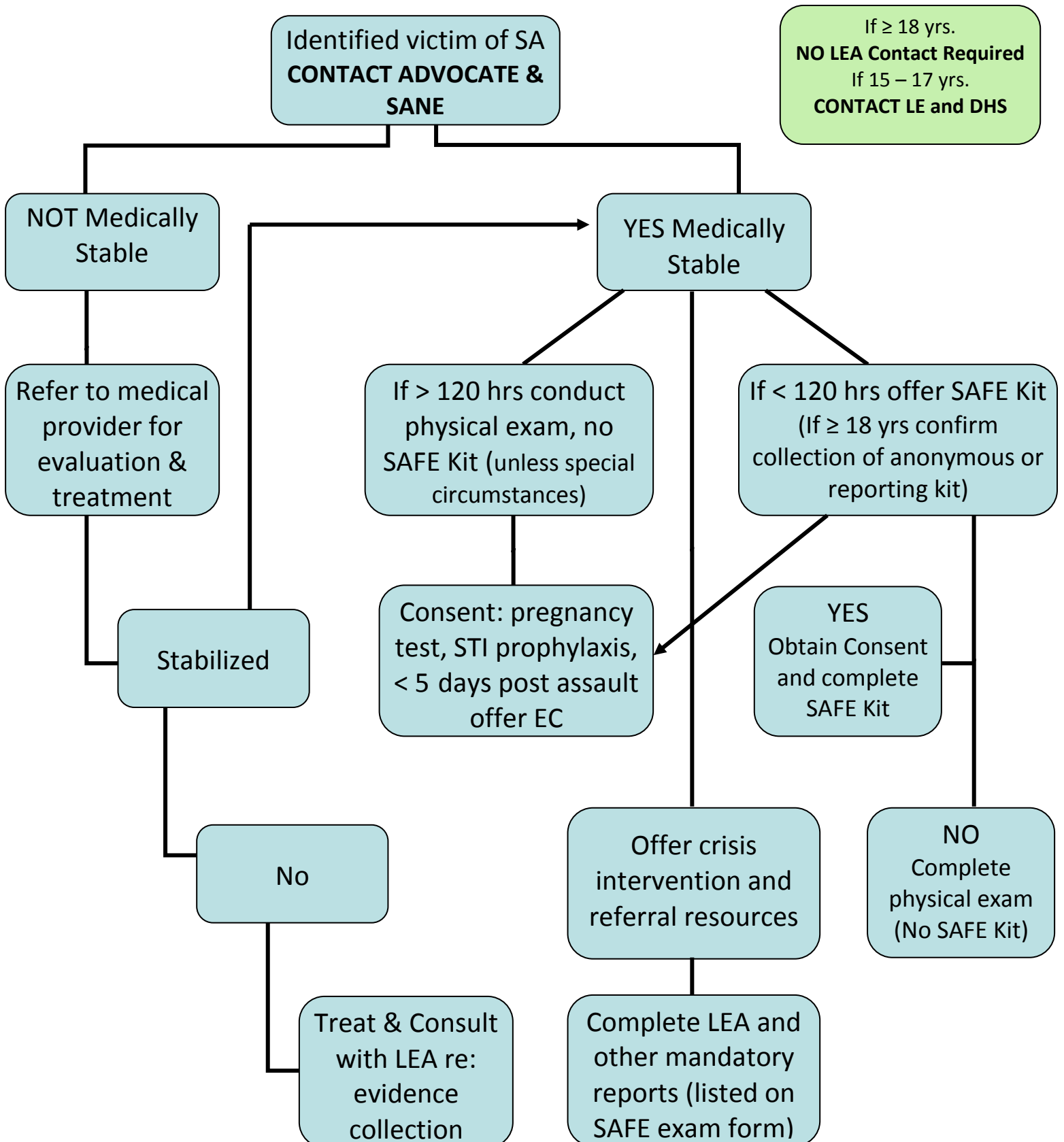


# Sexual Assault (SA) Triage Algorithm for Patients 15 Years and Above



# State of Oregon Medical Guidelines for Sexual Assault Evaluation<sup>†</sup>

## ADOLESCENT (≥ 15 years)/ADULT

### Overview

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

### Age Considerations

- This guideline is for the care of the adolescent (age 15 years and older) and adult with a history or concern of sexual abuse or assault.
- For care of children age 14 years and younger, see the *Oregon Medical Guidelines for Evaluation of Sexual Abuse in Children and Adolescents*, found at <https://www.doj.state.or.us/wp-content/uploads/2017/06/ormedicalguidelines.pdf>.
- **Acute triage assessment should include assessment of the specific aspects of physical and cognitive development of the individual adolescent patient to determine whether the Child or Adult Guideline should be used.**

### Key Points

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

# State of Oregon Medical Guidelines for Sexual Assault Evaluation<sup>‡</sup>

## ADOLESCENT (≥ 15 years)/ADULT

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**I. GENERAL INFORMATION**

**Purpose of Exam**

**Medical/Forensic**

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

**Social/Psychological**

1. Respond to patient’s immediate mental health needs
2. Respond to patient’s support person’s immediate emotional needs and concerns
3. Assess patient safety
4. Explain reporting process, Crime Victims Compensation, Sexual Assault Victims’ Emergency (SAVE) Fund and resources for advocacy and counseling, including campus support resources if patient is a college student
5. Access to advocacy services

**Report/Refer**

1. Refer for follow-up medical care
2. Refer for advocacy or counseling
3. In the case of minors report to Oregon Department of Human Services (DHS) and/or law enforcement agency (LEA) ASAP
4. If report is mandated, report to LEA in the jurisdiction where the crime occurred  
(See section “Mandated Reporting” below)
5. If patient is a college student, discuss option of patient reporting assault to college student conduct office if perpetrator/s are also students

**II. TRIAGE DECISIONS**

**Initial Triage**

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

1. Patients may be evaluated at the ED, PCP, or other clinical setting by a Licensed Independent Provider for a Medical Screening Exam prior to discharge from the facility.

