

DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY MEDICAL COMMAND
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Medical Services
MEDICAL FACILITY MANAGEMENT OF SEXUAL ASSAULT

Supplementation of this regulation and establishment of forms other than MEDCOM forms are prohibited without prior approval from HQ MEDCOM, ATTN: MCHO-CL-H.

TABLE OF CONTENTS

	<u>PARAGRAPH</u>	<u>PAGE</u>
History	1	3
Purpose.....	2	3
Applicability	3	3
References.....	4	3
Explanation of abbreviations and terms	5	3
Responsibilities	6	3
Policy.....	7	10
Confidentiality and reporting options	8	10
Sexual assault forensic examinations	9	12
Triage and intake	10	13
Documentation by healthcare personnel.....	11	14
The medical forensic history.....	12	15
Photography.....	13	17
Examination and evidence collection procedures	14	20
Drug-facilitated sexual assault	15	30
Sexually transmitted infections: evaluation and care.....	16	34
Pregnancy	17	39
Discharge and follow up	18	39

*This regulation supersedes MEDCOM Regulation 40-36, 23 December 2004.

Appendix A. References.....	43
Appendix B. MOU/MOA Template	45
Appendix C. Sexual Assault Healthcare Training Guidance	52
Appendix D. Sexual Assault Response Program Tracking Application	54
Appendix E. Annual Sexual Assault Prevention and Response Program Assessment	55
Appendix F. AMEDD Sexual Assault Response Program ICD-9 CM Coding Guidance	56
Appendix G. Sexual Assault Response Pathway	57
Glossary	58

1. History. This is the third issue of this regulation and publishes a major revision.

2. Purpose. This regulation implements the U.S. Army Medical Command (USAMEDCOM) policy to provide timely, accessible, and comprehensive medical management of sexual assault victims to include compassionate, confidential treatment aimed at restoring health and well-being.

3. Applicability. This regulation pertains to all USAMEDCOM personnel who are directly or indirectly involved in the provision of care to victims of sexual assault.

4. References. References are listed in appendix A.

5. Explanation of Abbreviations and Terms. Abbreviations and special terms used in this regulation are provided in the glossary.

6. Responsibilities

a. The director, health policy and services is responsible for establishing policy and providing guidance for the timely, compassionate, and expected standard of care for victims of sexual assault.

b. The military treatment facility (MTF) commander will—

(1) In accordance with this regulation, ensure that all patients who present to the MTF with an allegation of sexual assault receive a uniform standard of care which is monitored and tracked until the provision of health care related to the sexual assault is completed.

(2) Ensure that the MTF's management of sexual assault victims is compassionate, sensitive, and not burdensome upon the patient.

(3) Ensure that all victims of sexual assault, upon initial encounter with the MTF, have immediate access to assessment by a provider trained in performing forensic examination and evidence collection. The forensic examiner may be a member of the MTF medical staff or available outside the MTF by established memorandums of understanding (MOUs)/memorandums of agreement (MOAs).

(4) Ensure appropriate MOUs/MOAs are established with local non-military medical treatment facilities and medical support activities. The MOUs/MOAs will ensure adequate and comprehensive response and care of victims and will incorporate appropriate administrative procedures to ensure victims who receive care in civilian hospitals are not charged for any aspect of that care. MOUs/MOAs should always be coordinated beforehand with the regional medical command/MTF agreement managers

(normally in the resource management division) and the servicing staff judge advocate. See the MOU/MOA template at appendix B.

(5) Ensure that a sexual assault clinical provider (SACP) manages each sexual assault patient's medical treatment— as directly related to the sexual assault incident— from initial presentation to completion of all follow-up visits.

(6) Ensure that initial and follow-up evaluations/treatments are clinically appropriate for each individual patient consistent with his/her clinical diagnosis, circumstances, and needs and are in accordance with this regulation.

(7) Ensure that all healthcare providers and MTF personnel participate in annual sexual assault awareness and responder training (see appendix C).

(8) Designate a representative to the Installation Sexual Assault Review Board to ensure appropriate information is provided to assist in the case management process.

(9) Ensure that each sexual assault victim is assigned to an SACP.

(10) Assign sexual assault care coordinators (SACCs) to assist SACPs with the delivery of a uniformed standard of care.

(11) Ensure assigned SACCs utilize the Sexual Assault Response Program Tracking Application (SARPTA) (see appendix D) or future enterprise-wide military health system (MHS) applications to maintain the requisite MTF commander database.

(12) Ensure that resources are available to support the standards of practice outlined in this regulation.

(13) Ensure that all clinical staff respond to allegations of sexual assault with sensitivity and compassion.

(14) Ensure unit leaders understand the seriousness and potential consequences of sexual assault and know the proper procedures for referring victims for medical treatment, counseling, and obtaining other services available to them in accordance with Department of Defense (DOD) and Department of the Army (DA) confidential reporting policies.

(15) Ensure the appropriate number of unit victim advocates (UVAs) is appointed on orders to support victim services.

(16) Ensure and maintain collaborative, supportive relationships with relevant installation agencies that have vested interests in the sexual assault victim (for example, the criminal investigation division (CID), Victim Advocacy Program, and the judge advocate general).

(17) Ensure that all providers document (in AHLTA) encounters associated with sexual assault patients according to applicable regulations.

(18) Ensure all those involved in the handling, transferring, and collection of evidence regarding a sexual assault maintain the chain-of-custody according to applicable regulations.

(19) Annually submit questionnaires, including all applicable documentation (no later than 15 Oct for the previous fiscal year), in accordance with Section 113, Title 10, United States Code (USC) and the Department of Defense Instruction (DODI) 6495.02 as related to sexual assaults involving members of the Army (see appendix E of this regulation).

c. The deputy commander for clinical services will—

(1) Ensure that MTF clinical personnel are adequately trained in the standard of care for victims of sexual assault.

(2) Ensure that those who function as forensic sexual assault examiners are trained to the standard of care as provided in this regulation, to include the use of the evidence collection kit.

(3) Ensure that all sexual assault records are reviewed to ensure compliance with established standards of care and that corrective actions are taken when standards of care are not met.

(4) Designate a sufficient number of privileged healthcare providers on orders to be SACPs to ensure adequate, comprehensive continuity of care and management of sexual assault patients according to this regulation.

(5) Designate a sufficient number of healthcare providers on orders to be SACCs so they can assist the SACPs with the delivery of care and management of sexual assault patients according to this regulation.

(6) Develop, maintain, and disseminate a sexual assault standing operating procedure (SOP) for MTF medical personnel consistent with the standards of practice as contained in this regulation. Ensure appropriate State and local jurisdictional laws are considered and incorporated in the medical response and evidence collection portion of the SOP.

(7) Review the MTF SOP and MOUs/MOAs on an annual basis and update as needed in order to meet the objectives of this regulation.

d. The chief, obstetrics/gynecology will ensure that a gynecologist is available for consultation, if needed by the provider performing the forensic examination and collecting forensic evidence.

e. The chief, urology will ensure that a urologist is available for consultation, if needed by the provider performing the forensic examination and collecting forensic evidence.

f. The chief, pediatrics will ensure a pediatrician is available for consultation, if needed by the provider performing the forensic examination and collecting forensic evidence.

g. The chief, family practice will ensure a family practitioner is available for consultation, if needed by the provider performing the forensic examination and collecting forensic evidence.

h. The chief, pathology/laboratory services will—

(1) Ensure that all forensic material forwarded to their service is appropriately labeled, handled, and stored according to applicable regulations.

(2) Ensure that laboratory personnel receive mandatory annual sexual assault awareness training in order to promote the standard of care requiring that sexual assault victims be treated with sensitivity and compassion.

i. The chief, patient administration division will—

(1) Ensure that reports and records of sexual assault patients are received and processed during both duty and nonduty hours in an appropriate and timely manner.

(2) Ensure that clinical encounters of all sexual assault patients documented “sensitive” in AHLTA receive special handling and management according to applicable regulations.

(3) Ensure that patients’ diagnoses are identified with the appropriate International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) code and tracked by this code (see appendix F).

(4) Ensure release of records requested by the CID or civilian law enforcement agencies, in accordance with applicable regulations.

(5) Ensure that electronic and paper records are appropriately retired.

j. The chief, social work service will—

- (1) Ensure that an on-call staff roster is provided to all departments where examiners are located.
- (2) Ensure that a provider physically reports to the examiner location to assist the victim and their caretakers when the victim is a child.
- (3) In instances of assault on an adult, ensure that the on-call provider offers a response to the examiner when no other provision for a victim advocate is available and when the victim requests an advocate.
- (4) Ensure that all sexual assault victims seen by providers are screened for traumatic stress upon initial contact.
- (5) Ensure mental health follow-up care is provided to sexual assault victims, as needed. (In the event that mental health resources are unavailable, the SACC will facilitate mental health care within the community.)
- (6) Ensure social work follow-up care is provided to sexual assault victims as needed.
- (7) Ensure behavioral health encounters are documented in the AHLTA medical record according to applicable regulations.

k. The sexual assault clinical provider will—

- (1) Be responsible for the primary medical management of all identified victims of sexual assault from initial contact to completion of care related to the sexual assault incident according to this regulation.
- (2) Ensure that the patient obtains comprehensive, timely, and appropriate medical care (including follow-up care) relevant to medical conditions arising from the sexual assault incident. This includes, but is not limited to, specialty care and referrals, ancillary support services, and diagnostic testing.
- (3) Coordinate and collaborate with the SACC and installation agencies (for example, Victim Advocacy Program and CID), as needed.
- (4) Be a fully privileged healthcare provider of the MTF medical staff, able to address the medical needs of sexual assault victims.
- (5) Develop an individualized patient management care plan in collaboration with the patient and SACC.

(6) Document the patient's complete care and management according to the provisions of this regulation.

l. The sexual assault care coordinator will—

(1) According to this regulation, monitor and track the healthcare management of each identified victim of sexual assault who presents to the MTF.

(2) Collaborate and coordinate with the SACP to ensure the patient's healthcare needs are addressed from the time of his/her initial MTF encounter until completion of all health care related to the sexual assault incident.

(3) Collaborate and coordinate with the installation sexual assault responses coordinator (SARC) to facilitate resolution of related issues.

(4) Facilitate the timely completion of the patient's comprehensive individualized care plan in a timely manner to include supportive and responsive interaction with the patient.

(5) Maintain the requisite MTF commander database, SARPTA, or future enterprise-wide MHS applications in order to manage sexual assault victims.

(6) Be directly responsible to the MTF commander.

(7) Explain advocacy and counseling services and assess acute stress reaction.

m. The forensic examiner will—

(1) Be a fully privileged healthcare provider of the MTF medical staff, able to address the medical needs of the sexual assault victim.

(2) Be qualified to evaluate, diagnose, and treat a victim of sexual assault.

(3) Ensure continuity of care and appropriate follow up for each patient by direct contact with and referral to the SACP. The best means of achieving this requirement is for the SACP to be the forensic examiner.

(4) Be trained in the performance of forensic examination and evidence collection. (Note: Most of the sexual assault research has shown that the best and most compassionate care is obtained from an individual who is trained and routinely performs these examinations. Sexual assault nurse examiner training is one method that has been shown to accomplish the level of expertise required.)

(5) Perform the forensic examination of all victims/alleged victims of sexual assault. The MTF may, through established MOUs/MOAs, use an alternative provider to perform

the forensic examination and collection of evidence. The SACP must ensure the patient's continuity of care.

n. First responders (emergency medical services/emergency department personnel) will—

(1) Assess the victim's need for treatment of potentially life-threatening or serious injuries, administer necessary first aid, and request/obtain emergency medical assistance according to jurisdictional policy.

(2) Address safety needs of the victim and others at the scene (for example, offenders) and call for assistance/backup, if needed.

(3) Quickly assess the age, abilities, communication modality, and health condition of the victim and tailor response as appropriate (for example, a language interpreter or child protective service worker may be needed).

(4) Notify the SARC (if not present with the victim) to coordinate and respond to requests for victim assistance as quickly as possible. Understand that a victim needs immediate assistance for many reasons: he/she may not be safe, may be physically injured, and/or is experiencing trauma. Be aware that time delays in response can cause loss of evidence and increased trauma.

(5) If injuries do not appear serious, emphasize to the victim the need for medical evaluation and address related health concerns. Also, explain the purpose of the assessment and what happens during the examination process, keeping in mind that the amount of information that the victim wants at this time varies.

