ORDERS MUST BE SIGNED BY LICENSED INDEPENDENT PRACTITIONER (LIP)

Check box directions: CHECK BOX “☐” FOR YES  ■ SOLID BLACK BOX IS CONSIDERED AN AUTOMATIC “YES” CHECK “☐ NO” FOR NO

Allergies and Reactions: ______________________________________________________

Weight: ____________ kg  Height ____________ cm  BMI ____________

Meds/IVs Only

LABORATORY

☐ Urinalysis Complete with Culture if Indicated
☐ GC/Chlamydia RNA
  ☐ Dirty Urine
☐ GC Culture
  ☐ Rectal/Throat
    Plate at bedside; Add comments in computer “Concerned for GC” and “Medical/Forensic Exam;” Call Microbiologist at 55686
☐ CT Culture
  ☐ Rectal/Throat
    Use viral medium (COPAN) Add comments in computer “Concerned for CT” and “Medical/Forensic Exam;” Call Microbiologist at 55686
☐ Genital Culture
  ☐ Order “Aerobic Culture” in computer for external female and male genitalia; Add comments “R/O strep,” and “Medical Forensic Exam;” Call Microbiologist at 55686
  ☐ Order “Genital Culture” in computer when swabbing inside labia; Add comments “R/O strep,” and “Medical Forensic Exam;” Call Microbiologist at 55686
☐ Wet Prep (This is the same)
☐ Herpes Culture
☐ Urine Toxicology

MEDICATIONS

☐ Prescription to be sent to pharmacy: Betamethasone Ointment 0.05% 45 grams. Apply to labial adhesions  two to three times a day until resolved.

Prescriber's Initials: __________________________________________________________
ORDERS MUST BE SIGNED BY LICENSED INDEPENDENT PRACTITIONER (LIP)

Check box directions: **CHECK BOX “☐” FOR YES**  ■ **SOLID BLACK BOX IS CONSIDERED AN AUTOMATIC “YES”**  **CHECK “☐ NO” FOR NO**

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<td>☐</td>
<td>A&amp;D emollient once labial adhesions have separated. Apply 3 to 5 times a day up to 2 months to prevent recurrence. <strong>OR</strong></td>
<td>☐</td>
</tr>
<tr>
<td>☐</td>
<td>Prescription to be sent to pharmacy: Estradiol Cream 0.01% 42.5 grams. Apply externally to labial adhesions two times a day, for up to 2 weeks. Do not use applicator that accompanies the medication. Follow up with primary care provider in 2 weeks if not resolved.</td>
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All home, post-operative/procedure, transfer and discharge medication orders must be reconciled and written or verified by LIP

LIP Signature ____________________________ Date/Time ____-____-_____/_____  
LIP Print First and Last Name or ID number ____________________________  
RN Signature ____________________________ Date/Time ____-____-_____/_____  
RN Printed Name ____________________________  
RN Noting Orders ____________________________ Date/Time ____-____-_____/_____
Name of Person Filling out this Form:__________________________________________________________

Relationship to child (biological mother, etc):___________________________________________________

Date of Visit:_______________________________________________________________________________

Child’s Medical History:_______________________________________________________________________

Child’s Surgical History:_______________________________________________________________________

Immunizations:______________________________________________________________________________

Is this child being treated for anything at this time?_______________________________________________

Does this child have a problem with constipation (really hard stools)?______________________________

   If the child has constipation, are they being treated with anything?______________________________

Does this child have a problem with diarrhea (really loose stools)?_______________________________

   If the child has diarrhea, are they being treated with anything?______________________________

Does the child attend daycare/ school? If so, where:_____________________________________________

What grade is the child in?____________________________________________________________________

Does the child have any identified learning disabilities and/or an IEP at school?____________________

Does the child exhibit any behaviors that are concerning to you? (If so, please describe in detail):________

__________________________________________________________________________________________

__________________________________________________________________________________________

What made you bring the child in today (in detail)/what are your concerns?________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

What is your primary language?

