# PEDIATRIC – ED SEXUAL ASSAULT PEDIATRIC ORDERS
# FORENSIC NURSE EXAMINER PROGRAM

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

MUST PLACE ID LABEL IN THIS BOX ONLY

# PEDIATRIC – ED SEXUAL ASSAULT PEDIATRIC ORDERS
# FORENSIC NURSE EXAMINER PROGRAM

**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

☐ A&D emollient once labial adhesions have separated. Apply 3 to 5 times a day up to 2 months to prevent recurrence. **OR**

☐ Triple antibiotic ointment once labial adhesions have separated. Apply 3 to 5 times a day up to 2 months to prevent recurrence.

☐ 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.

*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 _____-_____-_____/______

MUST PLACE ID LABEL
IN THIS BOX ONLY

**FNE PROGRAM**
**Caregiver Questionnaire - Pediatric**

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?______________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

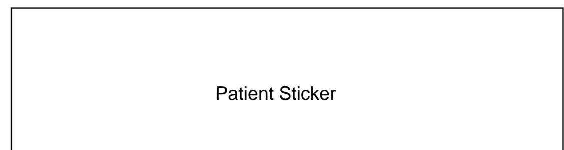
______________________________________________________________________________

What is your primary language?

☐ English ☐ Other (please list)__________________________________

Memorial Hospital
UNIVERSITY OF COLORADO HEALTH

1400 E Boulder
Colorado Springs, CO 80909

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:

| Name | Relationship | Age/DOB (If known) | Ethnicity |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

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:

| Name | Relationship | Age/DOB (If known) | Ethnicity |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

☐ Reviewed by FNE prior to discharge    FNE Signature: ________________________________________

Memorial Hospital
UNIVERSITY OF COLORADO HEALTH

1400 E Boulder
Colorado Springs, CO 80909
Form #1260059 07/20/2013



Patient Sticker

# MEMORIAL HOSPITAL SEXUAL ASSAULT MEDICAL/FORESNIC 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:___________________________________________**

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

1400 E Boulder St
Colorado Springs, CO 80909

Patient Label (all copies please)

## A) HISTORY

Patient's Name:_________________________

1. Patient's description of assault in own words:_____________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

2.Age________________________3.Gravity___________________________4.Parity________________

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:______________________________________________**

1400 E Boulder St
Colorado Springs, CO 80909

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:**_____________________________________________

1400 E Boulder St
Colorado Springs, CO 80909

Patient Label (all copies please)

## DETAILED ASSESSMENT

**Neurological**

**Cardiovascular**

**Respiratory**

**HEENT**

**Gastrointestinal**

**Genito-uniary** ☐ See male detailed ano-genital assessment

**OB/Gynecological** ☐ See female detailed ano-genital assessment

**Skin/Muscle/Bone** ☐ See detailed body map description

**Medical/Surgical History**

**Medications**

**Allergies** **Immunizations**

**Psych/Social**

**Examiner Signature:**________________________________________________

1400 E Boulder St
Colorado Springs, CO 80909

Patient Label (all copies please)

**PHYSICAL ASSESSMENT (continued)**

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

**Tanner Stage: Male**

Genitalia **5 4 3 2 1** Pubic Hair **5 4 3 2 1**

Circumcised: ☐ Yes ☐ No ☐ ALS Used

**Examiner Signature:**____________________________________________

1400 E Boulder St
Colorado Springs, CO 80909

Patient Label (all copies please)

**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: ___________________________________________________**

1400 E Boulder St
Colorado Springs, CO 80909

Patient Label (all copies please)

## 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 Combings | ☐ 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:**____________________________________________

Patient Label (all copies please)

## D) ANO-GENITAL ASSESSMENT

Colposcope:

