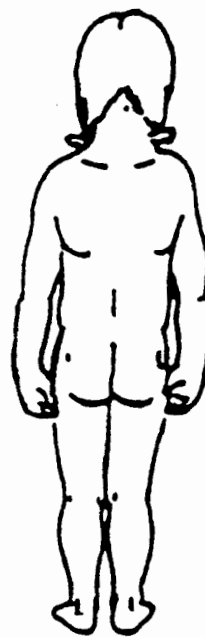
12. **Medical Impressions** _____

13. **Treatment and Follow Up:**

- a. Treatment of Injury Done
- b. Management of STD Risk Done
- c. Management of Pregnancy Risk Done
- d. Psychological Support Done
- e. Medical/Investigative follow up: Yes No
Request patient return to OB/GYN
clinic 36-48 hours later. (Bruises may
take that long to develop.)
- f. Other Yes No



Juvenile Female (front view)



Juvenile Female (rear view)



Adult Female (front view)



Adult Female (rear view)

FIGURE 1 BODY DIAGRAM CHART (FEMALE)

GLOSSARY

Section I Abbreviations

CID.....	Criminal Investigation Division
CDC.....	Center for Disease Control
DNA.....	deoxyribonucleic acid
HBIG.....	hepatitis B immune globulin
HBV.....	hepatitis B virus
HIV.....	human immunodeficiency virus
ICD.....	International Classification of Disease
MTF.....	military treatment facility
MOA.....	memorandum of agreement
MOU.....	memorandum of understanding
PAD.....	patient administration division
SACC.....	sexual assault care coordinator
SACP.....	sexual assault clinical provider
SOP.....	standing operating procedure
STI.....	sexually transmitted infection
USAMEDCOM.....	U.S. Army Medical Command

Section II Terms

Chain of custody. Documented proof from initial receipt through final disposition of the transfer and safekeeping of identified articles between receipt and disposition to prevent tampering with or contamination of evidence (DA Form 4137).

Evidence collection kit. Contains devices used for collecting and preserving medical evidence in support of sexual assault investigations. It includes directional notes to the physician and investigator and the medical examination report with consent authorizations. NOTE: This kit would not be appropriate for victims of chronic sexual abuse without a recent incident; however, a colposcopic examination would be relevant.

Forensic examination. The medical examination, care, and collection of relevant physical evidence in conjunction with supportive medical laboratory testing.

Military treatment facility. All United States Army Medical Centers, medical department activities, U.S. Army health clinics, troop medical clinics, and other health care facilities authorized to provide medical care.

Responders.

First responder. MEDCOM personnel who have the initial contact or encounter with the victim of sexual assault.

Sexual assault responder. Those personnel directly involved in the care and management of sexual assault victims to include the SACP, the SACC, the forensic examiner, victim advocate, social worker, and others as deemed appropriate.

Sexual assault. Sexual assault includes rape, sodomy, indecent acts with another, and indecent acts or liberties with a child.

Sexual Assault Care Coordinator. When available, a social worker (BSW or MSW) or nurse (LVN or RN), familiar with both sexual assault victim dynamics and medical treatment facility procedures. Knowledge of community resources related to services for sexual assault victims and their families is critical.

Sexual Assault Clinical Provider. A privileged health care provider (physician, nurse practitioner, or physician assistant) who has been designated by the Deputy Commander for Clinical Services to manage each sexual assault patient's medical treatment related to the sexual assault incident from initial presentation to completion of all follow-up visits.

Special handling file. File maintained by the patient administration division to safeguard the confidentiality of sensitive medical record information and to ensure its medicolegal integrity. This is the designation given to the outpatient medical record in order to ensure its integrity for possible use in legal proceedings.

The proponent of this publication is the Office of the Assistant Chief of Staff for Health Policy and Services. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) to Commander, U.S. Army Medical Command, ATTN: MCHO-CL-H, 2050 Worth Road, Fort Sam Houston, TX 78234-6010.

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