(6) Inform the victim about examination facility options (if options exist) and seek the victim's consent for transportation to the facility of his/her choice.

(7) Ensure timely interaction among the victim and victim advocates as soon as possible after disclosure of the assault, even if the victim refuses medical care and refuses the medical forensic examination. Follow local procedures for activating an advocate.

(8) Ensure preservation of crime scene evidence, including evidence on the victim. Document the victim's demeanor and statements related to the assault.

(9) If a victim agrees to seek emergency care and/or have evidence collected—

(a) Explain to the victim how to preserve bodily evidence until it can be collected (for example, do not wash, change clothes, urinate, defecate, smoke, drink, eat, brush hair or teeth, or rinse mouth).

(b) Explain to the victim that clothing most likely will be taken as evidence. He/she may wish to bring or have someone bring a clean change of clothes to the examination facility. If applicable, let the victim know that replacement clothing will be available at the examination site. If he/she changed clothes since the assault, clothing worn during and immediately after the assault will be required for evidence. Follow law enforcement procedures for retrieving clothing or other items from a crime scene so that evidence is not inadvertently destroyed or contaminated.

(c) In suspected cases of drug-facilitated assault, the victim's first available urine sample should be sought if he/she cannot wait to urinate until arrival at the examination site. (The victim may have been drugged without his/her knowledge.) If the victim or his/her family, friends, or responders suspect a drug-facilitated assault, a urine sample should be sought.

(d) Transport or arrange transportation for the victim to the examination site. A victim with disabilities may have equipment (for example, wheelchairs and other assistive devices) and/or service animals that also need to be transported. Equipment should be treated with care because victims may consider equipment as extensions of themselves.

(e) Follow the MTF's SOP and applicable jurisdictional policy on alerting examination facilities about the pending arrival of patients.

(f) Ensure that suspects and victims are not in the same examination facility at the same time, if possible.

7. Policy

a. USAMEDCOM policy is to treat victims of sexual assault and to ensure that MTF personnel are professionally trained to intervene in sexual assault cases. Since incidents of sexual assault constitute violations of the law, DA policy also recognizes a commander's authority to take disciplinary or administrative action in appropriate cases.

b. Medical personnel will execute the requirements of this regulation (for example, the forensic history and examination) in a nonjudgmental manner exemplifying the USAMEDCOM's commitment to establish a healthcare environment that is sensitive, compassionate, responsive, and supportive to sexual assault victims.

8. Confidentiality and reporting options

a. Sexual assault is the most under reported violent crime in our society and in the military. Although the victim's decision to report is a crucial step, reporting is often precluded by the victim's desire that nobody else know about the incident. Assuring privacy and providing a confidential disclosure option for sexual assault victims is critical.

b. Confidentiality or confidential reporting allows a Uniformed Service member to report a sexual assault to designated individuals. Confidential reporting consists of restricted and unrestricted reporting (see appendix G).

(1) Restricted reporting. A Soldier who is sexually assaulted desires medical care, counseling, and victim advocacy without initiating the investigative process should use the restrictive reporting option. Restricted reporting allows a sexual assault victim to confidentially disclose the details of his/her assault to designated individuals and receive medical treatment and counseling, without triggering the official investigative process. Restricted reporting is intended to give victims additional time and increased control over the release and management of their personal information, to empower them to seek relevant information and support, and to allow them to make more informed decisions about participating in the criminal investigation. This additional reporting avenue gives commanders a clearer picture of the sexual violence within their command and enhances a commander's ability to provide a safe environment that contributes to the well-being and mission readiness of its members.

(2) Unrestricted reporting. A Soldier who is sexually assaulted desires medical treatment, counseling, and an official investigation of his/her allegation. Details regarding the incident will be limited to personnel who have a legitimate need to know.

c. Regardless of whether the Soldier elects restricted or unrestricted reporting, confidentiality of medical information will be maintained in accordance with current Health Insurance Portability and Accountability Act (HIPAA) guidelines.

(1) Improper disclosure of covered communications, improper release of medical information, and other violations of this policy are prohibited and may result in disciplinary actions under the Uniform Code of Military Justice, loss of credentials, or other adverse personnel or administrative actions.

(2) Healthcare providers may convey to the command any possible adverse duty impact related to the victim's medical condition and prognosis in accordance with DOD 6025.18-R. Such circumstances, however, do not otherwise warrant an exception to policy, and, therefore, the specific details of the sexual assault will still be treated as covered communication and may not be disclosed.

(3) Additional exceptions are outlined below in cases in which victims elect restricted reporting.

(a) Command or law enforcement officials when disclosure is authorized by the victim in writing.

(b) Command or law enforcement officials when disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of the victim or to another.

(c) Disability retirement boards and officials when disclosure by a healthcare provider is required in determining fitness for duty and disability retirement qualifications. Disclosure is limited to information that is necessary for processing the disability retirement determination.

(d) SARC, victim advocates, or healthcare providers when disclosure is required for the supervision of direct victim services.

(e) Military or civilian courts of competent jurisdiction when disclosure is ordered or required by Federal or State statute. SARC, victim advocates, and healthcare providers will consult with the servicing legal office in the same manner as other recipients of privileged information to determine if the criteria apply and if they have a duty to obey. Until those determinations are made, only non-identifying information should be disclosed.

9. Sexual assault forensic examinations

a. A sexual assault victim has the option to have a sexual assault forensic examination (SAFE) in addition to the general medical care provided as a result of the sexual assault.

b. Healthcare providers performing the SAFE will use the approved DOD Sexual Assault Evidence Collection Kit to gather and preserve evidence. The DOD SAFE kit can be ordered through the MTF medical logistics division.

c. The same process is used for the collection and preservation of sexual assault evidence under the restricted and unrestricted reporting option; however, the restricted reporting option will not trigger the official investigative process and any evidence collected will be documented in a way that ensures the confidentiality of the victim's identity.

(1) For restricted cases, the SARC will generate an alphanumeric restricted reporting case number (RRCN) unique to each incident that will be used (in lieu of personal-identifying information) to label and identify the potential evidence collected from a SAFE, the accompanying documentation, as well as the evidence container (that is, SAFE kit).

(2) Upon completion of the SAFE, the healthcare provider will package, seal, and label the potential evidence container(s) with the RRCN and notify the supporting provost marshal or appropriate agency designated by local policy.

(3) Restricted evidence will be stored for 1 year from the date of the victim's report of the sexual assault.

10. Triage and intake

a. Priority cases.

(1) Sexual assault patients, with or without overt physical injury, will receive priority medical attention.

(2) A private location within the examination facility will be used for taking histories and performing the physical examination of sexual assault victims. This designated area will facilitate meeting the patient's healthcare needs as well as maximizing his/her safety and privacy.

(3) MTF personnel will immediately notify the SACP and SACC to coordinate care of identified sexual assault victims, irrespective of when and where the patient presents for care.

(4) Medical evaluation and treatment of acute injury, trauma care, and safety needs take precedence over the forensic examination and SARC notification. Medical personnel have an affirmative responsibility to preserve forensic materials and evidence in conjunction with any and all administered medical care.

b. Notification of sexual assault responders.

(1) Alert the SACP and SACC of the sexual assault victim's presence and his/her status.

(2) Alert the identified sexual assault forensic examiner of the need for their services. The examiner may be an MTF staff member, such as the SACP, or may be a forensically trained provider outside the MTF per MOUs/MOAs.

(3) Examiners should be available to evaluate a sexually assaulted patient within 2 hours of notification, or a patient should be transported to the designated site for forensic examination within 30 minutes.

(4) Contact the SARC, if not already done.

(5) Contact the on-call social work provider. The social work provider will report for all child cases and, as requested by the examiner, for all adult cases when no other provision for a victim advocate is available and when the victim requests an advocate.

c. Immediate medical and mental health interventions.

(1) Assess the patient's need for immediate medical or mental health intervention prior to the medical forensic examination.

(2) Once any emergent medical injuries have been treated, the SARC or victim advocate (VA) will—

(a) Advise the victim of the reporting options available to him/her.

(b) Explain the benefits and limitations of each option, especially the impact of any State mandatory reporting laws on restricted reporting.

(c) Document the reporting option the victim selects using DD Form 2910 (Victim Reporting Preference Statement).

(3) The SARC or VA will inform the victim about the availability of an optional SAFE. If a victim chooses to undergo a SAFE, and the healthcare provider determines a SAFE is indicated by the facts of the case, the healthcare provider at MTFs that possess a SAFE capability will conduct the examination.

(4) The SARC or VA will also ensure that the victim is aware of any local or State mandatory sexual assault reporting requirements that may limit the possibility of restricted reporting prior to proceeding with the SAFE at the off-base, non-military facility.

11. Documentation by healthcare personnel

a. Medical forensic report.

(1) Examiners are responsible for documenting forensic details of the examination in the medical forensic report, according to jurisdictional policy.

(2) The medical forensic report is documented on DD Form 2911 (Forensic Medical Report: Sexual Assault Examination) provided at DOD Web site: <http://www.dtic.mil/whs/directives/infomgt/forms/eforms/dd2911.pdf>: This form guides the examination and methodical documentation of physical findings and collection of evidence putting together a picture of what happened in an objective and scientific way.

(3) The only medical issues documented in this report are findings that potentially relate to the assault or preexisting medical factors that could influence interpretation of findings.

(4) If the case is reported, the criminal justice system will use the medical forensic report, along with collected evidence, photographs and video images, and victim/witness statements as a basis for investigation and possible prosecution. When custody of forensic reports and collected evidence is transferred to law enforcement officials, DA Form 4137 (Evidence/Property Custody Document) will be used in accordance with AR 195-5.

(5) If examiners are required to testify in court, they will use the report to recall the incident.

(6) Forensic examination records will be maintained separately from the outpatient treatment record to avoid inadvertent disclosure of unrelated information and to preserve confidentiality. The examination site should have clear policies about personnel allowed access to these records according to the HIPAA requirements.

(7) It is vital that the examination documentation be thorough, precise, and accurate.

b. Medical records.

(1) The medical record is not part of the evidence collection kit, and it should not be submitted to the crime lab.

(2) SACPs, SACCs, and all healthcare providers will document the encounter as “sensitive” in AHLTA to protect and promote the welfare of the patient. Paper records will be treated as “sensitive” (that is, maintained in a locked file).

12. The medical forensic history

a. Coordination of history taking and investigative interviewing. The examiner obtains a detailed forensic and medical history by asking questions related to the assault. Such information is intended to guide the examination, evidence collection, and crime lab analysis of findings.

b. Presence of advocates during the history. Victim advocates will provide support and advocacy during the history, if desired by patients.

c. Patient’s needs.

(1) Consider the patient’s needs before gathering the history.

(2) The facility should have procedures in place and examiners should be educated to accommodate the patient’s communication skill level and preferred mode of communicating.

(3) It is important that examiners are aware of and responsive to verbal and nonverbal cues from patients.

(4) Use a private and quiet setting for information gathering.

d. Obtaining the history.

(1) The following information should be routinely obtained from patients:

(a) Date and time of the sexual assault(s).

(b) Pertinent patient medical history.

(c) Recent consensual sexual activity.

(d) Post-assault activities of patients. (For example, have patients urinated, defecated, wiped genitals or the body, douched, removed/inserted a tampon/sanitary pad/diaphragm, used oral rinse/gargled, washed, brushed teeth, ate or drank, smoked, used drugs, or changed clothing?)

(e) Assault-related patient history (for example, memory loss; lapse of consciousness; vomiting; nongenital injury, pain, and/or bleeding; and anal-genital injury, pain, and/or bleeding can direct evidence collection and medical care). Note: Collecting toxicology samples is recommended if there was either loss of memory or lapse of consciousness, according to jurisdictional policy.

(f) Suspect information (if known). Suspect information gathered during this history should be limited to that which will guide the examination and forensic evidence collection.

(g) Nature of the physical assault(s), information about the physical surroundings of the assault(s) (for example, indoors, outdoors, car, alley, room, rug, dirt, mud, or grass), and methods employed by suspects are crucial to the detection, collection, and analysis of physical evidence. Knowing whether suspects may have been injured during the assault may be useful when recovering evidence from patients (for example, blood) or from suspects (for example, bruising, fingernail marks, or bite marks).

