

INFORMATION PERTAINING TO ASSAULT & KIT TRACKING FORM PROVIDER SEXUAL CRIME REPORT – FORM 2A

FAX FORM 2A ONLY

Per MGL C.112, S. 12A 1/2

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
 3A. Military Affiliated: Yes No Other Race: _____

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/Step parent	_____	_____	<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