**Medical stabilization always precedes forensic examination**

1. The following history or conditions should be evaluated medically *prior* to the sexual assault exam:
  - History of loss of consciousness
  - Head injury
  - Altered consciousness or mental status
  - Significant facial injury
  - Possible fractures
  - Blunt injury to abdomen or back
  - Active bleeding
  - Strangulation
  - Risk or concern for any life or limb threatening injury
  - Abdominal pain
2. Psychiatric illness
  - If apparent psychiatric illness complicates assessment of alleged sexual assault, both psychiatric assessment and medical forensic exam generally will be necessary. Proceed according to patient tolerance and needs

**Forensic Exam**

**Acute:  
If assault within prior 120  
hours**

**Medical/forensic exam is appropriate on an urgent basis**

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

**Non-Acute:  
If assault >120 hours prior**

**Forensic exam is generally not indicated on emergency basis**

1. Crime lab generally does not recommend evidence collected more than 120 hours after an assault
2. Individual case circumstances may warrant urgent evidence collection beyond 120 hours after assault (i.e., multiple assailants, patient was unconscious for a period of time) or when requested by LEA

**Advocacy**

**Per SB 795 (Chapter 349), medical staff will dispatch an advocate, per their local Sexual Assault Response Team (SART).**

1. Medical staff will dispatch an advocate from their local program as soon as a patient presents for sexual assault-specific care.
2. Medical staff should inform the patient that an advocate is on their way per protocol and that the advocate will explain their role fully, at which point the patient may accept or decline the advocate’s involvement. Medical staff should understand that advocates are the best people to explain the advocacy role and avoid giving patients incorrect or incomplete information about advocacy services.
3. Once the advocate arrives, inform the patient that the advocate is present and offer the patient the opportunity to speak with the advocate one-on-one. Patients may then have the option to decline advocacy services. If the patient does not feel comfortable meeting the advocate in person, then medical staff should give the patient any informational materials delivered by the advocate. Advocate should only be allowed in the patient’s room with patient consent.

