Commonwealth of Massachusetts
Department of State Police Crime Laboratory
Sexual Assault Evidence Collection Kit

AFFIX BARCODE LABEL HERE ON BOTH WHITE AND PINK COPIES

CONSENT FOR COMPREHENSIVE TOXICOLOGY TESTING
DO NOT WRITE PATIENTS NAME ON THIS FORM

VERY IMPORTANT: Retain WHITE copy of form for hospital records. In order for the crime lab to process, analyze and report results of toxicology to the submitting agency (reported) or hotline (unreported), the PINK copy of the consent form must be initialed by patient, placed INSIDE the Step 2 envelope and packaged with the Comprehensive Toxicology Testing kit box.

Examining Clinician:

Please ensure your patient reads the entire consent form and understands all segments before signing it to consent to toxicology testing. All information must be reviewed with ample time given for the patient to have questions answered. If the patient chooses to consent to the comprehensive toxicology testing:

1) *Please complete the information requested below.*
2) Ensure your patient signs **with his/her initials only** where indicated on form.
3) **Print and sign** your name only where indicated on form.

- Date of assault:____/____/____ Approximate time of assault:___ : ___ □ AM □ PM
- Date of evidence collection: ____/____/____ Time of evidence collection: ___:___□ AM □ PM
- Has the sexual assault been reported to law enforcement? □ Yes □ Not at this time
- Is the patient a smoker? □ Yes □ No
- Is the patient taking any prescriptions? □ Yes □ No (Contraceptives need not be listed)

If yes, names of prescription drugs last taken:
*drug(s):*_____
_____

Date and time drug(s) last taken: ____/____/____ ____:____ □ AM □ PM

- Is the patient taking any over the counter drug(s)? □ Yes □ No

If yes, names of over the counter drug(s) last taken:
_____
_____

Date and time over the counter drug(s) last taken: ____/____/____ ____:____ □ AM □ PM

Name of Hospital:_____

For the patient:

Please read the following and review each segment with your examining clinician. If you choose to consent to comprehensive toxicology testing, please sign with ***your initials only*** on the page where indicated.

□ ***I consent and authorize_____(name of examiner) to obtain:***
□ ***Blood and Urine samples (if the assault occurred within 24 hours, or unclear/unknown timeframe)***
□ ***Urine sample only (if the assault occurred > 24 hours ago)***
These samples are collected for the purpose of detecting the presence of drugs or other substances that may have caused sedation and/or amnesia in the setting of a suspected sexual assault.
□ I understand this sample must be obtained within 96 hours of ingestion.
□ I understand that my samples will be transferred to the State Police Crime Laboratory and that information regarding the results of the drug testing may be released to the defense, prosecution, and other law enforcement officials.
□ The drug test that I consent to will include a full toxicology panel which may detect any substances, medications, or drugs, both legal and/or illegal (such as marijuana, cocaine, alcohol, amphetamines, barbiturates, opiates, antidepressants, antihistamines, and others) that I may have taken in the weeks prior to the assault.
□ Once I report the assault to law enforcement officials, law enforcement officials will have access to my test results even if I change my mind about voluntary participation in prosecution of the assailant(s).
□ I understand that this blood and urine sample will be tested and will be discarded within 6 months of the date the results were reported to law enforcement (reported cases) or Toxicology Line (unreported cases).
□ If I have reported this assault to the police, the results will be available to law enforcement officials within approximately 12 weeks after testing. I understand that I may obtain the results by contacting the law enforcement agency of the city/town where the assault occurred and ask to speak with the assigned investigator or detective in my case.
□ If I have *not* reported this assault to the police, the results will be available to a confidential service approximately 12 weeks after testing. The service will receive my barcode number and test result but not my name or any other identifying information. I understand that I must contact the confidential service listed under the aftercare instructions on the Treatment and Discharge form, and provide my barcode number if I want to find out these results.
□ I have discussed toxicology testing with the medical provider and have had an opportunity to ask questions and discuss concerns.

Patients Initials ONLY_____

_____ ____/____/____
Printed name of clinician provider or S.A.N.E. Date

_____ _____
Signature of clinical provider or S.A.N.E. If applicable, certified S.A.N.E. number of the examiner