(h) Description of the sexual assault(s) including an accurate but brief description is crucial to detecting, collecting, and analyzing physical evidence. The description should include whether or not there was any—

1 Penetration of genitalia (for example, vulva, hymen, and/or vagina of female patient), however slight;

2 Penetration of the anal opening, however slight;

3 Oral contact with genitals (of patients by suspects or of suspects by patients);

4 Other contact with genitals (of patients by suspects or of suspects by patients);

5 Oral contact with the anus (of patients by suspects or of suspects by patients);

6 Nongenital act(s) (for example, licking, kissing, suction injury, and biting);

7 Other act(s) including use of objects;

8 Ejaculation and location(s) of ejaculation (for example, mouth, vagina, genitals, anus/rectum, body surface, on clothing, on bedding, or other); and

9 Use of contraception or lubricants.

(2) The above questions require specific and sometimes detailed answers. Some may be difficult for patients to answer. Examiners should explain that these questions are asked during every sexual assault medical forensic examination. They should also explain why each question is being asked.

13. Photography

a. Extent. Taking photographs of those parts of a patient's anatomy involved in the assault can supplement the medical forensic and physical findings in sexual assault cases.

b. Photographers and equipment. Photographers should be familiar with equipment operation and be educated on forensic photography in sexual assault cases. Jurisdictional and/or local policy will determine which types of equipment produce acceptable results.

c. Patient comfort and privacy.

(1) Minimize the patient's discomfort while they are being photographed and respect their need for modesty and privacy.

(2) Drape the patient appropriately while taking photographs. Take measures to avoid allegations of impropriety when photographing patients. For instance, when a male photographer is photographing a female patient, another woman should be present.

d. Explanation of photography procedures.

(1) Photographers will explain forensic photography procedures to patients. Taking photographs of patients in the aftermath of an assault can be re-traumatizing.

(2) To help reduce the chances of re-traumatization, help patients understand the purpose of photography in forensic evidence collection, the extent to which photographs will be taken and procedures that will be used, potential uses of photographs during

investigation and prosecution (especially anogenital images if taken), and the possible need to obtain additional photographs following the examination.

e. Taking photographs.

(1) Photographers will—

(a) Take initial and follow-up photographs as appropriate.

(b) Strive to control every element in the photograph to produce a clear, powerful statement. Photographs should be taken prior to evidence collection.

(c) Link patient's identity and the date to the photographs. For example, print the patient's name, date of examination, and the photographer's name/initials on a plain sheet of paper. Photograph this sheet at the beginning and end of the roll of film for identification. Also photograph the face of patients for identification purposes. Some cameras offer the option of imprinting the date and/or time on the negative, and some have the ability to enter a case number so the face or name of a patient is not on the film. Mechanisms should be in place (for example, at law enforcement agencies and examination facilities) to protect the patient's privacy and confidentiality while photos are being taken.

(d) Take clear and accurate photographs by using the shutter speed and lens aperture to control exposure (automated cameras and flash units can give incorrect exposures). Use adequate lighting whether the source is natural, flood, or flash. Use of flashes and lighting in the examination room can change the color of evidence; a filter may help adjust lighting so that the photograph is truer to color (noting in records any alternations to the environment to enhance photographs). Include a color bar in the photograph to ensure accurate color reproduction.

(e) Strive for undistorted photographs with good perspective (whenever possible, use a normal focal length lens, keep the camera level, and photograph the subject at eye level). Maintain sharp focus (keep the camera steady, focus carefully, use maximum depth of field, and look at the frame of the scene). A good quality macros lens with a ring strobe flash offers the best quality and most flexibility for forensic photography involving sexual assault.

(f) Use an inch scale or ruler for size reference in photographs. In addition to those photographs that identify patients and anatomical locations being photographed, take at least two photographs of each area—one with and one without scale. Taking two photographs in this manner demonstrates that the scale was not concealing critical evidence. Photograph evidence in place before moving it or collecting it. Do not alter or move evidence when photographing, and make every effort to minimize distraction in photographs while maintaining the focus of areas being photographed.

(g) Photograph bite marks.

(h) Take at least two shots at three orientations—

1 Take full-body images (anterior, posterior, and lateral) with the patient's face visible and clearly identifiable. Position patients approximately two feet from the corner of the room, using walls to reflect and diffuse flash illumination. When photographing the backs of patients, turn their faces toward the camera so that they can be recognized.

2 Take medium-range photographs of each separate injury, including cuts, bruises, swelling, lacerations, and abrasions. Work from one side to the other and then top to bottom or design a workable method. Be consistent. Take "regional" shots to show injuries in the context and orientation of a body region; these photographs should include easily identifiable anatomical landmarks.

3 Take close-up images of particular injuries, using the scale. When photographing a wound, show its relationship to another part of the body. Take at least three photographs involving a wound area. Shield uninvolved breast or genital areas when possible; highly graphic photos may be inadmissible in court and make the case less credible. All injuries should be recorded with a close-up attachment. Try to capture subtleties in texture and color. Document pattern injuries caused by an object. Do not use an external light source around an injured eye as it can cause retinal damage.

(2) Close-up photographs of hands and fingernails may show traces of blood, skin, or hair. Be sure to look for damage to nails or missing nails. Photograph marks of restraint or bondage around wrists, ankles, or neck; they may be compared later with the object in question that made the marks. Photograph transfer evidence present on the body or clothing, such as dirt, gravel, or vegetation.

(3) All photographs should be clearly labeled and the chain-of-custody maintained. Follow jurisdictional policy for the development, transfer, and duplication of film and storage of photographs. Do not include photographs in the evidence collection kit sent to the crime lab.

(4) Follow-up photographs may be necessary. Additional photographs should be taken as new or different evidence on the patient's body is found following the examination (for example, bruising may appear days later). Create procedures for examiners, law enforcement investigators, and patients that ensure this evidence is documented. In addition to documenting emerging or evolving injuries, follow-up photographs provide documentation of healing or resolving injuries and clarify findings of stable, normal variants in anatomy that could be confused with acute injuries.

14. Examination and evidence collection procedures

a. Forensic examination.

(1) Purpose of the forensic examination.

(a) Patient healthcare needs and concerns discovered in the course of the examination should be addressed prior to discharge. However, patients must understand that the examination does not provide routine medical care. For example, a pap smear will not be done during the female pelvic examination.

(b) Every precaution should be taken by all first responders to reduce outside contamination and dilution of evidence. For example, examiners should wear nonlubricated gloves and change them throughout the examination/evidence collection whenever cross-contamination could occur.

(c) Examiners should—

1 Collect as much evidence as possible.

2 Be aware of evidence that may pertain to whether or not the patient consented to the sexual contact with the suspect.

3 Modify the examination and evidence collection to address the patient's needs and concerns.

4 Explain examination and evidence collection procedures to patients.

(2) Procedures.

(a) In addition to instructions included in the evidence collection kit, the examination should be guided by the scope of informed consent and the medical forensic history. In the course of the examination, examiners may question patients about trauma related to the assault. These questions should be specific enough to yield clinically relevant information. For example, simply asking patients if they are injured or hurt anywhere is not as specific as asking if they hurt in specific body locations.

(b) During the general physical examination—

1 Obtain the patient's vital signs.

2 Note the date and time of the examination; physical appearance; general demeanor, behavior, and orientation; and condition of clothing on arrival.

3 Record all physical findings (which include observable or palpable tissue injuries; physiologic changes; and foreign materials such as grass, sand, stains, dried or moist secretions, or positive fluorescence) on body diagram forms.

4 Use an alternate light source to assist in identifying findings.

(c) During the female genital examination, evaluate—

1 The external genitalia and perineal area for injury, foreign materials, and other findings in the following areas: abdomen, thighs, perineum, labia majora, labia minora, clitoral hood and surrounding area, perurethral tissue/urethral meatus, hymen, fossa navicularis, and posterior fourchette. The use of a colposcope during the external genital examination enhances viewing microscopic trauma and may provide photographic documentation.

2 The vagina and cervix for injury, foreign materials, and foreign bodies. Use a colposcope or other magnifying device, if available. In some jurisdictions, toluidine blue dye may be used to detect trauma, either with or without the use of a colposcope.

3 The buttocks, perianal skin, and anal folds for injury, foreign materials, and other findings. If rectal injury is suspected, an anoscope can be used as a tool to identify and evaluate trauma (it may also be used to help obtain anal swabs and trace evidence).

(d) For male patients, examine the external and perineal area for injury, foreign materials, and other findings, including the abdomen, buttocks, thighs, foreskin, urethral meatus, shaft, scrotum, perineum, glans, and testes. Document whether or not the patient is circumcised.

(e) Record findings from the general physical and anogenital examinations on appropriate body diagram forms. Detailed descriptions of findings should be provided as required. During the examination, collect evidence as specified in the evidence collection kit.

b. Collection of biological evidence.

(1) Collect clothing evidence. Paragraphs (a) through (g) below provide procedures for collecting clothing, underwear, and foreign material dislodged while undressing.

(a) Place a clean hospital sheet on the floor as a barrier. Then place the collection paper on the barrier sheet. Be careful to prevent evidence transfer. Document all findings. Ask patients to disrobe (assisting them as requested and then draping them appropriately). When disrobing, have patients remove shoes and then undress over the collection paper to catch any foreign material that is dislodged. If someone assists, he/she should wear gloves. If patients are concerned about privacy while disrobing,

advocates and/or support personnel can turn around, hold up a sheet to shield patients, or leave the room.

(b) Collect clothing pertinent to the assault. First, determine if patients are wearing the same clothes they wore during or immediately following the assault. If so, the clothing should be examined for any apparent foreign material, stains, or damage. When the determination has been made that items may contain possible evidence, those items should be collected. If it is determined that patients are not wearing the same clothing, examiners should inquire as to the location of the original clothing. If the original clothing is not at the examination site, information on clothing location should be provided to law enforcement personnel (if involved) so that clothing can be retrieved before any potential evidence is destroyed. In addition to collecting underwear worn at the time of or immediately after the assault, collect underwear patients are wearing at the time of the examination (if relevant to the case).

(c) Be sensitive about how much clothing to take as evidence. For example, take the patient's coat or shoes only if it is determined that there may be evidence on them. Examination site personnel can coordinate with advocacy programs to ensure that replacement clothing is available for patients in a range of sizes. This clothing is critical in some instances (for example, a patient may own only the clothing that is being collected).

(d) If female patients are menstruating, collect tampons and sanitary napkins. Air-dry them as much as possible and then place them in a separate paper collection bag.

(e) Follow jurisdictional policy for handling and transporting wet evidence that cannot be dried thoroughly at the examination site (for example, wet clothing, tampons, and sanitary napkins).

(f) Ensure wet evidence is packaged in leak-proof containers and separated from other evidence when being transported. It is critical to alert involved law enforcement representatives and crime lab personnel about the presence of wet evidence and the need for immediate analysis or further drying. After drying items according to jurisdictional policy, place each piece of clothing and collection paper in a separate paper bag. Label, seal, and initial seal. If additional bags are needed, use new grocery-style paper bags only. The barrier sheet is not submitted as evidence.

(g) Package evidence in bags. Label, seal, and initial the seal.

(2) Collect debris.

(a) Collect obvious debris on the patient's body (for example, dirt, leaves, fibers, and hair) on a collection sheet. Package, label, seal, and initial seal.

(b) For fingernail evidence, ask patients whether or not they scratched the suspect's face, body, or clothing. If so, or if fibers of other materials are observed under the patient's fingernails, collect fingernail clippings, scrapings, and/or swabbings. If fingernail scrapings are collected, package fingernail scrapings and tools used to obtain the sample. Label, seal, and initial seal. Cut broken fingernails at the remaining jagged edge for later comparison. Collect a fake nail as a known sample if one is missing. Package, label, seal, and initial the seals.

(c) If requested, assist patients in putting on examination gowns after clothing and debris are collected.

(d) Collect foreign materials and swabs from the surface of the body.

1 Carefully inspect the body—including head, hair, and scalp—for dried or moist secretions and stains (for example, blood, seminal fluid, sweat, and saliva) and other foreign material.

2 Use an alternate light source to assist in identifying evidence. Obtain swabs from any suspicious area that may be a dry secretion or stain, any moist secretion, any area that fluoresces with longwave ultraviolet light, and any area for which patients relate a history or suspicion of bodily fluid transfer (for example, licking, kissing, biting, splashed semen, or suction injury).