**Mandated Reporting**

**Serious Physical Injury/Injury from weapons**

ORS 146.710 to 146.780; ORS 161.015

**Minors < 18 years**

ORS 419B.005 to 419B.045

**Adults ≥18 years**

**Disabled**

ORS 430.735 to 430.765

**Mentally Ill**

ORS 430.735 to 430.765

**Adults ≥65 years of Age**

ORS 124.050 to 124.095

1. Serious physical injury or injury caused by any weapon must be reported to the medical examiner or appropriate designee (per statute) irrespective of reporting the sexual assault
2. Consult with provider (MD, DO, ND, NP, PA)
3. Mandated oral report of injury by telephone or otherwise, and followed soon thereafter by a written report to appropriate medical examiner

1. Nursing and medical providers are mandated to report to police or DHS when they have a reasonable suspicion of child abuse
2. A report to police and DHS is mandatory if patient is under 18 years of age
3. Mandatory reporting applies even when minor has signed for own care
4. Mandated within 24 hours

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

1. If the patient is age 18 years or older and is disabled or mentally ill; or 65 years and over: a report to police and to county Adult Protective Services or State Residential Care Services is mandatory
2. Mandated within 24 hours

**Consent**

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

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

**Release of Information**

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

**Cost of Evidence Collection**

**Within certain timeframes, patients are not charged for the cost of the medical examination, collection of forensic evidence, or other costs associated with the sexual assault incurred at the initial medical visit. These costs are paid for by the Department of Justice through its Sexual Assault Victims' Emergency Medical Response Fund. Patients are not required report to police to access these funds or to have a SAFE Kit collected. Please refer to the SAVE Fund Application for restrictions.**

**III. HISTORY AND INITIAL EVALUATION**

**Discussion with Patient**

1. Discuss each step of the medical and forensic procedures
2. Discuss patient reporting and non-reporting to law enforcement
3. Discuss mandatory DHS and LEA report
4. Let patient know that written information and educational literature will be provided

**Patient Demographic**

**Document the following information if it is available and pertinent**

1. Routine data: patient name, gender, age, birth date, hospital/clinic number or medical records number, home address, phone number; telephone number for parent or guardian if different
2. Date and time of arrival
3. Who accompanied patient, and their relationship
4. Interpreter name, if used, and language
5. Name of LEA assigned officer
6. Name of DHS caseworker if patient is less than 18 years old or adult protective caseworker if adult is disabled
7. LEA case number, if available

**History of Assault****Obtain patient history and document the following:****Facts about assault**

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

**Nature of force used**

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

**Physical facts of sexual assault**

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

**Post assault activity of patient**

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

**Risk factors of assailant regarding hepatitis B/C, syphilis, and HIV, if known**

1. Known or suspected IV drug use
2. Man who has had sex with men
3. From a high risk community
4. STI history or history of prostitution
5. Blood or mucous membrane exposure

**Past Medical History**

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

**IV. PHYSICAL EXAM & EVIDENCE COLLECTION****Forensic Evidence Collection**

1. Standard Sexual Assault Forensic Evidence (SAFE) Kit, provided by Oregon State Police Crime Lab, is used for evidence collection in both reported cases and non-reported cases
2. Complete Oregon State Police Sexual Assault Forensic Lab information form
3. The evidence collection exam is done by a qualified registered nurse or LIP currently licensed in Oregon.



**Chain of Custody of Forensic Specimens**

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

1. Observes specimens OR
2. Designates another staff member to watch specimens (documenting this in chain of custody) OR
3. Secures specimens in freezer, refrigerator, cabinet or specific area

**General Information**

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

**Exam Procedures**

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

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

**Clothing Collection**

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

1. Place each item of clothing in a separate paper bag
2. Place kit number, case number, and contents on each bag. IF the patient is reporting to LEA, put name on bag. Tape bag closed, and sign and date over tape.
3. Maintain chain of evidence for clothing bags. Place in secured area when not directly observed

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

**Underpants**

**Collect patient's underpants routinely, even if changed after assault**

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

**Trace Evidence Collection**

**To collect foreign material which may fall when patient undresses. Omit if patient has bathed or changed clothes since assault**