☐ English  ☐ Other (please list)__________________________________________________________

Patient Sticker
HOUSEHOLD INFORMATION

Biological Mother (or Guardian): ___________________________ Age/DOB ____________

Visitation Schedule/Guardianship Arrangement: ____________________________

Address: __________________________________________________________

City, State, Zip: ____________________________

Phone: __________________________________________

Name, Relationship, Age and Ethnicity of Persons Living at this Address:

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<th>Name</th>
<th>Relationship</th>
<th>Age/DOB (If known)</th>
<th>Ethnicity</th>
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Biological Father (or Guardian): ___________________________ Age/DOB ____________

Visitation Schedule/Guardianship Arrangement: ____________________________

Address: __________________________________________________________

City, State, Zip: ____________________________

Phone: __________________________________________

Name, Relationship, Age and Ethnicity of Persons Living at this Address:

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<th>Name</th>
<th>Relationship</th>
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☐Reviewed by FNE prior to discharge  FNE Signature: ________________
MEMORIAL HOSPITAL SEXUAL ASSAULT MEDICAL/FORENSIC RECORD

Name and Location of Examining Facility: ___________________________________________________

Address: _____________________________________________________________________________

Date of Admission: __________________________ Time: __________________________

Name of Patient: ____________________________________________ Date of Birth: _______________

Address: _____________________________________________________________________________

Brought in by: _________________________________________________________________________

Others Present in Exam: __________________________________________________________________

Date of Assault: __________________________ Time: __________________________

Location of Assault: ______________________________________________________________________

Name of Assailant(s) if Known: __________________________________________________________

Relationship of Patient to Assailant: _______________________________________________________

Examiner Signature: _____________________________________________________________________

UCHealth MEMORIAL HOSPITAL
1400 E Boulder St
Colorado Springs, CO 80909

Patient Label (all copies please)
INFORMED CONSENT AND RELEASE FOR THE SEXUAL ASSAULT MEDICAL/FORENSIC EVALUATION

I, _____________________________________, hereby request and authorize the staff at Memorial Hospital to conduct a medical/forensic examination, including the collection of evidence requiring crime lab analysis, necessary for my diagnosis and treatment, as well as possible investigation of my sexual assault. I understand that I can stop the exam at any time and can decline any portion of the exam or the collection of any sample.

I understand that the examination will include photo-documentation (photographs), and I authorize the taking and reproducing of these photographs conditioned upon their being viewed only by those persons officially involved in the investigation or legal proceedings which may be initiated. Photos may also be used for educational/training/quality assurance purposes.

In the event of evidence collection during my exam, I understand my options for evidence collection, analysis and storage as outlined by the state of Colorado.

_____Evidence: I have reviewed my options and indicated my choices for evidence collection, analysis and storage on the Colorado Sexual Assault Consent and Information form.

My initials below indicate my understanding of and the level of authorization for release of my records, including photographs.

_____Report to Law Enforcement: I authorize the release of my medical record, including photographs to law enforcement for the purpose of investigating my sexual assault and any resulting legal proceedings. I understand that law enforcement agencies are not health plans or providers, and the released medical information may no longer be protected by the federal HIPAA privacy regulations. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present the written revocation to the Legal Department at Memorial Hospital. This revocation will not apply to information that has already been released.

_____Medical Report Only: At this time, I am choosing not to report to law enforcement. I understand that my medical record, including photographs will not be released to law enforcement for the purposes of investigating my sexual assault and any resulting legal proceedings. I understand that in order to release my medical record in the future, I will be required to sign an additional release. I understand that I can change my mind and make a report to law enforcement.

_____Anonymous Report: At this time, I am choosing to make an anonymous report. I understand that I will have evidence collected that will be stored anonymously at a law enforcement agency. I understand that law enforcement will not be given my name or other identifying information. I understand that my medical record, including photographs will not be released to law enforcement for the purposes of investigating my sexual assault and any resulting legal proceedings. I understand that in order to release my medical record in the future, I will be required to sign an additional release. I understand that I can change my mind and later report to law enforcement by providing the unique identifying number given to me.