3 Also collect swabs from potentially high-yield areas (for example, neck, breasts, or external genitalia) if the history is absent or incomplete.

4 Flake off dried secretions and/or swab-dried secretions with a swab moistened with one drop of water. Swab moist secretions with a dry swab. Separate swabs should be used for every sample area collected. Follow local policies regarding the number of swabs required to collect each specimen.

5 Swab bite marks.

6 Optional: Smear swabs onto microscope slides, according to local policy.

7 Cut matted head, facial, or pubic hairs bearing crusted material (or flake off material if possible) and place in an envelope.

8 According to local policy, air-dry all specimens and package swabs and slides separately. Label, seal, and initial seals. Note that coding of evidence must allow the crime lab to know which swab was used to prepare which slide.

9 If teeth are flossed prior to oral swab collection, package the used floss. Label, seal, and initial the seal.

(3) Collect hair combings.

(a) The purpose of this procedure is to collect hair shed of suspects that may have been transferred to the patient's hair. Hair combings may also reveal other foreign materials. Some jurisdictions collect head hair combings only if indicated. Whether or not head hair combings are collected, it is important to examine head, facial, and pubic hair for secretions, foreign materials, and/or debris and collect as appropriate. Pubic hair combings are typically collected if the assault involved the genital area of patients.

1 Head and hair combings. Use the comb and collection paper provided for this procedure. Place the unfolded paper under patient's head. Comb head hair towards paper (patients may comb). Fold comb with debris/hair into paper and package paper. Label, seal, and initial the seal.

2 Pubic hair combings. Use the comb and collection paper provided for this procedure. Place the unfolded paper under the patient's buttocks and comb hair toward paper (patients may comb). Fold comb with debris/hair into paper and package paper. Label, seal, and initial the seal.

(b) Collect hair reference samples as needed. Follow local policy for collection of hair reference samples. Many jurisdictions do not collect pubic hair reference samples routinely. In other jurisdictions, both samples are collected routinely unless otherwise indicated or declined by patients. Whatever the jurisdictional policy, patients should always be informed about the purpose of collection, procedures used to collect samples, discomfort that may be involved, and how these samples may be used during the investigation and prosecution. If hair reference samples are not collected at the initial examination, it is important to inform patients that there might be a need to collect these samples for crime lab analysis at a later date. They should be aware that hair evidence collected at a later date may not be as conclusive as it is if collected at the time of the initial examination due to the fact that hair characteristics can change over time.

(c) When these samples are collected, the indications, timing, and techniques vary. Jurisdictional policies should be in place and followed. Give patients the option of collecting samples themselves.

(4) Collect oral and anogenital swabs and smears.

(a) With the patient's consent, the medical forensic history and examination findings should guide collection of oral and anogenital specimens. In general, specimens should be collected only from orifices and areas surrounding the orifices that patients report as being involved in the assault. Some patients may be vague about the type(s) of sexual contact that occurred. Examiners can help clarify which orifices were involved by

asking appropriate questions. If there is uncertainty about involved orifices (for example, because patients have little memory of the assault, were unconscious or incoherent, or do not understand what occurred), collection from oral, vaginal, and anal orifices (with the patient's permission) may be appropriate. In some jurisdictions, policy requires collection from all three orifices. In all cases, the patient's consent is needed to collect these samples.

(b) When collecting these swabs and smears—

1 Caution patients who use the bathroom prior to the examination that evidence may be present in pubic, genital, and anal areas and urge them not to wash or wipe away secretions until after evidence collection.

2 When taking a swab, examiners should take care to not contaminate the collection with secretions or materials from other areas, such as vaginal to rectal or penile to rectal.

3 Follow jurisdictional policy for collecting swabs (and the number of swabs used to collect a sample), smearing swabs on slides, and drying and packaging swabs and slides. Also, follow local policy for timeframes in which samples should be collected (for example, in one jurisdiction, oral and penile samples are only collected within 24 hours of the assault) unless otherwise indicated.

4 Do not stain or chemically fix swabs or smears.

5 When preparing slides, note that coding of evidence must allow the crime lab to know which swab was used to prepare which slide.

6 Document any foreign substance or material introduced by healthcare providers (for example, lubricating jelly on a speculum or betadine prior to introduction of a catheter).

(c) Oral sample.

1 Place swabs together to collect specimen from oral cavity between gums and cheeks and under tongue. Remove dentures and swab with same swabs.

2 Optional: Smear swabs onto two microscopic slides.

3 Air-dry swabs and slides.

4 Package slides and swabs and place in envelope. Label, seal, and initial the seal.

(d) External genital sample.

1 Swab external genital dry-skin areas with swabs (blind swabbing by protocol or history), at least one dry and one moistened with a drop of sterile, distilled, or deionized water, according to jurisdictional policy.

2 Optional: Smear swabs on two microscope slides.

3 Air-dry swabs and slides.

4 Package slides and swabs and place in envelope. Label, seal, and initial the seal.

(e) Vaginal/cervical sample.

1 Use swabs together to collect a sample from vaginal pool. It is prudent to collect swabs from both the vagina and cervix, regardless of the time between assault and examination.

2 Optional: Smear swabs onto microscope slides.

3 Air-dry swabs and slides.

4 Package slides and swabs and place in envelope. Label (specifically indicating sampling site), seal, and initial the seal.

(5) Wet-mount examinations.

(a) Some jurisdictions require examiners to conduct wet-mount examinations of vaginal/cervical secretions for motile and nonmotile sperm when a male suspect may have ejaculated in a patient's vagina.

(b) Because sperm motility decreases quickly with time and removal from the vagina/cervix, wet-mount evaluation during the examination can provide the only opportunity to see sperm motility.

(c) The presence of motile sperm may help define the timeframe in which the crime occurred. In other jurisdictions, however, the crime lab is responsible for all analysis of evidence and examiners do not conduct the wet-mount evaluation for sperm.

(d) Follow jurisdictional policy on whether wet-mount evaluation for sperm is needed and methods of evaluation. If it is required, examiners should be educated on using the microscope, identifying sperm, and reporting their findings.

1 Prepare a wet-mount slide according to jurisdictional policy. Smear one swab collected from the vaginal pool on a slide. Typically, the slide is prepared by placing one drop of normal saline onto the slide. Roll the swab into the drop and place a cover slip on the slide.

2 View for presence of sperm under a microscope at 400x or by using a phase contrast or other optically staining microscope (within 10 minutes of preparing slide).

3 Air-dry this swab and slide (not removing the cover slip).

4 Package swab and slide and place in envelope. Label as “wet mount” (specifically indicating sampling site), seal, and initial the seal. Immediately following collection of vaginal/cervical samples and any necessary wet-mount evaluation, the pelvic examination should be performed and any necessary medical cultures taken.

(e) Penile sample.

1 Slightly moisten swabs with distilled water and thoroughly swab the external surface of the penile shaft and glans. Swab all outer areas of the penis and scrotum where contact is suspected.

2 Gently roll the swabs over one of the microscope slides, according to jurisdictional policy.

3 Air-dry swabs and slides.

4 Package slides and swabs and place in envelope. Label, seal, and initial the seals.

5 Immediately following this procedure, any necessary medical cultures should be taken.

(f) Perineal area sample.

1 If there was vaginal/anal contact, there may be leakage of semen in the perineal area. Use an alternate light source on the anal area and flake off or swab areas of dried secretions.

2 Optional: Smear swabs on microscopic slides, according to jurisdictional policy.

3 Flaked dried secretions should be placed into the provided container. Air-dry swabs and slides and package them separately and place in envelope. Label, seal, and initial the seal.

4 Avoid contaminating anal/rectal samples by cleansing the perianal area after external secretions and foreign materials have been collected.

(g) Anal/rectal sample.

1 Collect swab from the anal cavity. Avoid contact with external skin surfaces.

2 Optional: Smear swabs on microscopic slides, according to jurisdictional policy.

3 Air-dry swabs and slides.

4 Package swabs and slides and place in envelope. Label, seal, and initial the seal.

5 At this time, any additional examinations or tests involving the anus should be conducted.

(6) Buccal swabs, saliva, and blood for deoxyribonucleic acid (DNA) analysis and comparison.

(a) DNA reference samples. Many samples collected during the examination contain a mixture of secretions. To interpret genetic typing results obtained from these swabs, it is essential to know the genetic profile of patients. The patient's DNA reference samples are used for this purpose. Follow jurisdictional policy regarding the type of samples accepted by the crime lab. Collection of a buccal swab or saliva sample is encouraged unless it is medically or forensically necessary to take blood. If a blood sample is collected, the most noninvasive method of collection should be used.

(b) Buccal swabs.

1 On a case-by-case basis, decide whether it is appropriate to collect a buccal (inner cheek) swab reference sample for DNA typing rather than a blood sample. For example, a blood sample may not be needed or patients might not allow blood to be drawn. A saliva sample is an alternative to the buccal swab. (Note that buccal swabs and saliva samples are not suitable for blood typing and serology.) If oral copulation is asserted or suspected, a buccal swab or saliva sample for the patient's DNA reference may be contaminated. In those cases, blood is usually the better reference sample.

2 To collect, have patients rinse their mouths with tap water and then expose the inner cheek area. Swab this area with gentle pressure. Air-dry the swab, package, and place in envelope. Label, seal, and initial the seal.

(c) Saliva sample.

1 Have patients saturate with saliva the inner circle of a folded piece of absorbent paper (for example, filter paper).

2 Allow the paper to air-dry according to jurisdictional policy.

3 Without touching the inner circle, package the paper and place in envelope. Label, seal, and initial the seal. (Patients should not eat, drink, or smoke for at least 15 minutes prior to the saliva sample collection.)

(d) Dry blood.

1 If drawn blood is not being collected for medical or toxicological purposes, consider dry blood collection because it is a less invasive method of blood collection.

2 Using a betadine swab, wipe the tip of the left or right ring finger.

3 Using a sterile lancet, prick the finger.

4 While holding the finger over one of four circles on the blood collection card, milk the finger, allowing two drops of blood to fall in a circle. Repeat the procedure for the remaining circles as required by jurisdictional policy (it may not be necessary to fill all four circles).

5 Allow blood to air-dry according to jurisdictional policy. Write the patient's name on the first line. Package according to jurisdictional policy and place in envelope. Label, seal, and initial the seal.

(e) Drawn blood.

1 In order to minimize the patient's discomfort, collect drawn blood needed for the reference sample at the same time blood is collected for medical or toxicological purposes.

2 Blood for the reference sample may be collected in lavender-top and/or yellow-top blood drawing tubes. These colored tubes contain preservatives suitable for forensic blood typing. The color to use is typically specified by the designated crime lab. If tubes are included in the evidence collection kit, check expiration dates and replace if expired. Mix according to jurisdictional policy.

3 Write the patient's name, date and time of collection, and the collector's initial on the tube. Package according to jurisdictional policy and place in envelope. Label, seal, and initial the seal.

(f) Collect other evidence. Other evidence may be collected beyond that required for the sexual assault evidence collection kit.

c. Toxicology samples.

(1) Make the decision about whether to collect toxicology samples for forensic purposes, what to collect, and collection methods according to jurisdictional policy.

(2) Do not put toxicology samples in the sexual assault evidence collection kit, unless otherwise indicated. Identify which forensic labs the jurisdiction has selected to analyze these samples, choose a lab, and follow transfer policies.

(3) Keep medical specimens separate from forensic specimens obtained during the examination. Specimens collected for medical purposes should be kept and processed at the medical facility, and specimens collected for forensic analysis should be transferred to the crime laboratory or other specified laboratories for analysis (with the patient's consent).

(4) It is not necessary to maintain the chain-of-custody on medical specimens; instead, follow examination facility policy for documenting medical care and storing medical records.

15. Drug-facilitated sexual assault

a. Training and development of policies.

(1) MTF providers must recognize that sexual assault assailants may use numerous drugs (including alcohol) to facilitate sexual assault, and providers must also understand the urgency of collecting toxicology samples, if medically necessary, or if a drug-facilitated sexual assault is suspected.

(2) MTF providers should also be aware that collection of toxicology samples is typically separate from the sexual assault forensic evidence collection kit, and procedures for toxicology analysis may be different from that of other evidence analysis.

(3) Ideally, the first available urine sample should be collected in suspected drug-facilitated sexual assault cases.