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

**Photo Documentation General**

1. Medical-forensic examiner may take photographs or may assist law enforcement. Medical-forensic examiner may take photos for law enforcement using law enforcement camera. Only medical-forensic examiner should photograph ano-genital injuries. Advise patient what may happen with the pictures before taking the photographs.
2. Digital photography is the recommended means of photo documentation.
3. Ensure that the correct date and time are set on any camera that is used.
4. Complete body maps are always done.
5. Patient comfort, dignity, and privacy must be a priority at all times. Drape sheet over body whenever possible.
6. Prints of photographs should be labeled individually with patient label and examiner initials on the back of the print. Note each photograph taken in the chart and type of camera used.
7. Consider use of photo log to document the date, time, camera, photographer, and number of photographs.

**Technique**

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

**Ano-Genital Photographs**

1. It is the recommendation of the Medical Forensic Subcommittee of the Oregon Sexual Assault Task Force that ano-genital photos not be taken except in rare circumstances, due to their sensitive nature and their limited usefulness in criminal justice settings.
2. Should ano-genital photos be taken, due to the extremely sensitive nature of these photographs, they are to be kept with the medical record. They are released only in response to a subpoena and are then released directly to the medical expert who is reviewing them.

**Collect standard head hair samples on all patients.**

1. Pre-fold blank sheet of paper in thirds, both horizontally and vertically
2. With gloved hand run fingers through hair to collect any loose hair and place on paper

**Head Hair**

3. 24 head hairs are required. Ask patient if he/she would like to pull hair or would rather the provider do it
4. Bindle paper and place in envelope
5. Seal in envelope, label, sign over seal and place in the Evidence Kit

**Skin Exam:**

**Document**

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

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

**Fingernail Debris/Swabbing**

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

1. Place small paper sheet labeled "Left hand" or "Right hand" on flat surface
2. If scraping: using disposable plastic scraper or clean, disposable blunt metal scissors, or sterile clipper/scissors, scrape under all five fingernails of each hand, allowing any debris to fall onto paper. Fold scraper in paper, place each paper in a separate labeled envelope.
3. If swabbing: use one moistened swab under all five fingernails of one hand, then swab the same five fingers with a dry swab. Do the same procedure with the other hand. Dry swabs, place the paper immediately into envelopes and once swabs are dry, place those in the same envelope as the corresponding papers.
4. Alternatively, with patient's permission, cut fingernails
5. Patient may be able to do this with direct supervision
6. Bindle paper (using a square or rectangular piece of paper, fold all edges inward so that there are no open edges) to retain debris and scraper
7. Seal envelope (do not LICK), place patient label over seal, sign over seal and store securely in the Evidence Kit