_____________________________________  ________________________________
Person Examined                      Date

_____________________________________  ________________________________
Parent or Guardian                   Date

Patient Label (all copies please)
A) HISTORY

Patient’s Name: ____________________________

1. Patient’s description of assault in own words: ________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________

   Vaginal delivery? ☐ Yes ☐ No

5. LMP _____ Was the LMP normal? ☐ Yes ☐ No Why not? ________________________________

6. Most recent coitus prior to or since the assault:
   Date: ________________ Time: ________________ Condom Used? ☐ Yes ☐ No

7. Current mode of contraception used by patient, if any: ______________________________________

Examiner Signature: ____________________________________________________

Patient Label (all copies please)
8. During the assault:

Did finger penetrate?  □ Vagina  □ Anus  □ Oral  □ Unknown  □ None
Did object penetrate?  □ Vagina  □ Anus  □ Oral  □ Unknown  □ None
Did penis penetrate?  □ Vagina  □ Anus  □ Oral  □ Unknown  □ None
Did assailant ejaculate?  □ Yes  □ No  □ Unknown
Location of ejaculation: _________________________________________________________________
Did the assailant wear a condom?  □ Yes  □ No  □ Unknown
Did the assailant use lubricant?  □ Yes  □ No  □ Unknown
Did the assailant put his/her mouth on your genitalia?  □ Yes  □ No  □ Unknown
Did the assailant put his/her mouth on any other part of your body?  □ Yes  □ No  □ Unknown
Did the assailant make you put your mouth on any other part of his/her body?  □ Yes  □ No  □ Unknown
Other assault details: ________________________________________________________________

9. Since the time of the assault, have you:

Douched  □ Yes  □ No
Bathed/showered  □ Yes  □ No
Changed clothe  □ Yes  □ No
If yes, where are the original clothes now? ______________________________________________
Ate  □ Yes  □ No
Drank  □ Yes  □ No
Smoked  □ Yes  □ No
Brushed teeth/gargled  □ Yes  □ No
Urinated  □ Yes  □ No
Defecated  □ Yes  □ No
If yes, what consistency: ______________________________________________________________
Used tampons/liners  □ Yes  □ No
Other: ____________________________________________________________________________

B) PHYSICAL ASSESSMENT
MentalStatus/Behavior/Appearance: ______________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
Examiner Signature: ________________________________________________________________

UCHealth MEMORIAL HOSPITAL
1400 E Boulder St
Colorado Springs, CO 80909

Patient Label (all copies please)
**DETAILED ASSESSMENT**

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<th>Neurological</th>
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<tr>
<th>Genito-uniary</th>
<th>See male detailed ano-genital assessment</th>
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<tr>
<th>OB/Gynecological</th>
<th>See female detailed ano-genital assessment</th>
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<tr>
<th>Skin/Muscle/Bone</th>
<th>See detailed body map description</th>
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<th>Medical/Surgical History</th>
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<th>Allergies</th>
<th>Immunizations</th>
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<th>Psych/Social</th>
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**Examiner Signature:** ________________________________
PHYSICAL ASSESSMENT (continued)

Numerically mark each finding (1, 2, ...) and provide a detailed description below.

Tanner Stage: Male

Genitalia 5 4 3 2 1

Circumcised: [ ] Yes [ ] No

Pubic Hair 5 4 3 2 1

[ ] ALS Used

Examiner Signature: ________________________________
PHYSICAL ASSESSMENT (continued)

Numerically mark each finding (1,2...) and provide a detailed description below.

**Tanner Stage: Female**

Breasts  5  4  3  2  1  
Pubic Hair  5  4  3  2  1  

☐ ALS Used

Examiner Signature: _________________________________________________
DETAILED BODY SURFACE FINDINGS

☐ Digital photographs obtained of body surface injuries
1. ____________________________________________________________
2. ____________________________________________________________
3. ____________________________________________________________
4. ____________________________________________________________
5. ____________________________________________________________
6. ____________________________________________________________
7. ____________________________________________________________
8. ____________________________________________________________
9. ____________________________________________________________
10. ____________________________________________________________

If more space is required, please use a progress note and check the box below.
☐ Please see progress note for additional findings.