(4) Law enforcement agencies and emergency medical services should develop procedures and staff training for collection in cases where patients must urinate before arriving at the examination site. Advocates and other professionals who may have contact with patients prior to their arrival at the examination site should also be educated to provide those who suspect that drugs were used to facilitate the assault with information on how to collect a sample if they cannot wait to urinate until they get to the examination site.

b. Response to voluntary use of drugs and/or alcohol.

(1) It may be revealed during the examination process or through toxicological analysis that patients voluntarily used drugs and/or alcohol just prior to the assault.

(2) Voluntary drug and/or alcohol use by patients during this period should not diminish the perceived seriousness of the assault. Law enforcement officers and prosecutors should guard against disqualifying cases in which patients voluntarily used illegal drugs or illegally used alcohol.

(3) Patients should understand that information related to voluntary alcohol or drug use may be used against them in court, but also that in some instances it might be helpful in prosecuting a case (see para d below on explanation of procedures). Also, before pursuing charges related to illegal drug or alcohol use by patients, prosecutors should give careful consideration to the impact that the threat of such charges may have on the patient's willingness to report the sexual assault and be involved in subsequent criminal justice proceedings.

(4) Some patients may self-medicate to cope with post-assault trauma and require immediate medical treatment. In addition, ingestion of drugs and/or alcohol during this period may affect the quality of evidence and impede the patient's ability to make informed decisions about treatment and evidence collection. Such voluntary use of drugs and alcohol between the assault and the examination must be documented.

c. Circumstances in which testing may be indicated.

(1) Routine toxicology testing is not recommended. However, in any of the following situations, the collection of a urine and/or blood sample may be indicated:

(a) If a patient's medical condition appears to warrant toxicology screening for optimal care (for example, the patient presents with drowsiness, fatigue, light-headedness, dizziness, decreased blood pressure, memory loss, impaired motor skills, or severe intoxication);

(b) If a patient or accompanying persons (for example, family member, friend, or law enforcement representative) states the patient was or may have been drugged; and/or

(c) If a patient suspects drug involvement due to a lack of recollection of event(s).

(2) Patients should be questioned about involuntary drug/alcohol use only if determined to be medically necessary or if there is a suspicion the assault was drug-facilitated.

d. Explanation of testing procedures.

(1) Seek informed consent from patients to collect toxicology samples. Patients should understand the following before agreeing to toxicology testing:

(a) The purposes of toxicology testing and the scope of confidentiality of results;

(b) The ability to detect and identify drugs and alcohol in the blood and urine can only occur during a limited time period following ingestion;

(c) There is no guarantee that testing will reveal that drugs were used to facilitate the assault;

(d) Testing may or may not be limited to drugs commonly used to facilitate sexual assault and may reveal other drugs or alcohol that patients may have ingested voluntarily;

(e) Whether or not any follow-up treatment is necessary if testing reveals the presence of drugs used to facilitate sexual assault;

(f) Test results showing voluntary use of drugs and/or alcohol may be discoverable by the defense and used to attempt to discredit patients or to question their ability to accurately perceive the events in question (however, these results could also help substantiate that voluntary drug and/or alcohol use sufficiently impaired the patient's consent and prevented legal consent);

(g) Whether or not there is a local prosecution practice of charging sexual assault victims for illegal voluntary drug and/or alcohol use revealed through toxicology screening;

(h) Failure or refusal to undergo testing when indicated by circumstances as described above may negatively impact the investigation and/or prosecution;

(i) When and how to obtain information on the results from toxicology testing;

(j) Who will pay for toxicology testing; and

(k) Whether or not patients have the opportunity to revoke their consent to toxicology testing.

(2) Care should be taken when providing the above information to patients. In particular, they may need to hear repeatedly from examiners that voluntary use of drugs and/or alcohol, if any, does not reduce the seriousness of the assault. Under no circumstances should the medical forensic examination and treatment be conditional based on whether or not the patient consents to toxicology testing.

e. Collecting samples.

(1) Toxicology samples should be collected as soon as possible after a suspected drug-facilitated case is identified and informed consent is obtained, even if patients are undecided about reporting to law enforcement.

(2) The length of time that drugs used for drug-facilitated assault remain in urine or blood depends on a number of variables (for example, the type and amount of drug

ingested, the patient's body size and rate of metabolism, whether patients had a full stomach, and whether they previously urinated).

(3) Collect a urine sample.

(a) Urine allows a longer window for detection of drugs commonly used in these cases than does blood. The sooner a urine specimen is obtained after the assault, the greater the chances of detecting drugs that are quickly eliminated from the body.

(b) Immediately collect a urine sample when appropriate. If patients may have ingested a drug used for facilitating sexual assault within 96 hours prior to the examination, a urine specimen of at least 30 milliliters but preferably 100 milliliters (about 3 ounces) should be collected in a clean plastic or glass container (follow jurisdictional policy).

(c) The urine sample does not have to be a clean catch (for example, blood in the urine will not compromise test results). If patients cannot wait to urinate until their arrival at the examination facility, first responders should ask them to provide a sample and bring it to the facility, documenting the chain-of-custody. It is suggested that law enforcement officers and emergency medical technicians keep toxicology screening kits readily available, according to local agency policy.

(d) Ideally, patients should not urinate until after evidence is collected. However, the number of times that patients urinated prior to collection of the sample should be documented.

(4) Collect a blood sample when appropriate.

(a) If ingestion of drugs used to facilitate sexual assault may have occurred within 24 hours prior to the examination, a blood sample of at least 20 milliliters should be collected in a gray-top tube (contains preservatives sodium fluoride and potassium oxalate) according to jurisdictional policy.

(b) A blood sample taken within this time period may pinpoint the time when drugs were ingested. If a blood sample is collected for toxicology screening, it should be accompanied by a urine sample.

(c) If blood alcohol determination is needed, collect blood within 24 hours of alcohol ingestion, according to jurisdictional policy. (If blood has already been taken due to suspected drug ingestion, that sample can be used to determine blood-alcohol level. An additional sample usually is not needed.)

(5) Occasionally, patients of drug-facilitated sexual assault vomit. The analysis of the vomit may also be useful to an investigation. Collect and preserve according to jurisdictional policy.

(6) Package all samples as appropriate, but pay particular attention to toxicology samples and package according to the policy of the lab doing the analysis and place in envelope. Label, seal, and initial the seal.

f. Toxicology labs.

(1) Examination facility laboratories should not analyze toxicology samples in suspected drug-facilitated sexual assault cases. Instead, involved criminal justice agencies should identify forensic laboratories that can analyze these toxicology samples (they should have the capacity to detect drugs in very small quantities). Information about these labs (for example, contact information, evidence collection and packaging procedures, and transfer procedures) should be provided to law enforcement representatives, examination facilities, and examiner programs investigating these cases.

(2) If toxicology tests are needed purely for the medical evaluation of patients, the examination facility lab typically performs these tests. Lab results are recorded in the patient's medical record, according to facility policy. If toxicology samples are needed for both clinical and forensic purposes, one sample can be collected for immediate evaluation by the examination facility lab and another for analysis by the identified forensic lab. Take samples at the same time to minimize patient discomfort.

g. Preservation of evidence and chain-of-custody.

(1) Involved healthcare personnel should be aware of the toxicology lab's requirements on collection, packaging, labeling, storage, handling, transportation, and delivery of specimens.

(2) Policies should be in place for storage of these samples when patients are undecided about reporting. As with any forensic evidence, the chain-of-custody must be maintained.

16. Sexually transmitted infections: evaluation and care

a. Information on sexually transmitted infections (STIs).

(1) Offer patients information to include the risks of STIs, symptoms and the need for immediate examination if symptoms occur, testing and treatment options (and the need for abstinence from sexual intercourse until treatment is completed), follow-up care, and referrals as needed.

(2) Patients should be aware of the scope of confidentiality related to STI information in their medical records. The level of detail needed when providing this information verbally varies (for example, some patients may be aware of risks and want treatment, while others may not be as knowledgeable of risks or their options).

b. STI testing.

(1) The medical forensic examination presents an opportunity to identify preexisting STIs, regardless of when they were acquired, and for examiners to make recommendations for specific treatment. Testing for STIs at the time of the examination also gives examiners and patients the option of deferring treatment until it is needed.

(2) Trichomoniasis, bacterial vaginosis, gonorrhea, and chlamydial infections are the most frequently diagnosed infections among sexually assaulted women.

(3) Seek the informed consent of patients for testing, if indicated, following Centers for Disease Control and Prevention (CDC) guidelines.

(4) The identification of STIs after an assault is usually more important for psychological and medical management than for forensic purposes.

c. STI prophylaxis.

(1) Encourage patients to accept STI prophylaxis, if indicated.

(2) Routine preventive therapy after a sexual assault is often recommended because follow up with these patients can be difficult. It also may reduce the need for more expensive/extensive treatment if an STI is discovered at a later time.

(3) Meet or exceed current CDC guidelines for STI preventive therapy.

(4) If prophylaxis is declined at the time of the initial examination, it is medically prudent to obtain cultures and arrange for a follow-up examination and testing (it is recommended that all patients are reexamined (see para d below on follow-up activities)).

(5) Document, in their medical record on either SF 600 (Chronological Record of Medical Care) (outpatient) or SF 509 (Medical Record Progress Notes) (inpatient) or the electronic equivalent(s), the patient's decision and rationale for declining prophylaxis.

(6) For nonsexually active patients, taking a prophylaxis may prevent development of STIs that could be used as evidence if the suspect had an STI. In all cases, the patient's medical needs take priority over collection of forensic evidence. However, patients should understand the consequence of taking the STI prophylaxis and be able to make their own decisions about treatment.

(7) If the patient's clinical presentation suggests a preexisting ascending STI, such as fever, abdominal or pelvic pain, and/or vaginal discharge, they should be evaluated

and treated for the ascending infection. This treatment may differ from suggested STI prophylaxis.

(8) Hepatitis B virus (HBV) and postexposure prophylaxis.

(a) See CDC recommendations related to HBV diagnosis, treatment, prevention, postexposure immunizations, prevaccination antibody screening, postexposure prophylaxis, and special considerations.

(b) Patients who have completed a full hepatitis B vaccination regimen prior to the assault are protected from HBV infection and do not need further doses. For those who were not fully vaccinated prior to the assault, the vaccine should be completed as scheduled.

(c) Patients unvaccinated prior to the assault or unsure of whether they have been vaccinated should receive active post-exposure prophylaxis (for example, hepatitis B vaccine alone) upon the initial clinical evaluation. Follow-up doses should be given 1 to 2 and 4 to 6 months after the first dose. Unless suspects are known to have acute hepatitis B, hepatitis B immune globulin (HBIG) is not required. (When HBIG is needed, use CDC recommended doses.)

(d) Examiners must stress to patients receiving the HBV vaccine the importance of following up for administration of doses as scheduled for full protection. Advocates should also be educated about the possibility of patients receiving HBV prophylaxis and encourage those who start the vaccine regimen to follow up for required additional doses.

(e) Obtain informed consent from patients for treatment. Patients should be aware of the benefits and toxicity associated with recommended regimens.

d. Follow-up care.

(1) Encourage follow-up STI examinations, testing, immunizations, counseling, and treatment as directed. Although patients may be reluctant to go for STI follow-up examinations, such examinations are essential because they provide an opportunity to detect new infections acquired during or after the assault; complete hepatitis B immunization, if indicated; and complete counseling and treatment for other STIs. STI examinations for all patients should be repeated according to examination facility policy. The CDC recommends a follow-up appointment within 1 to 2 weeks of the assault. If patients tested negative at the time of the medical forensic examination and chose not to receive prophylaxis, follow-up testing should be conducted. The CDC recommends that in this case the follow-up examination be done within a week to ensure that positive test results are discussed promptly with patients and treatment is offered. The CDC recommends follow-up testing for patients who received treatment only if they report having symptoms consistent with an STI. (However, patients who were treated should

be informed of the option of follow-up testing to confirm the presence or lack of infection.) The CDC recommends that testing for syphilis and human immunodeficiency virus (HIV) infection be repeated 6, 12, and 24 weeks after the assault if initial test results were negative and if these infections are likely to be present in assailants.

