Form 1 Commonwealth of Massachusetts
Sexual Assault Evidence Collection Kit

PATIENT'S CONSENT FOR SEXUAL ASSAULT EXAM

AFFIX BARCODE LABEL HERE

PATIENT LABEL

Patient's Name: _____

Patient's Date of Birth _____/_____/_____

Patient's Address: _____ Patient's Phone Number: _____

Interpreter services utilized: ☐ Yes ☐ No If Yes, Name: _____

I consent and authorize _____ (medical provider or Sexual Assault Nurse Examiner (SANE)) and

_____ Hospital to perform the following procedures:

PROCEDURE	CONSENT	DO NOT CONSENT	PATIENT INITIALS
• Obtain history	☐	☐	_____
• Perform physical exam	☐	☐	_____
• Collect evidence which may include: hair, blood samples, body fluid samples and clothing	☐	☐	_____
• Administer appropriate medical treatment	☐	☐	_____
• Discuss and collaborate with care team regarding: o Medications to prevent Sexually Transmitted Infections (STI) and STI testing o Pregnancy screening o Emergency Contraception for pregnancy prevention	☐ ☐ ☐	☐ ☐ ☐	_____ _____ _____
• Photograph physical injuries	☐	☐	_____
• Discuss case with law enforcement (police)	☐	☐	_____
• Discuss case with Medical Provider/Pedi SANE at Children's Advocacy Center/Child Protection Team, if indicated	☐	☐	_____
• Other (please specify): _____	☐		_____
• Exam Consultation with MA Tele SANE (If utilized) Name: RN	☐	☐	_____

Patient Initials _____: I understand that if I choose to report my assault to the police or I am under 16 years of age my kit will be transported to the crime lab and WILL BE ANALYZED. I understand that if I am 16 years of age or older and I do not report my assault to the police, my kit will be stored and NOT ANALYZED unless I choose to report to law enforcement at a later date.

Patient Initials _____: I understand that my Kit # will be entered into the Massachusetts' TRACK-KIT® system but will not include my name or personal information. I will be given a card with my Kit # and a password that will allow me to track the location of my Kit. If I report to the police, the police will have access to my name and Kit #.

Patient Initials _____: I understand the information contained in this medical record is confidential and private and protected under state law. In most circumstances, the medical record will be released only with my written permission. However, I understand the medical information must be released if subpoenaed by the court.

Patient Initials _____: I understand that the Sexual Assault Nurse Examiner Program of the Massachusetts Department of Public Health may review the documentation of my E.D. visit, including photos, for quality assurance purposes.

_____
Signature of Patient or Guardian

_____
If Guardian, print relationship to patient

Date: _____/_____/_____

_____
Printed Name of Medical Provider or SANE

_____
Signature of Medical Provider or SANE

Date: _____/_____/_____

If applicable, MA SANE Certification # _____