C) COLLECTION OF FORENSIC EVIDENCE

1) Collection of clothing ☐ Yes ☐ No
   List items collected:
   ____________________ ____________________ ____________________
   ____________________ ____________________ ____________________

2) Trace Evidence ☐ Yes ☐ No
3) Oral Swabs and Smear ☐ Yes ☐ No
4) Foreign Stains on Body Swabs ☐ Yes ☐ No
5) External Genital Swabs ☐ Yes ☐ No
6) Pubic Hair Comblings ☐ Yes ☐ No
7) Pubic Hair Standard ☐ Yes ☐ No
8) Head Hair Standard ☐ Yes ☐ No
9) Anal Swabs and Smear ☐ Yes ☐ No
10) Vaginal/Penile Swabs and Smear ☐ Yes ☐ No
11) Cervical Swabs and Smear ☐ Yes ☐ No
12) Fingernail Clippings and Swabbings ☐ Yes ☐ No
13) Buccal Swabs ☐ Yes ☐ No
14) Additional Evidence ☐ Yes ☐ No
   ☐ Urine for DFSA Collected
   ☐ Blood for DFSA Collected

Examiner Signature: ____________________________________________

UCHealth MEMORIAL HOSPITAL

1400 E Boulder St
Colorado Springs, CO 80909

Patient Label (all copies please)
D) ANO-GENITAL ASSESSMENT

Colposcope:
Used: [ ] Yes [ ] No  Colposcope Photos: [ ] Yes [ ] No
Magnification: [ ] 3.75  [ ] 7.5  [ ] 15.0

Saline/H2O Used: [ ] Yes [ ] No  Foley Used: [ ] Yes [ ] No
Swabs Used: [ ] Yes [ ] No  Toluidine Blue Used: [ ] Yes [ ] No
ALS Used: [ ] Yes [ ] No

Male Assessment

Anal Area: _________________________________________________________________
Penis:  _________________________________________________________________
Scrotum: __________________________________________________________________
Perineum: _________________________________________________________________

Examiner Signature:__________________________________________________

Anal Drawing
ANO-GENITAL ASSESSMENT (continued)

Female Assessment

Mons Pubis: ________________________________________________________________

Clitoral Hood & Clitoris: ____________________________________________________

Urethra: ___________________________________________________________________

Labia Majora: __________________________________________________________________

Labia Minora: __________________________________________________________________

Hymen: _______________________________________________________________________

Fossa Navicularis: ____________________________________________________________

Posterior Fourchette: _________________________________________________________

Perineum: __________________________________________________________________

Examiner Signature: _________________________________________________________
ANO-GENITAL ASSESSMENT (continued)

Female Assessment

Vagina: ___________________________________________________

Cervix: ___________________________________________________

Anal Area: ___________________________________________________

☐ Labial Separation  ☐ Lithotomy  ☐ Prone Knee-chest
☐ Labial Traction  ☐ Supine Frog-leg  ☐ Supine Knee-chest

E) ADDITIONAL NOTES:

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

___________________________________________________________________

Examiner Signature:__________________________________________________

UCHealth
MEMORIAL HOSPITAL

1400 E Boulder St
Colorado Springs, CO 80909

Patient Label (all copies please)
Please email this form to Deb Paton at dpaton@safepassagecac.org when a child presents with a report of child sexual and/or physical abuse.

Name of Child: ____________________________________________________________

Reporting Parent/Caregiver: ________________________________________________

Law Enforcement Agency Responding: ________________________________________

Case Number: __________________________________________________________________

Officer Responding: _________________________________________________________

DHS Notified:  ☐ Yes  Name/Referral Number: ______________________________________

☐ No  ☐ N/A

Date of Exam: __________________________________________________________________

Injury Present:  ☐ Yes  ☐ No

Follow-up Medical Exam Recommended:  ☐ Yes  ☐ No

Reason: ___________________________________________________________________

Follow-up Medical Exam to be completed at:  ☐ Memorial Hospital  ☐ Safe Passage

Assailant Name: __________________________________________________________________

Patient/Assailant Relationship: ______________________________________________

Additional Details: __________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

FNE: _________________________________  Date: _________________________________