(2) It is important that follow-up communication with patients (particularly by examiners and advocates) include a reminder to go to follow-up examinations and receive STI-related testing, immunizations, and treatment as directed. Advocates and healthcare personnel may be able to assist patients in making follow-up appointments, obtaining transportation to and from appointments, and determining how to pay for expenses involved with follow-up testing and care. Some jurisdictions may cover follow-up treatment as part of initial care through funds such as crime victims' compensation. In such instances, patients may be more likely to seek follow-up treatment. Advocates may also be able to accompany patients to these follow-up appointments.

e. Concerns about HIV infection.

(1) Although the risk of HIV infection from a sexual assault appears to be low, it is typically of grave concern for sexual assault patients.

(2) Provide information and referrals. Examiners should talk with patients about their concerns regarding the possibility of contracting HIV. As with other STIs, offer patients information about HIV risks, symptoms and the need for immediate examination if symptoms occur, testing and treatment options, and the need for abstinence from sexual intercourse until any treatment received is completed. Include local referrals for testing/counseling and comprehensive HIV services in the community and region. This information can help patients make decisions about testing and treatment based on facts rather than fear.

(3) Discuss testing options. Baseline HIV testing is not typically an examination component. However, if the assault is considered at high risk for HIV exposure, patients should establish their baseline HIV status within 72 hours after the assault and then be tested periodically as directed by healthcare personnel. Even if the assault is not considered at high risk for HIV exposure, some patients may still wish to be tested.

(4) HIV testing should occur in settings where counseling can be offered to explain results and implications. When providing testing referrals, let patients know whether testing services are free, anonymous, and/or confidential. Confidential and anonymous testing is recommended.

(5) Assess the need to offer HIV post-exposure prophylaxis. In certain circumstances, the likelihood of HIV transmission may be reduced by post-exposure therapy for HIV with antiretroviral agents. Post-exposure therapy with zidovudine has been associated with a reduced risk for HIV infection and has become the standard of care for health workers who have percutaneous (for example, needle stick) exposure to

HIV, but whether these findings can be extrapolated to other exposure situations, including sexual assault, is unknown.

(6) The use of antiretroviral agents after possible exposure through sexual assault must balance potential benefits of treatment with its possible adverse side effects. Healthcare personnel must evaluate the patient's risk of HIV exposure and consider whether to offer treatment based on their perceived risk. Examiners unfamiliar with known risks associated with exposure or side effects of postexposure therapeutic agents should consult with an HIV treatment specialist. Numerous factors may influence the decision to offer treatment, such as the time since the exposure occurred, the probability that the assailant is infected with HIV, the likelihood that transmission could occur from the assault, and the prevalence of HIV in the geographic area or institutional setting (for example, a prison) where the assault occurred.

(7) Offer post-exposure HIV prophylaxis to patients at high risk for exposure, particularly when it is known that suspects have HIV/AIDS. If offered, the following information should be discussed with patients:

(a) The unknown efficacy of postexposure prophylaxis for HIV in cases of sexual assault;

(b) The known side effects and toxicity of antiretroviral medications;

(c) The need for frequent dosing of medication and the follow-up care necessary;

(d) The importance of compliance with the recommended therapy;

(e) The necessity for immediate initiation of treatment for maximum effectiveness; and

(f) The estimated costs of the medication and monitoring.

(8) When given following a sexual assault, post-exposure prophylaxis is the same as for occupational exposure to HIV. Refer to CDC recommendations for post-exposure antiretroviral therapy and consult with an HIV specialist where possible. Careful monitoring and follow up by a healthcare provider or agency experienced in HIV issues is required. Patients should be alerted to symptoms of primary HIV infection (for example, fever, fatigue, sore throat, lymphadenopathy, and rash) and seek care if these symptoms arise.

(9) Seek informed consent from patients to administer treatment. The decision to begin or withhold treatment should be made by patients and healthcare personnel after patients have been adequately informed of the risks and benefits of treatment options.

17. Pregnancy

a. Patients of different ages, social, cultural, and religious/spiritual backgrounds may have varying feelings regarding acceptable treatment options. Examiners and other involved healthcare personnel must be careful not to influence the patient's choices of treatment.

b. Discuss the probability of pregnancy with female patients. The risk of pregnancy from sexual assault is estimated to be two to five percent. However, pregnancy resulting from sexual assault often is a cause of great concern and significant additional trauma to the victim; victims' fears, therefore, should be taken seriously. Discussion with patients should include treatment options and reproductive health services.

c. Plan B (Levonorgestrel) is the approved U.S. Food and Drug Administration emergency contraceptive drug for the prevention of pregnancy after a contraceptive failure, unprotected sex, or sexual assault. It is available as both a prescription and over the counter (OTC) product and can be considered for use following a sexual assault. Follow local policy governing the distribution, documentation, and patient accessibility to Plan B with the following age restrictions:

(1) Women who are 18 years of age and older can obtain the drug without a prescription from a pharmacy as an OTC drug product.

(2) Women who are 17 years of age and under will require a prescription.

d. Conduct a pregnancy test for all patients with reproductive capability (with their consent). An exception is if a patient clearly is pregnant. If a patient is pregnant, the pregnancy may affect which medications can be administered or prescribed in the course of or after the examination.

18. Discharge and follow up. This paragraph discusses discharge and follow up of sexual assault victims following the initial presentation at the MTF.

a. Medical discharge and follow-up care. Healthcare personnel have important tasks to accomplish prior to discharging patients, as do advocates and law enforcement representatives (if involved). Medical personnel should coordinate their activities with all vested parties (for example, CID) to minimize repetitive actions and to avoid overwhelming the patient.

(1) Forensic examiner. The forensic examiner (preferably an SACP) will address the following issues with patients prior to discharge:

(a) Ensure that the patient's medical and mental health needs related to the assault have been addressed.

(b) Provide the patient with oral and written medical discharge instructions. Include a summary of the examination (for example, evidence collected, tests conducted, medication prescribed or provided, information provided, and treatment received), medication doses to be taken, follow-up appointments needed or scheduled, and referrals.

(c) Provide the patient with the name and contact information, as well as date and time of a follow-up appointment with the SACP and SACC. Follow-up appointments must be made within two duty days of discharge. The patient's immediate follow-up care and planning will be provided by the designated SACP.

(2) Offer patients clear and concise information, both orally and in writing. Information should be tailored to the patient's communication skill level/modality and language.

b. Coordination among responders.

(1) The SACP.

(a) At the initial visit, the SACP will develop an individualized plan of care for the victim. The SACP will work in collaboration with the SACC and patient to schedule necessary appointments as indicated by the individualized plan of care. The SACP will ensure that the patient understands his/her right to confidentiality and nondisclosure and that he/she does not have to disclose the assault to additional providers in order to receive follow-up medical care.

(b) For those with evidence of acute trauma, a short-term follow-up appointment will be scheduled to reexamine and document the development of visible findings and photograph areas of injury. An examination will be scheduled 2 to 4 weeks later to document resolution of findings or healing of injuries.

(c) Repeat examinations for STIs according to established documented guidelines and protocols.

(d) SACPs or other nonacute care providers can provide longer-term care as needed (for example, for HIV testing, STI testing, and administering doses of hepatitis B vaccine).

(e) The SACP will work in collaboration with the Installation Victim Advocacy Program.

(f) The SACP will assist in explaining support services as discussed in paragraph (2) (e) below.

(2) The SACC.

(a) The SACC will monitor the provision of care for victims of sexual assault until the completion of care related to the sexual assault and will follow the established case management criteria. Upon completion of all sexual assault related care, the SACP will document in the outpatient treatment record the resolution and/or the need for the continuation of care related to the sexual assault.

(b) Personnel following up with patients should be familiar with the case, confidentiality issues, and potential medical needs. Explain follow-up contact procedures of all responders involved. Coordinate follow-up contact of involved agencies as much as possible, keeping the number of responders contacting patients to a minimum. Explain if contact procedures are different for non-English-speaking patients.

(c) After the examination is finished, address the patient's physical comfort needs. Jurisdictional and examination site policies should be in place to facilitate this process. Assist patients in developing a post-examination plan that addresses their physical safety and emotional well-being.

(d) Planning must take into account the needs and concerns of specific populations. For example, if patients with physical disabilities require shelter, the shelter must be accessible and staff able to meet their needs for personal assistance with activities of daily living. If patients living in institutional settings have been assaulted by another resident, a staff person, or person who has easy access to residents, the institution should offer alternative living arrangements and reduce the likelihood that patients have to come into contact with the assailant again. It should also ensure them access to services designed to promote their recovery.

(e) Review and explain available supportive services. The SACP and SACC will explain to the patient the role of the Victim Advocacy Program in his/her health care. The SACC can describe and offer patients, their family members, and friends these services, as well as explain options for counseling in the community and offer referrals. The SACP and SACC will explain/reinforce the patient's role and responsibilities in the continued care and management of his/her health care related to the sexual assault. Before being discharged, the SACC should ask patients if they can follow up with them. If they agree, they can determine optimal methods and times for the contacts. During follow-up contacts, the SACP and SACC can help patients reassess their safety, offer support and crisis counseling, answer their questions and provide additional referrals and information, and help coordinate other advocacy services and counseling based upon identified needs.

(f) The SACC will work in collaboration with the SACP and patient to schedule necessary appointments as indicated by the individualized plan of care.

(g) The SACC will work in collaboration with the Installation Victim Advocacy Program to assist patients in considering things such as—

1 Where are they going after being discharged? With whom? Will these individuals provide them with adequate support? Is there anyone else they would like to contact? (Provide information about available community resources for obtaining support and help in making the contact, if needed.)

2 Will their living arrangements expose them to the threat of continued violence or harassment? Is there a need for emergency shelter or alternative housing options? (Provide options and help obtain, if needed.)

3 Are they eligible for protective orders? (Provide information and help obtain, if desired.)

4 Is there a need for enhanced security measures? (Discuss options and help obtain, if desired.)

5 If they feel unsafe, what will they do to get help? (Discuss options and help them develop a plan.)

(h) Closing a case (that is, making it inactive) involves disengaging the patient from services. Reasons for closing a case may include one or more of the following:

1 Ability to function independently.

2 Achievement of treatment goals.

3 Exhaustion or termination of benefits.

4 Inability to contact patient.

5 Patient refusal of services.

6 Patient relocation or transfer to another region/MTF.

7 Routine care or services no longer needed.

8 Transfer of care to another case manager/facility.

(i) Ensure all outstanding items in the patient case file are closed out, to include notification of the SACP and any specialty providers, as applicable. The summary note should include the reason for case closure; a final functional assessment; and information of services, resources, or interventions provided. A copy of the summary note should be placed in the main outpatient record.

APPENDIX A

References

Section I

Required Publications

There are no entries in this section.

Section II

Related Publications

AR 25-50
Preparing and Managing Correspondence

AR 40-66
Medical Record Administration and Healthcare Documentation.

AR 195-5
Evidence Procedures

AR 600-20
Army Command Policy

AR 608-18
The Army Family Advocacy Program

DOD Regulation 6025-18-R
DOD Health Information Privacy Regulation

DOD Directive 6495.01
Sexual Assault Prevention and Response (SAPR) Program

DODI 4000.19
Interservice and Intragovernmental Support

DODI 6495.02
Sexual Assault Prevention and Response Program Procedures

MEDCOM Suppl 1 to AR 190-45
Serious Incident Report

TB MED 293
Procedures for Medicolegal Examinations in Alleged Sex Crimes.

The Joint Commission, Comprehensive Accreditation Manual for Hospitals (CAMH): The Official Handbook.

U.S. Department of Justice, Office on Violence Against Women, A National Protocol for Sexual Assault Medical Forensic Examinations.

U.S. Department of Justice, Office on Violence Against Women, National Training Standards for Sexual Assault Medical Forensic Examiners.

**Section III
Prescribed Forms**

There are no forms prescribed by this regulation.

**Section IV
Referenced Forms**

DA Form 4137
Evidence/Property Custody Document

DD Form 448
Military Interdepartmental Purchase Request

DD Form 1144
Support Agreement

DD FORM 2910
Victim Reporting Preference Statement

DD FORM 2911
Forensic Medical Report: Sexual Assault Examination

SF 509
Medical Record Progress Notes

SF 600
Chronological Record of Medical Care

APPENDIX B
MOU/MOA Template

MEMORANDUM OF UNDERSTANDING (or AGREEMENT)^{1,2,3}
BETWEEN
(INSERT NAME OF THE OFFICE OF THE SURGEON GENERAL (OTSG)/MEDCOM
ORGANIZATION)
AND
(INSERT NAME OF OTHER PARTY)

SUBJECT: Quickly identifies to readers what the agreement covers.

