

# PROVIDER SEXUAL CRIME REPORT (PSCR) - FORM 2A

SEND FORM 2A ONLY\*

Per MGL C.112, S. 12A ½

FEB 2023

**A. PATIENT INFORMATION:** Name, address and other identifying information should not be written on this anonymous form

1. Age: \_\_\_\_\_ 2. Gender: ☐ Female ☐ Male ☐ Transgender (M to F) ☐ Transgender (F to M) ☐ Other: \_\_\_\_\_

3. Race: ☐ White ☐ Black/African Am ☐ Hispanic/Latino ☐ Am Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander  
☐ Other Race: \_\_\_\_\_ 3A. Preferred Language \_\_\_\_\_ 3B. Military Affiliated ☐ Yes ☐ No

4. Date of Assault (e.g. 01/01/2020): \_\_\_\_\_ 5. Approx. Time of Assault: \_\_\_\_\_ ☐ AM ☐ PM

6. City/Town of Assault: \_\_\_\_\_ State: \_\_\_\_\_ Neighborhood: \_\_\_\_\_

7. Specific surroundings at time of Assault: ☐ House/Apartment ☐ Outdoors ☐ College/University ☐ Hotel/Motel  
☐ Prison ☐ Jail ☐ DYS ☐ Motor Vehicle ☐ Unsure ☐ Other (specify): \_\_\_\_\_

8. Date of hospital exam (e.g., 01/03/2020): \_\_\_\_\_ 9. Time of Hospital Exam: \_\_\_\_\_ ☐ AM ☐ PM

10. Hospital Providing Service: \_\_\_\_\_

11A. Exam completed by: ☐ MA SANE ☐ SANE-A ☐ MD  
☐ NP ☐ PA ☐ CNM ☐ RN

11B. Assisted by TeleSANE? ☐ Yes ☐ No

**AFFIX BARCODE LABEL HERE  
ON BOTH WHITE AND YELLOW COPIES**

**B. ASSAILANT(S) INFORMATION:** Did the patient voluntarily report any of the following relationships with the assailant(s)?

12. Total Number of Assailants: \_\_\_\_\_ ☐ Unsure

13. Assailant(s) relationship to patient and gender of assailant (m/f). If >1 assailant, designate relationship of each.

	# Male	# Female		# Male	# Female
<input type="checkbox"/> Parent/Stepparent	_____	_____	<input type="checkbox"/> Boy/girlfriend	_____	_____
<input type="checkbox"/> Spouse/live-in partner	_____	_____	<input type="checkbox"/> Ex-boy/girlfriend	_____	_____
<input type="checkbox"/> Ex-Spouse/live-in partner	_____	_____	<input type="checkbox"/> Date	_____	_____
<input type="checkbox"/> Parent's live-in partner	_____	_____	<input type="checkbox"/> Acquaintance	_____	_____
<input type="checkbox"/> Other relative	_____	_____	<input type="checkbox"/> Friend	_____	_____
<input type="checkbox"/> Stranger	_____	_____	<input type="checkbox"/> Unknown	_____	_____
			<input type="checkbox"/> Other (specify): _____	_____	_____

**C. WEAPONS/FORCE USED:** (Check all that apply as per patient report and/or physical findings)

14. ☐ Verbal threats ☐ Restraints (ropes, ties, cords, etc.) ☐ Strangulation ☐ Chemical(s) (pepper spray, mace, etc.)  
☐ Bites ☐ Hold Down/Body Weight ☐ Hitting ☐ Other physical force Describe: \_\_\_\_\_  
☐ Burns ☐ Other Weapons Describe: \_\_\_\_\_ ☐ Gun ☐ Alcohol  
☐ Knife ☐ Drugs ☐ Blunt Object ☐ Unsure

**D. ACTS DESCRIBED BY THE PATIENT:**

**Was there penetration, however slight of:**

15. Vagina ☐ No ☐ Unsure ☐ Attempt ☐ Yes ☐ N/A **BY** ☐ Penis ☐ Finger ☐ Tongue ☐ Object/Other: \_\_\_\_\_  
16. Anus ☐ No ☐ Unsure ☐ Attempt ☐ Yes ☐ N/A **BY** ☐ Penis ☐ Finger ☐ Tongue ☐ Object/Other: \_\_\_\_\_  
17. Mouth ☐ No ☐ Unsure ☐ Attempt ☐ Yes ☐ N/A **BY** ☐ Penis ☐ Finger ☐ Tongue ☐ Object/Other: \_\_\_\_\_  
18. Did ejaculation occur? ☐ Yes ☐ No ☐ Unsure ☐ N/A  
19. Did assailant(s) use a condom? ☐ Yes ☐ No ☐ Unsure ☐ N/A  
20. Any injuries to patient resulting in bleeding? ☐ Yes ☐ No ☐ Unsure  
If yes, specify: \_\_\_\_\_  
21. Any injuries to assailant resulting in bleeding? ☐ Yes ☐ No ☐ Unsure  
If yes, specify: \_\_\_\_\_

**E. CASE STATUS AT TIME OF THE EXAM:**

22a. Evidence Collection Kit utilized? ☐ Yes ☐ No  
22b. Toxicology Kit collected? ☐ Yes ☐ No  
23. Reported to Police? ☐ Yes ☐ No **If yes, specify police dept:** \_\_\_\_\_  
24. DCF involved? ☐ Yes ☐ No **If yes, describe status:** \_\_\_\_\_  
25. Restraining order in place before assault? ☐ Yes ☐ No **If yes, date and court location:** \_\_\_\_\_  
26. Restraining order filed after assault? ☐ Yes ☐ No **If yes, date and court location:** \_\_\_\_\_

**F. MANDATORY REPORTING:**

27. 19A Elder Abuse Report ☐ Yes ☐ No File with Elder Services if patient is age 60 or above  
28. 51A Child Abuse Report ☐ Yes ☐ No File if patient is <18yo or if children <18yo were present during assault  
29. 19C Disabled Persons Report ☐ Yes ☐ No File with DPPC for patients with a disability ages 18-59  
30. 12A Weapon Report ☐ Yes ☐ No If patient injured by a weapon, the treating clinician files this report  
31. 70E Emergency Contraception Administered ☐ Yes ☐ Not Indicated ☐ Declined ☐ Not offered

**G. KIT TRANSPORT INFORMATION:**

32. Name of Police Department notified for pick up and transport of Evidence: \_\_\_\_\_  
33. Date Notified: \_\_\_\_\_ Time Notified: \_\_\_\_\_

**Please Remember to Enter Kit Information into the Massachusetts TRACK-KIT SYSTEM - <https://ma.track-kit.us>**

**Retain White Copy of Form 2A and 2B for Hospital Records; Return Yellow Copy of Form 2A and 2B to Step 1 Envelope**

\*Send completed report to Massachusetts Executive Office of Public Safety and Security

SCAN and EMAIL to [PSCR@MASS.GOV](mailto:PSCR@MASS.GOV) or FAX to 617-725-0260 AND to the police in city/town where assault occurred.