PATIENT LABEL

Consent - Medical Forensic Examination

I authorize the facility medical personnel or designee to examine and treat me at _____ _____(hospital) on _____(date) for injuries and/or conditions incurred as a result of a sexual assault that occurred on or about _____ (date). I authorize the hospital staff to obtain any samples and specimens and to conduct any medical tests deemed necessary or helpful for treatment, legal purposes, and to take photographs of any injury or abnormality found.

I understand that I may decline this examination or any part of it. I understand that once the exam begins, I may decline any portion of the exam and I must notify the person conducting the exam that I wish to stop the exam. I understand that this consent authorizes a medical forensic exam, but does not obligate me to report a crime to law enforcement.

The examination is not a routine medical exam. It is being performed in order to document, diagnose, and treat any injuries related to a sexual assault. The medical personnel will not attempt to identify, diagnose, or treat any unrelated and/or pre-existing medical problems that you may have.

I do hereby authorize the following as indicated by my initials but recognize I may change my mind at any time:

_____ Documentation of pre- and post- assault history;
_____ Description of the assault and suspect(s);
_____ Physical examination, which may include genital and rectal exam;
_____ Photographs of injuries;
_____ Swabs from areas of the body that may contain matter such as DNA or debris related to the event;
_____ Blood and/or urine collection for toxicology testing, pregnancy testing, and/or sexually transmitted infection testing;
_____ Medication options for prevention of sexually transmitted infections, HIV, and/or pregnancy; and,
_____ Referral for treatment of injuries related to the assault and/or other medical needs

_____AM / PM	_____	_____	_____
Time	Date	Patient, Parent or Legal Representative Signature	Relationship to Patient

_____
Print Name

Patient unable to sign due to altered mental status - exam completed under implied consent.
Reason for altered mental status:_____

Time:_____ Date:_____ Examiner Signature:_____

PATIENT LABEL

Consent - Medical Forensic Examination

I authorize the facility medical personnel to use photographs and information obtained during my medical-forensic exam for education and training purposes at the designated facility.

___ (initials)

To be completed by the facility medical personnel or designee:
I have fully discussed the procedure and the information included in our facility protocol, which includes a description of the medical-forensic exam as well as a description of the patient's options regarding consent to standard or anonymous collection of the samples, specimens, and information that will be released to law enforcement. The patient was given the opportunity to ask questions and receive information to their satisfaction.

_____AM / PM _____ _____
Time Date Examiner Signature or designee

_____
Printed Name

Interpreter

_____AM / PM _____ _____
Time Date Signature if needed

_____
Printed Name

Declination of Consent for Medical-Forensic Exam:
Patient declined to consent to a medical-forensic exam due to:

_____

_____AM / PM _____ _____ _____
Time Date Patient, Parent or Legal Representative Signature Relationship to Patient

_____
Printed Name

_____AM / PM _____ _____
Time Date Examiner Signature or designee

_____
Printed Name