**Skin and Hair Debris**

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

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

**Forensic Swabs**

**Collect when assault occurred within last 120 hours:**

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

<p><b>Swab Technique</b></p>	<ol style="list-style-type: none"> <li>1. Use 4 cotton swabs for moist mucous membranes, 2 cotton swabs (moist to dry) on non-mucous membranes</li> <li>2. Lightly moisten one swab with tap water if secretions are dried</li> <li>3. Swab areas of possible dried secretions, follow moist swabbing with one dry swab</li> <li>4. Label swabs with site where collected</li> </ol>
<p><b>Oral Exam</b></p>	<p><b>Document</b> <b>Lacerations, abrasions, petechiae, and bruises. Check mucosa, palate, upper/lower frenula, and tongue</b></p>
<p><b>Forensic Swabs</b></p>	<p><b>Collect four swabs when</b></p> <ol style="list-style-type: none"> <li>1. Abuse/assault occurred within prior 24 hours or</li> <li>2. Visible oral injury or</li> <li>3. History of oral/genital contact in prior 24 hours</li> </ol>
<p><b>Reference Swabs</b></p>	<p><b>Collect reference oral standard swabs to establish patient DNA</b></p> <ol style="list-style-type: none"> <li>1. Use 4 swabs on mucous membranes,</li> <li>2. Vigorously swab inside of cheek of the mouth</li> <li>3. Process as forensic swab (page 15)</li> </ol>
<p><b>Pubic Hair Combing, Plucking and Cutting</b></p>	<p>If pubic hair is present comb onto a paper and bundle</p> <p><b>CONSIDER plucking pubic hairs when one or more of the following conditions apply:</b></p> <ol style="list-style-type: none"> <li>1. Stranger or unknown assailant or multiple assailants</li> <li>2. Foreign pubic hair is collected in the pubic combing</li> <li>3. Assailant is an acquaintance that has not previously been in the environment where the assault(s) occurred</li> <li>4. Matted pubic hair should be cut in addition to plucking.</li> </ol> <p><b>If plucking is necessary ASK THE PATIENT IF THEY WANT TO PLUCK THEIR OWN. Collect 24 hairs from all around the pubic area via combing, plucking, or shed hairs</b></p>
<p><b>Genital Exam – Female</b></p>	<p><b>Document</b> <b>Genital lacerations, abrasions, bruises, petechiae, erythema, inflammation, bleeding, edema, and discharge; Tanner Stage</b></p> <p><b>Forensic Swabs</b> Use 4 cotton swabs on moist mucous membranes, 2 cotton swabs (one moist then one dry) on non-mucous membranes</p> <p><b>Collect when</b></p> <ol style="list-style-type: none"> <li>1. Assault occurred within prior 120 hours and</li> <li>2. History of penile-genital or oral-genital contact or</li> <li>3. Report of contact to genitalia, perineum, or anus by any part of assailant's body or</li> <li>4. Ejaculation occurred near anogenital area or</li> <li>5. Visible acute genital or anal injury or</li> <li>6. Alternate light source scan is positive</li> </ol>
<p><b>External Genital Area Swabs</b></p>	<p><b>Collect routinely when report of contact to genitalia, perineum, or anus by any part of assailant's body.</b></p> <ol style="list-style-type: none"> <li>1. For non-mucous membranes, lightly moisten one swab with tap water if secretions are dried</li> <li>2. Swab labial folds, clitoral hood and perineum, fossa navicularis, posterior fourchette using wet swab, followed by dry swab</li> <li>3. Label swabs with site where collected</li> </ol>
<p><b>Internal Genital Area Swabs</b></p>	<p><b>Collect routinely when report of contact to genitalia, perineum, or anus by any part of assailant's body. For young adolescents who have not had a prior pelvic exam, or post-menopausal adults, or any other patient who cannot tolerate a speculum exam, forensic swabs may be collected by directly inserting swabs 2-3 inches into the vagina</b></p>

1. Use vaginal speculum to visualize vagina and cervix, and note lacerations, abrasions, petechiae, and bruising
2. Rinse speculum in warm water for patient's comfort.
3. If lubricant is needed use minimum amount, water based and document type used.
4. Sites to consider swabbing include:
  - Vagina (particularly posterior vaginal pool)
  - Endocervix
  - Cervical os
5. Use 4 swabs total: 2 swabs collected from the vagina, 2 swabs collected from the endocervix and cervical os
6. Use 1 or 2 swabs at a time. Do not moisten swabs for areas that are moist

**Genital Exam – Male**

**Document**

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

**Forensic Swabs**

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

1. Retract foreskin to examine glans penis
2. Areas to consider swabbing
  - Mons pubis
  - Inner thighs
  - Inguinal folds
  - External surface of glans/penis
  - Under foreskin (collect swabs even if patient has bathed or showered)
  - Scrotum
  - Perineal body
3. Swab surface of specific area with one swab lightly moistened with tap water followed by one dry swab
4. For each specific site, dry swabs, label site
5. Process as forensic swab (page 15)

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

**Document**

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

**Exam Technique**

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

**Forensic Swabs**

**Collect when**

1. Assault occurred within prior 120 hours and
2. History of penile-genital or penile-anal contact or
3. Report of contact to genitalia, perineum, or anus with any parts of assailant's body or
4. Visible acute anal trauma or
5. Alternate light source scan is positive