1. REFERENCES. Include references directly relating to the agreement and authorities or statutes governing it. Per AR 25-50, order references as they appear in the agreement; when not mentioned in agreement, list in order by date (oldest to most recent). Examples follow (insert references as appropriate).

a. The Economy Act, 31 USC 1535.

b. DOD Instruction 4000.19, Interservice and Intergovernmental Support, 9 August 1995.

c. Army Regulation X-XX.

d. MEDCOM Memorandum of Instruction, date, subject: XXXXXXXXXX.

2. PURPOSE. Provide a brief statement defining purpose of the agreement. For example, "To establish terms and conditions of an agreement between XXXXX and XXXXX for...."

3. BACKGROUND. Present a clear, concise statement of the issue being addressed by the MOU/MOA. Include a brief background and why the agreement is necessary.

4. APPLICABILITY AND SCOPE. Identify who the MOU/MOA applies to— who are the parties and how they relate? How far-reaching is the MOU/MOA? Does it cover the entire subject area or just a small aspect of it?⁴

5. RESPONSIBILITIES. List responsibilities and understandings of each party involved in the agreement and what each party will do in relation to the other.

a. (Name of MEDCOM/OTSG organization) will—

b. (Name of other party) will—

6. RESOURCES

a. Identify resources required to implement the agreement, if any. Include funding and manpower requirements for budget years and for POM out-years. For agreements involving resource transfers, either within the same appropriation (for example, Army to Army, DHP to DHP) or between different appropriations (Army to DHP, DHP to Army), use the format at enclosure 2; include in paragraph 6 or as a separate enclosure to the MOA.

b. If reimbursable support is involved, indicate whether a separate document (other than the agreement) will be used to certify and obligate funds (for example, DD Form 448 (Military Interdepartmental Purchase Request)). If the agreement itself is to serve as the funds obligating document, the agreement must include the fund citation and signature of the fund certifying authority (the fund certifying authority and approving authority for the agreement cannot be the same person).

c. Specify the procedure and frequency for billing by supplier and for payment by customer. Include year-end reconciliation procedures between supplier and customer, if necessary. NOTE: Collections and payments between Federal agencies will use the Treasury's Intragovernmental Payment and Collection System.

d. For MOAs involving reimbursable support, include the statement, "The undertakings described in this MOA are subject to availability of appropriated funds."

e. If the MOU/MOA involves no resource expenditures, insert the following statement: *"Any resource requirements (funding, personnel, supplies, equipment, etc.) associated with this MOA will be executed within available funding allocations (including supplemental funding) and programmed funding of the parties. No exchange of resources or reimbursement is required between the two parties. If these conditions should change, the MOA will be formally amended beforehand."*

7. EFFECTIVE DATE, TERMINATION, MODIFICATION, AND REVIEW

a. This MOU/MOA is effective on the date of final signature by all parties, hereto, and will remain in effect until XXXXX (or indefinitely).

b. The parties agree to review the MOU/MOA (insert review frequency). It will be subject to review at any time upon written request by either party.⁵

c. Either party may unilaterally modify, suspend, or terminate the MOA upon written notice to the other party. Under normal circumstances, the party unilaterally modifying, suspending, or terminating the MOA will provide 180 days prior written notice to the other party.

d. Should a dispute arise between the parties, it will be worked at the lowest possible level. If the issue cannot be resolved, it will be elevated to (insert appropriate organizations).

8. PRIMARY POINTS OF CONTACT⁶

MEDCOM Activity Name
Office Symbol
Street Address, City, State, ZIP
Phone (Commercial/DSN)
Organizational Email, if available

Other Party's Activity Name
Office Symbol
Street Address, City, State, ZIP
Phone (Commercial/DSN)
Organizational Email, if available

FOR (MEDCOM/OTSG Organization):⁷
FOR (Name of Other Party):

_____/S/_____

_____/S/_____

I.M. TUFF

U.R. KNOTT
Colonel, MS

Director of Data Analysis
ACS for Information Management

U.S. Army Signal Command
DATE:_____

DATE:_____

MOU/MOA Footnotes

¹ Per DOD Instruction 4000.19, a memorandum of understanding (MOU) defines general areas of understanding between two or more parties when support is not conditional (that is, what each party does is not dependent on what the other party does) and when no reimbursement is involved. A memorandum of agreement (MOA) defines areas of conditional agreement between two or more parties (that is, what one party does depends on what the other party does) and/or reimbursement is involved.

² This template can apply to agreements between DOD activities (*interservice* support agreements) or agreements between DOD and non-DOD Federal agencies (interagency/intragovernmental agreements).

- Interservice agreements are generally documented on an MOU/MOA or a DD Form 1144 (Support Agreement).
- Any agreement involving an “order” for reimbursable support must include all the essential elements of information (EEI) as required by DOD Financial Management Regulation, Vol 11A, Section 010204. For Interservice Support Agreements (intra-DOD) documented via an MOA instead of a DD 1144, all EEI is mandatory; otherwise, a determination and finding must be approved by a general officer or senior executive service (SES) (FAR 17.5).

EEI includes:

Firm, clear, specific, and complete description of goods or services ordered.

Generic descriptions are not acceptable.

Specific performance or delivery request.

Proper fund citation.

Payment terms & conditions (for example, direct or reimbursable fund cite).

Specific statutory authority (for example, Economy Act, Franchise Funds (PL 103-356 or Title IV / Section 403), etc.).

DOD Activity Address Code of ordering activity.

- Include the following statement in an interservice MOA: “MEDCOM and (other DOD party) have determined that the requested support is in the best interest of the U.S. Government and can be obtained most efficiently and effectively from (other party). (Other party) has determined it is capable of providing the requested support without jeopardizing its assigned missions.”
- If reimbursement is involved, funding is typically handled via a DD Form 448 (Military Interdepartmental Purchase Request, or MIPR). A MIPR alone does not suffice as, and should not be used in lieu of, an agreement. An agreement formally establishes specific terms of the relationship, standards of support, and other important information not necessarily included in a MIPR. A MIPR primarily

functions as a funding reimbursement document and can also be used between DOD and other non-DOD Federal agencies.

- Interagency agreements can be documented as an MOU/MOA if the DOD activity prepares the agreement. A non-DOD agency may use its own form or an interagency format if it prepares the agreement. While there are no set rules, the supplying (vs. requesting) activity generally should prepare the agreement since it sets the terms of supplying the support, the cost basis, and the billing and payment process to be used to ensure correct crediting to its accounting system. All Essential Elements of Information (EEI) are required as described for Interservice Support Agreements above. If OTSG/MEDCOM is the supplying agency, then the requesting agency should provide OTSG/MEDCOM a copy of its approved determination & finding (D&F) statement.
- Interagency agreements involving reimbursement require specific statutory authority, and it should be cited in the references. In the absence of other specific authority, the Economy Act (31 USC 1535) is the legal authority to collect reimbursements from other Federal agencies. Agreements citing the Economy require a D&F statement by a General Officer/SES before approval (see DODI 4000.19, para 4.4). In addition, interagency agreements involving use of non-DOD contracts (both direct and/or assisted acquisitions, regardless of dollar amount) require a separate written Certification for Use of Non-DOD Contract by the head of the requiring activity (06/GS15 or higher) prior to approval of the agreement. More information is at–
 - SAAL-PP memo, 12 Jul 05, subject: Proper Use of Non-DOD Contracts, at <https://www.alt.army.mil/portal/page/portal/oasaalt/documents/armypolicyuseofnon-dodcontracts.doc>
 - MEDCOM memo, 4 Jan 06, sab, at <https://www.us.army.mil/suite/doc/5142679>.
 - Army Contracting Agency (ACA) Policy Memo P-0010, subject: Proper Use of Non-DOD Contracts, at http://aca.saalt.army.mil/ACA/docs/Community/memo_p0010.pdf.
- For interservice or interagency agreements involving regularly recurring support (for example, base operations support), a support agreement (DD Form 1144) should be prepared in lieu of, or in addition to, an MOA. The DD 1144 is used to document specific standards of support; basis of reimbursement, billing, and payment procedures; and other details. It can include both reimbursable and non-reimbursable items of support.

³ For training agreements, either training affiliation agreements or gratuitous training agreements, separate formats apply and can be found at https://www.us.army.mil/suite/collaboration/folder_V.do?foid=681860. (NOTE: To

correctly link to this site, you need to first sign in to Army Knowledge Online (AKO) before navigating to this Web link.)

⁴ If the scope involves potential use or disclosure of Protected Health Information between MEDCOM and non-DOD parties, certain language is mandated in the agreement under the Health Insurance Portability and Accountability Act (HIPAA). For specific guidance on the HIPAA language, also go to https://www.us.army.mil/suite/collaboration/folder_V.do?foid=681860 on AKO; see the files *HIPAA ROE* and *HIPAA Cut & Paste*. If all parties in the agreement are DOD, then you need only cite DOD Regulation 6025-18 as a reference to satisfy HIPAA requirements - no separate HIPAA language is needed.

⁵ Agreements involving reimbursable support will be reviewed annually and should be done as part of the activity's annual budget process. Otherwise, agreements should be reviewed when changing conditions may require substantial modification of the agreement.

⁶ As a minimum, point of contact information should point to the primary functional manager for the program(s) involved in the agreement (for example, director of logistics, assistant chief of staff for health policy and services, etc.). In addition, specify a separate point of contact for resource management.

⁷ The approval authority for the agreement should normally reside at the lowest level possible, as long as the responsibilities, commitments, and resources covered under the agreement are within the signer's scope of authority. Signers for each party should be roughly at the same grade level.

**MOU/MOA Format for Resource Transfers
(Intra-Army, Intra-DHP, DHP-to-Army or Army-to-DHP)**

EXAMPLE involving transfer for execution year (FY07) and POM FY08-FY13:

SAMPLE ONLY								
Manpower Auth's	PE	FY07	FY08	FY09	FY10	FY11	FY12	FY13
FROM:								
Army OMA								
US Direct Hire Civilian	433709000	-1	-1	-1	-1	-1	-1	-1
Authorizations Subtotal		-1	-1	-1	-1	-1	-1	-1
TO:								
Army DHP (O&M, Def)								
US Direct Hire Civilian	847714000	1	1	1	1	1	1	1
Authorizations Subtotal		1	1	1	1	1	1	1
Net Change		0	0	0	0	0	0	0
Dollars (in \$000s)	PE	FY07	FY08	FY09	FY10	FY11	FY12	FY13
FROM:								
Army OMA								
CivPay	433709000	-68	-70	-73	-75	-78	-81	-83
Contract Personnel	433709000	-86	-88	-91	-94	-97	-99	-102
Mission	433709000	-119	-123	-126	-130	-134	-138	-142
Appropriation Subtotal		-273	-281	-290	-299	-309	-318	-327
TO:								
Army DHP (O&M, Def)								
CivPay	847714000	68	70	73	75	78	81	83
Contract Personnel	847714000	86	88	91	94	97	99	102
Mission	847714000	119	123	126	130	134	138	142
Appropriation Subtotal		273	281	290	299	309	318	327
Net Change		0	0	0	0	0	0	0

Appendix C

Sexual Assault Healthcare Training Requirements

1. The objective of sexual assault prevention and response training is to eliminate incidents of sexual assault through a comprehensive program that focuses on awareness and prevention, education, victim advocacy, reporting, response, and follow up. This appendix addresses the unit level training and mandatory training for healthcare response groups outlined by DOD and DA regulations.

2. Unit level training.

a. All Soldiers will attend and participate in unit level Sexual Assault Prevention and Response training annually. Training should be inclusive of real life situations to demonstrate the entire cycle of reporting, response, and accountability procedures.

b. Ensure unit level Sexual Assault Prevention and Response Program training is conducted annually and documented on unit training schedules

3. Healthcare provider training.

a. All personnel assigned to the MTF involved in the direct or indirect delivery of health services or patient care will receive initial and annual refresher training.

b. The Sexual Assault Prevention / Response Training For Healthcare Providers: 6H-F39/300-F33(DL) course is available through the Army Training Requirements and Resources System Self Development Portal. The goal of this training is to inform appropriate Army MTF medical personnel and ancillary staff on the management of medical, medicolegal, and psychological aspects of assisting sexual assault victims.

c. There are seven modules associated with this course (one introduction and six modules of lesson materials). Upon completion of the course examination, the user will receive a certificate of completion for training documentation.

