Sexual Assault Incident Form

SEXUAL ASSAULT INCIDENT FORM
(COMPLETED FORM MUST BE PLACED IN THE SEXUAL ASSAULT EVIDENCE KIT)

Date of Collection/Examination_____ Time:_____ am/pm

Patient's Name: _____

Patient's Hospital Number: _____

Date of Assault: _____ Time:_____ am/pm

Date of Last Consensual Intercourse _____ Condom used at that time? ☐Yes☐No

Patient menstruating at time of exam? ☐Yes ☐No ☐N/A

Number of Assailants _____

Type of Assault:
☐ Oral – Please specify method: ☐ Patient to Assailant ☐ Assailant to Patient
☐ Vaginal ☐ Anal ☐ Unknown
☐ Other _____

Type of Penetration:
☐ Penile ☐ Digital
☐ Unknown
☐ Other _____

Did Suspect Ejaculate
☐ Yes
If yes, where _____
☐ No
☐ Unknown

Was Condom Used:
☐ Yes
☐ No
☐ Unknown

After Assault Did Patient:
☐ Douche ☐ Shower/Bathe
☐ Brush Teeth ☐ Change Clothes
☐ Defecate ☐ Urinate/Wipe
☐ Eat/Drink

Trauma: ☐ Not Present ☐ Present – Describe:_____

_____

_____

_____

Location of Exam (Name of Facility):_____

Examiner: _____ _____
Print Name and Credential Signature

White copy – enclose with kit Yellow copy – law enforcement agency Pink copy – medical records