**External Anal/Perianal Swabs**

1. Sites to consider swabbing
  - Perianal area (external to anal sphincter)

- Anus
  - Gluteal cleft
2. Lightly moisten one swab with tap water before using
  3. Use moist swab to swab external anal rugal area. Repeat with second swabs
  4. Process as forensic swab

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

1. Use 4 cotton swabs total
2. Ensure that the rectum can be seen (past the dentate line, approximately 2 cm into the anal canal), either in conjunction with an anoscope exam performed by a provider or by placing the patient in prone knee-chest position and allowing the internal sphincter to relax
3. Use 1 or 2 swabs at a time
4. Process as forensic swab (page 15)

**Other Items****Collect items which may contain forensic evidence, such as tampon or pad, and condom. These should be collected on a case-by-case basis**

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

**V. EVIDENCE PACKAGING & STORAGE****Evidence Collection & Storage****Processing Forensic Swabs****Obtain forensic swabs (saliva, seminal fluid & perspiration)**

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

**As each swab is obtained**

1. Affix label on the shaft
2. Write on each label the site of specimen (e.g., "skin," or "oral," "vaginal," "anal").
3. Write on each label why collected (e.g., "saliva," "semen," "aggressive handling," etc.)
4. At conclusion of patient exam, place swabs in drying rack or drying box in secure area
5. Allow swabs to dry

**When swabs are dry**

1. Place all swabs from same site in one envelope (i.e., only one site per envelope)
2. Label envelope with specimen site (e.g., "oral," "vaginal," "skin")
3. Label envelope with reason collected (e.g., "saliva," "semen," "aggressive handling")
4. Affix patient label to envelope
5. Seal envelope with tape or patient label. Do NOT lick envelope to seal
6. Place patient label over seal, sign over seal, and store securely in Evidence Kit

**Note on Forensic Slides****Slides are no longer obtained as of 2016.**

**Processing Evidence  
Collection Kit**

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

**Drying Box**

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

**Evidence Storage**

**Temperature**

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

**Clothing**

1. Dry clothing should be placed in paper bags, sealed with tape, signed over seal, and labeled with patient ID label
2. Clothing should be stored in a secure area until transfer to law enforcement
3. Wet clothing must either be dried in a secure area, refrigerated or frozen and transferred ASAP to law enforcement
4. In order to maintain chain of custody of wet clothing you may double or triple paper bag wet clothing, utilizing evidence tape as described in step 1 prior to handing to LEA. Notify LEA representative that clothing will need to be dried.

**Photo documentation**

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

**Release**

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

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

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

1. Place all evidence in paper bag, kit, or envelope
2. Seal envelope (do not LICK), place patient label over seal, sign over seal, and place in Evidence Kit
3. All evidence in the Evidence Kit should be dry
4. Store entire, sealed Evidence Kit in room temperature secure area,



- refrigerator, or freezer until transfer to law enforcement
- 5. Blood tubes and urine samples should be packaged in a separate biohazard bag, outside of kit. Label and seal as you would per step 2.
- 6. Biological specimens (swabs, slides) should be labeled with site obtained from
  - Swabs should be dried in a secure drying box or area before transfer or freezing
  - Biologic specimens should be placed in a secure area until transfer to law enforcement

**Processing Non-Reporting/Anonymous Kits**

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

1. Note: These kits will be held by law enforcement for 60 years.
2. Patient signs consent for a non-reporting/anonymous exam
3. Label all evidence (minus the patient's name) and package as instructed to do above. The envelope should be sealed the same as for a reporting exam. When the kit is sealed; in place of the patients' name, you may use the kit number or 'Anonymous'. No patient name or label should be on the outside of the kit.
4. Clothing is packaged as previously described, but double bag all clothing. Bag#1 will have patients name on it and then placed inside of Bag#2, then sealed and the nurses name through the tape. Bag#2 is identified by the kit and case number, date, time, contents, facility where collected and nurses name.
5. The laboratory information form should not be separated but rather left complete and inserted into the kit prior to sealing.
6. The patient is provided the kit #, case # if available, name of the hospital and date kit will be held until.
7. After the patient leaves the appropriate LEA is called to pick up kit.