Used: ☐Yes ☐No     Colposcope Photos: ☐Yes ☐No

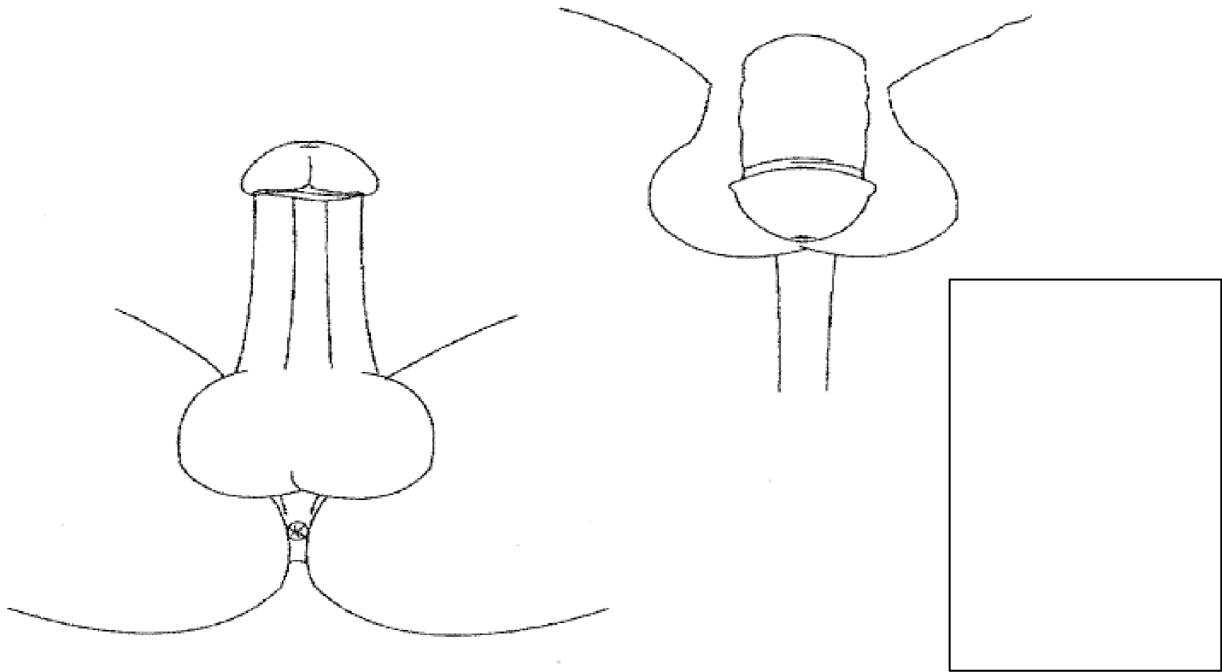
Magnification: ☐3.75     ☐7.5     ☐15.0

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 Drawing

Anal Area: ______________________________________________________________

Penis: ______________________________________________________________

Scrotum: ______________________________________________________________

Perineum: ______________________________________________________________

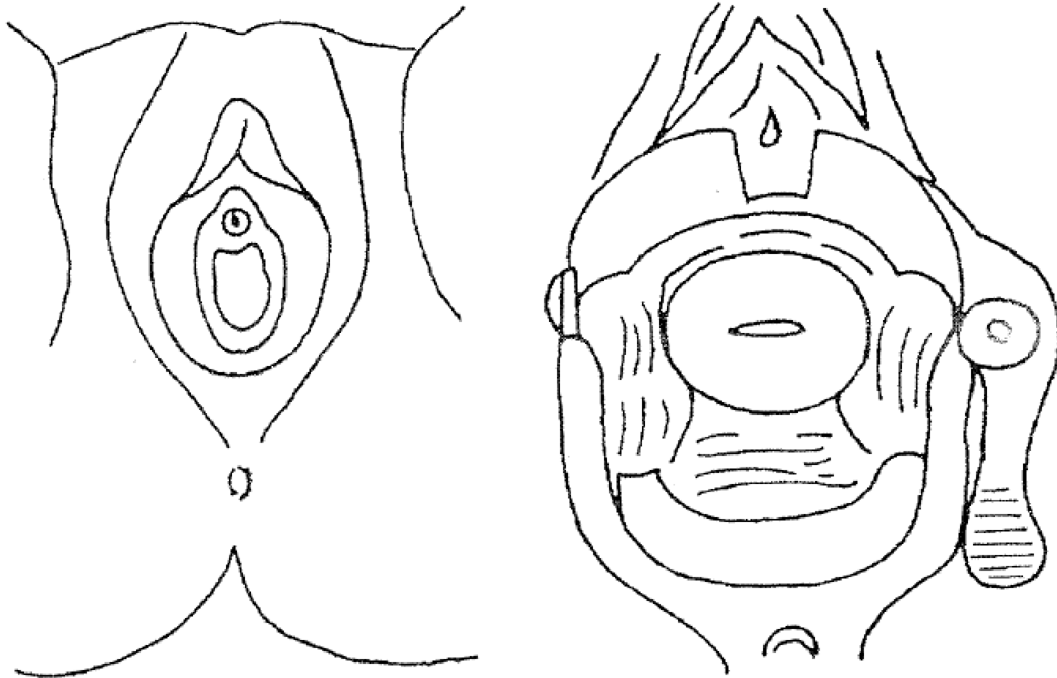
**Examiner Signature:______________________________________________________**

1400 E Boulder St
Colorado Springs, CO 80909

Patient Label (all copies please)

## ANO-GENITAL ASSESSMENT (continued)

### Female Assessment



Mons Pubis: ______________________________________________________________

Clitoral Hood & Clitoris:________________________________________________________

Urethra: __________________________________________________________________

Labia Majora:_______________________________________________________________

Labia Minora: _______________________________________________________________

Hymen: ___________________________________________________________________

Fossa Navicularis: ____________________________________________________________

Posterior Fourchette: __________________________________________________________

Perineum: _________________________________________________________________

**Examiner Signature:__________________________________________________**

1400 E Boulder St
Colorado Springs, CO 80909

Patient Label (all copies please)

**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:**____________________________________________

1400 E Boulder St
Colorado Springs, CO 80909

Patient Label (all copies please)

**FNE Program Child Advocacy Request Form**
**Safe Passage**

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 ☐ No    Name/Referral Number: ____________________ ☐ 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: ____________________

Memorial Hospital
UNIVERSITY OF COLORADO HEALTH

Patient Sticker