SA/DV Care and Treatment Centre (SA/DVTC)

Nursing Documentation Form for Sexual Assault Clients (age 12 and up)

Date: _____ Location of assessment: _____

Administrative Information

Client Referred by: □ Self □ Family/Friend □ Police □ Agency_____ □ Other _____

Accompanied by: □ Alone □ Family/Friend □ Agency_____ □ Other_____

□ Police Police Service_____ Officer's Name_____ Badge Number_____

Officer's Name_____ Badge Number_____

Occurrence Number _____

Time Client Arrived SA/DVTC _____

Lead SANE/RN _____ Trainee: _____

Physician consultation or referred: (reason for consultation, outcome of discussion)

Physician/Other Name: _____

Outcome: _____

_____

Child Protection: □ N/A □ Yes Worker Name :_____ Agency Name/Number_____

Interpreter/Support Person?: □ N/A □ Yes Name: _____ Language _____

Agency Name _____ Number _____

Relevant Health History

Allergies: _____

Immunizations: Hepatitis B Vaccine: □ No □ Complete □ Incomplete □ Unsure

Tetanus □ No □ Yes □ Unsure Last Immunization _____

Medications: _____

_____

Health Conditions: □ Liver Disease □ Epilepsy □ Diabetes □ Kidney Disease

□ Other/Explain: _____ □ Disability: _____

Relevant hospitalization: _____

Surgery: □ Hysterectomy □ Tubal Ligation □ Other: _____

Menstrual History: LMP: _____ Cycle: □ Regular □ Irregular Cycle Length: _____

Pregnant? □ No □ Yes # Weeks _____ First Response Test: □ Positive □ Negative

Breast Feeding □ No □ Yes

Sexually Active? □ No □ Yes Date of last unprotected vaginal intercourse _____

Method of Contraception: _____

Sexual Assault History

Date and time of assault _____ Location: _____

Assailant(s) □ Male # ____ □ Female # ____ □ Don't know

Known to Client? □ No □ Yes Length of Association: _____ Relationship: _____

Physical Contact with: □ Weapon Describe: _____ □ Object Describe: _____

Did Assailant: □ Hit □ Kick □ Grab □ Hold □ Burn □ Strangle

Strangulation Check List Completed □ No □ Yes

Verbal Threats □ No □ Yes □ Quotes _____

Suspected Drug Facilitated: □ No □ Yes If yes, please complete DFSA checklist

Describe any physical or mental impairment experienced prior to, during, or after the assault. When were these symptoms experienced? _____

_____

Suspected assault was recorded i.e. using a webcam, cellphone, camera, etc: □ No □ Yes

If yes describe _____

Time SAEK opened: _____ Kit # _____Time SAEK closed: _____

Sexual Assault History (To be completed if no forensic kit done)

Did assailant kiss/lick/bite etc? Location: _____

During the assault was there penile penetration of the victim's:

	Attempted			Completed		
	Yes	*No*	*Don't know*	*Yes*	*No*	*Don't know*
Vagina	□	□	□	□	□	□
Mouth	□	□	□	□	□	□
Anus	□	□	□	□	□	□

Condom Used □ □ □

Penetration by: □ Finger □ Foreign Object (describe) _____

	Yes	*No*	*Don't know*		*Yes*	*No*	*Don't know*
Vagina	□	□	□	Vagina	□	□	□
Mouth	□	□	□	Mouth	□	□	□
Anus	□	□	□	Anus	□	□	□

Care Options

Sexual Assault Evidence Kit (SAEK) offered □ Accepted □ Declined □ Collected & Frozen □ Released to Police

Diagnostic Testing offered □ Accepted □ Declined □ N/A

Medication offered □ Accepted □ Declined □ N/A

Injury Documentation □ Narrative □ Body Maps □ N/A

Photographs of Injuries offered □ Accepted □ Declined □ N/A

Third Party Report offered □ Yes □ No □ N/A

Diagnostic Tests

□ Pregnancy: □ Urine HCG Result _____ □ Blood HCG

□ Gonorrhea □ Cervix □ Urethral □ Rectal □ Throat

□ Chlamydia □ Cervix □ Urethral □ Rectal □ Urine □ Throat

□ Trichomonas □ Vaginal

□ Hepatitis B □ HbsAg □ AbsAb

□ Syphilis □ VDRL

□ Toxicology □ Blood □ Urine

□ HIV Hold

□ HIV PEP Screen

□ Other: _____

Medications

□ **As ordered by Physician** □ **As per Medical Directive**

□ Emergency Contraception:	□ Plan B (Levonorgestrel) 0.75mg 2 tab po STAT		
□ Gonorrhea	□ Cefixime (Suprax) 400 mg po, single dose	□ at visit	□ take home
	□ Ciprofloxacin 500 mg po, single dose	□ at visit	□ take home
	or □ Azithromycin 2g	□ at visit	□ take home
□ Chlamydia	□ Azithromycin 1 g (4 x 250 mg tabs) po, single dose	□ at visit	□ take home
	□ Doxycycline 100mg bid po x 7 days		
	□ Erythromycin 500 mg po x 7 days		
□ Hepatitis B	□ Hepatitis B Immune Globulin (HBIG) 0.06ml/kg ____ml □ single dose IM ____ gluteus		
	□ Engerix B (20mcg/ml) 1 ml IM _____deltoid or		
	□ Recombivax HB (10mcg/ml) ___ml IM deltoid (1.0 ml if ≥19 yrs old; 0.5 ml ≤18 yrs old)		
□ Tetanus	□ Tetanus toxoid .05 ml IM deltoid		
□ HIV PEP	□ No □ Yes *If yes please complete HIV PEP Initial Visit: Nursing Documentation Form*		

□ Other _____

Follow Up

□ SA/DVTC follow up clinic - Date: _____

Counselling Offered □ Accepted □ Declined □ Call to book an appointment

Counsellor Name_____ Date_____

□ With Family MD

□ With other service

□ Would client like a copy of results sent to Family physician? □ Yes □ No

□ MD Name: _____ Number: _____ (obtain signed release of information)

□ Other _____

Does client want follow up phone call? □ Yes □ No Safe Contact No.:_____

Can we leave a message? □ Yes □ No □ Use Code: _____

Discharge Time _____Discharged To: □ Home □ Shelter □ Other _____

Transportation □ Taxi □ Police □ Friend/Family

Accompanied □ Alone □ Police □ Friend/Family □ Agency Worker □ Other _____

Returned to: □ Emergency Department □ Other _____ Time _____

Discharge Plan

□ Provided After Care Information

□ Common reactions following a sexual assault and coping strategies

□ Strangulation Care Instructions

□ 24 Hour Crisis Line Support

□ Safety Plan

□ Community Services

□ Police and Legal System

□ Other: _____

Nursing Notes

Name & Designation _____ Signature_____