**VI. INITIAL LAB TESTS**

**Pregnancy Test**

**Obtain urine or serum pregnancy test on all patients at risk of pregnancy.**

**Toxicology Tests**

**Obtain toxicology and/or alcohol level when:**

1. Patient appears impaired, intoxicated, or has altered mental status
2. Patient reports blackout, memory lapse, or partial or total amnesia for event, or has baseline memory impairment
3. Patient or other is concerned that he or she may have been drugged
4. Separate consents for toxicology specimens need not be obtained, but patient should be informed that specimens are obtained

**Hospital/clinic toxicology**

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

**Forensic lab toxicology**

1. Drug and alcohol testing may be done for legal purposes; legal specimens follow a chain of custody and generally are given to LEA (not processed through hospital/clinic lab).
2. In some circumstances examiner may order tests to be run at "any detectible level," rather than the standard cut off. Talk with the lab toxicologist to determine how to order.
3. When it is deemed necessary to collect samples for toxicology purposes, collect blood for alcohol testing *and* urine for drug testing. Urine must be obtained as soon as possible.
4. Refer to Section V "Evidence Packaging & Storage: Evidence Storage" to process as forensic evidence. *Do not* place blood or urine samples in SAFE kit. Package separately.



**VII DIAGNOSTIC TESTS FOR MEDICAL TREATMENT**

**The following tests and procedures are not recommended for forensic purposes but may be done for patient care at the patient's expense (Crime Victims' Compensation may be available. Patient must be told that Sexual Assault Victims' Emergency Fund will not cover any medical testing except for pregnancy test.)**

**Pregnancy Test**

**(Refer to Section VI "Initial Lab Tests: Pregnancy Test")**

**Toxicology Tests**

**(Refer to Section VI "Initial Lab Tests: Toxicology Tests")**

**Vaginal Wet Mount**

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

**STI Tests for Gonorrhea and Chlamydia**

**Routine sexually transmitted screening for chlamydia and gonorrhea at the time of an acute sexual assault exam is *not* recommended. STI testing could be considered for Public Health reasons.**

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

**STI Tests for Syphilis and Syphilis Serology**

1. Syphilis baseline test may be offered
2. Serologic tests for syphilis should be repeated 6 and 12 weeks after the assault if initial test results were negative and these infections are likely to be present in the assailant.

**HIV Testing**

1. Serologic tests for HIV should be repeated in follow-up visit or preferably by the primary care provider at 6, 12, and 24 weeks after the assault if initial test results were negative and these infections are likely to be present in the assailant
  - Oregon law *does not require* doctors and other licensed health professionals to do **special pre-test or post-test counseling** (<http://www.oregon.gov/DHS/ph/cdsummary/2008/0hd572S.pdf>).
  - Patient must exhibit understanding that testing does not reflect acquisition of HIV from the assault, but related to possible exposure 2 weeks or more prior
2. If testing is done, arrangements must be made for follow-up visit to discuss results
3. Baseline HIV testing may be offered with knowledge of community epidemiology or if HIV nPEP is being offered (see HIV nPEP guidelines).

**Hepatitis B/C Serology**

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

**VIII TREATMENT**

**Pregnancy Prevention**

**Hospitals/clinics must inform patients of sexual assault about emergency contraception and provide emergency contraception upon request. Document the patient's response.**

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

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

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

Levonorgestrel (progestin only medication)

SIG: 100 mg tab (1.5 mg levonorgestrel), one tablet

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

**-OR-**

"Ella" (Ulapristal)

SIG: 30 mg tab one time, take one tablet

May be considered in women whose weight is >165 lbs (more effective than levonorgestrel in women with BMI >25) or present 3-5 days after unprotected sexual contact

**Anti-emetics**

Offer an anti-emetic medication if indicated.