4. Healthcare providers performing sexual assault forensic examinations.

a. The following healthcare providers are most likely to be called upon to provide medical treatment to a sexual assault victim, to include performing SAFEs: licensed physicians; advanced practice nurses with specialties in midwifery, women's health, family health, pediatrics; physician assistants trained in family practice or women's health; and registered nurses with documented education, training, and clinical practice in sexual assault examinations.

b. In addition to the training outlined above, the healthcare providers performing sexual assault forensic examinations will, at a minimum, receive initial and annual

refresher training that will adhere to the U.S. Department of Justice's National Protocol for Medical Sexual Assault Examination.

c. An interactive training digital video device, Sexual Assault Forensic Examination (SAFE) Virtual Practicum created the by Dartmouth Interactive Media Laboratory based on the U.S. Department of Justice's National Protocol for Medical Sexual Assault Examination supports the SAFE training requirements outlined in DODI 6495.02 Enclosure 6 and AR 600-20 chapter 8, appendix I. However, clinical guidance will not be solely limited to this resource.

5. Designated SACCs and SACPs will receive training annually focused on enhancing the medical management of sexual assault to facilitate the operational effectiveness of the AMEDD Sexual Assault Prevention and Response Program.

Appendix D

Sexual Assault Response Program Tracking Application

1. SARPTA is a secured access, Web-based program. The Patient Administration Systems and Biostatistics Activity (PASBA) developed SARPTA to track medical treatment for sexual assaults committed against active duty Army personnel. When active duty Soldiers allege sexual assault and receive treatment at Army MTFs—including combat support hospitals for deployed units—SARPTA is currently the database of record.
2. Designated SACCs and SACP's use SARPTA to record and update incidents. SARPTA records all subsequent treatment of the patient. Users of SARPTA can flag subsequent treatment as NOT related to the sexual assault.
3. To apply for SARPTA access, go to the PASBA Web site at: <https://pasba3.amedd.army.mil/login/login.fcc>. In order to access the PASBA Web site, the user must log on using his/her AKO user name and password.
 - a. On the left hand menu, select Request Access.
 - b. Scroll to Sexual Assault Response Program Tracking Application (SARPTA).
 - c. Select Access Request Form.
 - d. Complete the online application.
 - e. Print the application and security acknowledgement, and get the required signatures.
 - f. Fax the completed application to the MEDCOM Sexual Assault Prevention and Response Program Office for final verification and approval. All approved applicants will receive an e-mail from PASBA notifying them that their access has been approved.
3. A SARPTA Help file is located on the upper right of the SARPTA Web page. Click Help to find information about how to use SARPTA.

Appendix E

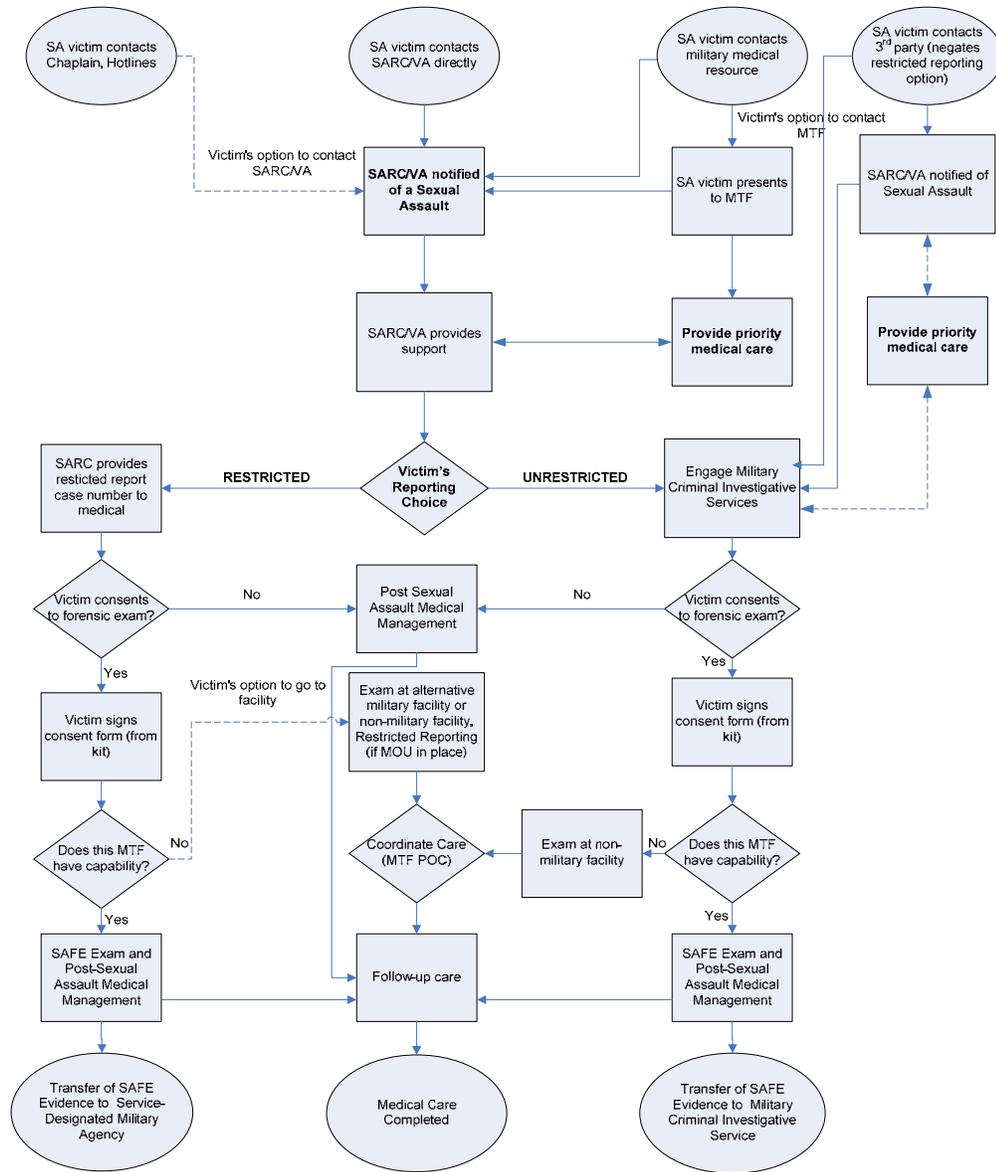
Annual Sexual Assault Prevention and Response Program Assessment

1. In accordance with the Section 113, Title 10, USC and the Department of Defense Instruction 6495.02, the Secretary of the Army will submit to the Secretary of Defense an annual assessment report on the sexual assaults involving members of the Army.
2. The SAPR annual program assessment provides a unifying assessment framework for documenting and capturing how well the MEDCOM is implementing its SAPR Program and providing insight as to where program improvements can be made.
3. The annual MEDCOM Sexual Assault Program assessment report will be submitted to the DCS, G-1 SAPR program manager NLT 1 December for the previous fiscal year inclusive of collected data, findings, and recommendations.
4. The annual MEDCOM Sexual Assault Program assessment report will address—
 - a. General findings from the evaluation of medical services related to sexual assault cases.
 - b. SAPR-related policies and/or procedures implemented during the year.
 - c. SAPR-related initiatives/actions planned for the coming year.
 - d. Recommendations for changes to Army SAPR Program or policy.
 - e. Any resource shortfalls and the potential implications they carry with respect to impact on standards of care and possible solutions to overcome these shortfalls.
 - f. Availability at medical treatment facilities of supplies needed for the treatment of sexual assault victims who present at an MTF, including rape kits/SAFE kits and supplies for testing and treating sexually transmitted infections and diseases– including HIV—and testing for pregnancy.
 - g. Status of healthcare provider responder training.

Appendix F
AMEDD Sexual Assault Response Program ICD-9-CM Coding Guidance

1. The coding mechanism established to capture the complete, accurate, and timely collection of relevant clinical information regarding victims of sexual assault is via International Classification of Disease, Ninth Revision, Clinical Modification (ICD-9-CM).
2. Document cases appropriately with the following codes:
 - a. 995.83: Adult Sexual Abuse.
 - b. 995.53: Child Sexual Abuse.
 - c. E960.1: Rape.
 - d. V71.5: Observation Following Alleged Rape or Seduction.
 - e. V15.41: Personal History of Sexual Assault.
3. If the victim sustains physical injuries, the primary diagnosis that identifies the assault is 995.83 (Adult Sexual Abuse) or 995.53 (Child Sexual Abuse). The cause of injury E-960.1 will be reported for all sexual assault incidents.
4. When a victim presents for treatment and has no physical findings, use V71.5 (Observation Following Alleged Rape or Seduction) as the primary diagnosis.
5. When a victim presents for follow-up care related to the sexual assault, the reason for the encounter is coded as the primary diagnosis along with code V15.41: (Personal History of Sexual Assault).

Appendix G Sexual Assault Response Pathway



Glossary

Section I Abbreviations

ACA

Army Contracting Agency

AKO

Army Knowledge Online

CID

criminal investigation division

CDC

Centers for Disease Control and Prevention

DA

Department of the Army

D&F

determination & finding

DNA

deoxyribonucleic acid

DOD

Department of Defense

DODI

Department of Defense Instruction

EEI

essential elements of information

HBIG

hepatitis B immune globulin

HBV

hepatitis B virus

HIPAA

Health Insurance Portability and Accountability Act

HIV
human immunodeficiency virus

ICD, CM
International Classification of Disease, Clinical Modification

MHS
military health system

MIPR
military interdepartment purchase request

MTF
military treatment facility

MOA
memorandum of agreement

MOU
memorandum of understanding

OTC
over the counter

OTSG
Office of the Surgeon General

PASBA
Patient Administration Systems and Biostatistics Activity

RRCN
restricted reporting case number

SACC
sexual assault care coordinator

SACP
sexual assault clinical provider

SAFE
sexual assault forensic examination

SAPR
sexual response prevention and response

*MEDCOM Reg 40-36

SARC

sexual assault responses coordinator

SARPTA

Sexual Assault Response Program Tracking Application

SES

senior executive service

SOP

standing operating procedure

STI

sexually transmitted infection

USAMEDCOM

U.S. Army Medical Command

USC

United States Code

UVA

unit victim advocate

VA

victim advocate

Section II

Terms

Chain-of-custody. Documented proof—from initial receipt through final disposition—of the transfer and safekeeping of identified articles between receipt and disposition to prevent tampering with or contamination of evidence (DA Form 4137).

Evidence collection kit. Contains devices used for collecting and preserving medical evidence in support of sexual assault investigations. It includes directional notes to the physician and investigator and the medical examination report with consent authorizations. NOTE: This kit would not be appropriate for victims of chronic sexual abuse without a recent incident; however, a colposcopic examination would be relevant.

Forensic examination. The medical examination, care, and collection of relevant physical evidence in conjunction with supportive medical laboratory testing.

Military treatment facility. All U.S. Army Medical Centers, medical department activities, U.S. Army health clinics, troop medical clinics, and other healthcare facilities authorized to provide medical care.

Responders

First responder. MEDCOM personnel who have the initial contact or encounter with the victim of sexual assault.

Sexual assault responder. Those personnel directly involved in the care and management of sexual assault victims to include the SACP, the SACC, the forensic examiner, VAs, social worker, and others as deemed appropriate.

Sexual assault. Sexual assault includes rape, sodomy, indecent acts with another, and indecent acts or liberties with a child.

Sexual assault care coordinator. When available, a social worker (BSW or MSW) or nurse (licensed vocational nurse or registered nurse), familiar with both sexual assault victim dynamics and medical treatment facility procedures. Knowledge of community resources related to services for sexual assault victims and their families is critical.

Sexual assault clinical provider. A privileged healthcare provider (physician, nurse practitioner, or physician assistant) who has been designated by the deputy commander for clinical services to manage each sexual assault patient's medical treatment related to the sexual assault incident from initial presentation to completion of all follow-up visits.

Section III

There are no entries for this section.

The proponent of this publication is the Office of the Assistant Chief of Staff for Health Policy and Services. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) to Commander, U.S. Army Medical Command, ATTN: MCHO-CL-H, 2050 Worth Road, Fort Sam Houston, TX 78234-6010.

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