**STI Prophylaxis**

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

The following recommended antimicrobial regimen for treatment of chlamydia, gonorrhea, trichomonas, and BV may be administered to **pregnant** and **non-pregnant** adolescent and adult patients of acute sexual assault (MMWR, January 2015 and <http://www.cdc.gov/STI/treatment>):

**Ceftriaxone** (Rocephin) 250 mg IM in a single dose (GC)<sup>1</sup>

PLUS

**Metronidazole** 2 g orally in a single dose (trich/BV)

PLUS

**Azithromycin** 1 g orally in a single dose (chlamydia)

**Alternative Medication Regimens**

1. Chlamydia

Erythromycin base 500 mg PO QID x 7 days

OR

Erythromycin ethylsuccinate 800 mg PO QID x 7 days

<sup>1</sup> If oral-pharyngeal exposure to gonorrhea is of significant concern, Ceftriaxone is recommended over Cefixime.

OR  
**In non-pregnant patients:**  
 Doxycycline 100 mg PO BID x 7 days  
 OR  
 Ofloxacin 300 mg PO BID x 7 days  
 OR  
 Levofloxacin 500 mg PO x 7 days

2. Gonorrhea  
**In non-pregnant patients:**  
Cefixime 400 mg orally in a single dose

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

**Hepatitis B Vaccine and Immunoglobulin**

The 2015 CDC guidelines recommend that Hepatitis B vaccine and HBIG, if indicated, should be administered at the time of the initial examination.

If patient has been previously immunized for Hepatitis B but did not receive post vaccination testing, give a single vaccine booster dose.

If hepatitis status of assailant/s is unknown and patient has not been previously vaccinated, administer first Hepatitis B vaccine dose.

If assailant/s are known to be HBsAg-positive and patient has not been previously vaccinated, administer first Hepatitis B vaccine dose and also give HBIG.

Follow-up doses of Hepatitis vaccine are given 1-2 months after initial dose and 4-6 months after first dose.

**Tetanus Prophylaxis**

**Offer when**

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

**HIV Prophylaxis**

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

See *HIV Postexposure Prophylaxis (PEP) after Sexual Assault Guidelines* and algorithm on the Attorney General's Sexual Assault Task Force website.

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

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

**HPV Vaccine**

It is recommended by the 2015 CDC updates to offer HPV vaccine post sexual assault for both genders <25 years of age who have not been vaccinated.

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

**Discharge**

1. Discuss safety issues/plan
2. Appropriate medical follow up will be identified for the patient with respect to the evaluation of possible sexually transmitted diseases, pregnancy and any physical injuries sustained during the assault
3. Explain follow-up for test results
4. Offer patient education materials

5. Confirm plans for medical and counseling follow-up
6. Give phone numbers for sexual assault victim advocate and other support services, including campus resources if the survivor is a college student
7. Follow up counseling information will be provided to the patient by the sexual assault advocate or the forensic examiner
8. Give written discharge instructions for all treatment and follow up
9. Information on area resources concerning: medical follow up, crisis intervention phone numbers, sexual assault crisis centers, shelters, DHS Child Welfare, Crime Victims Compensation Program, law enforcement and the district attorney's office will be given to the patient at the time of discharge
10. Per community protocol, refer minor patients to local child abuse intervention center for medical and forensic follow-up

## **Follow Up**

### **Medical Visit**

### **Recommended within two weeks of the initial exam**

#### Review with patient or guardian

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

### **Physical Exam**

### **Depending on history and symptoms**

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

### **Laboratory Tests**

### **Depending on risk and patient concerns**

1. Obtain urine pregnancy test. Let patient know that this is only a screening test and should be repeated if patient does not have a regular menstrual period
2. Nucleic Acid Amplification Test (NAAT) or culture for gonorrhea and chlamydia if single dose prophylaxis was not given in hospital/clinic
3. HIV: pre-test and post-test counseling required after exposure
  - Baseline
  - Three months
  - Six months
4. Hepatitis B/C serology--three months after exposure
5. Syphilis serology—6 weeks and 3 months after exposure

### **Treatment**

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

## **Referral**

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

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Revised October 2019

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