Yale Children's ED Sexual Assault Guidelines

- ☐ Consult Social Work

- ☐ Contact Sexual Assault Crisis Services 1-888-999-5545 or 203-235-4444 after consenting with patient and family

- ☐ DCF must be notified in cases of sexual abuse or Human Trafficking. 1-800-842-2288
- ☐ Complete Rape Kit if necessary; if not done please document reasons for why not

- ☐ The Blue Maxx can be found in the locked closet in the administrative office suite (1-2-3 code).

- ☐ Complete State of Connecticut Sexual Assault Form and place yellow copy in envelope in back of rape kit (at least complete duplicate form/page 1/yellow copy and use EPIC template (.KABSATemplate) to document PE, evaluation and management)

- ☐ All necessary serologic and microbiologic testing has been obtained:
  - Urinalysis or urine dip and urine culture
  - Urine for GC and Chlamydia DNA probe
  - Hepatitis B and C panel
  - VDRL
  - HIV EIA

- ☐ Pregnancy status has been documented and Emergency Contraception administered (up to 120 hours after assault)
  - Ulipristal (Ella) 30 mg PO for one single dose in the PED
  - Zofran 4-8 mg PO now and then every 8 hours PRN

- ☐ STI prophylaxis has been administered (adolescents ONLY)
  - Ceftriaxone 250 mg IM AND
  - Azithromycin (Zithromax) 1 gram PO x 1 dose

- ☐ HIV prophylaxis has been offered and whether or not the patient has accepted or refused it documented
  - Esentress (raltegravir) 400 mg PO BID for 28 days
  - Truvada tablets (200 mg emtricitabine and 300 mg tenofovir): 1 tablet PO QD for 28 days
  - Zofran 4-8 mg PO every 6 hours PRN

- ☐ Patient should be encouraged to receive HPV vaccination from their primary care provider as soon as possible.

- ☐ Primary Care Provider notified; can also arrange for follow up in the Sexual Abuse Clinic (688-2392) if unable to contact primary care provider for follow up or in cases of sexual abuse or Human Trafficking.

- ☐ Behavioral health referral to Yale Child Study Center Trauma Clinic (brochure) if parent/patient agree. Can make referral in EPIC.

- ☐ Local Police Department Officer name and badge number documented in medical record as one who picked up rape kit.

Pediatric Emergency Department
Yale New Haven Children's Hospital
Guidelines for forensic evidence collection in children and adolescents
Guidelines for STI evaluation and treatment

Before you start:

1-If possible, first contact the social worker on duty. Ideally the social workers should be notified at triage when the chief complaint is suspected child sexual abuse or acute sexual assault. He/she may already have information about the child from DCF or the police. You can initially discuss with him/her about who will talk to the child/adolescent and obtain a history of the alleged sexual contact. It may be helpful for both the resident and social worker to jointly obtain this history in an effort to save time.

In addition, contact the Sexual Assault Crisis Service Hotline (1-888-999-5545). A volunteer can come to the Pediatric Emergency to support the patient and family during the evaluation and provide post-evaluation support during the transition to outpatient mental health services, as well as being an advocate during any future legal proceedings. Please ask the patient and family if they would like a volunteer for support both in the ED and after discharge.

The police from the town in which the assault occurred should be notified when the Rape Kit is completed and the patient can be safely discharged from the PED. The police should allow for the medical and psychosocial evaluation to be completed before taking statements from the patient and family. **If there is a concern about the manner in which the police are interacting with the patient, family or PED staff, please notify the YNHH Security supervisor at 688-2500**.

2-**Who should or should not have an evaluation in the PED?**
If the last alleged sexual contact was greater than 110 hours ago, the patient is not having symptoms of genital pain, bruising or discharge, the alleged perpetrator does not live in the home and currently have ongoing access to the patient, and the parent or guardian is amenable and able to comply, then the evaluation can be deferred in the PED and the patient referred to the Child Sexual Abuse Clinic for colposcopic examination at 688-2392. This needs to be clearly documented in the PED medical record, and done after consultation with social work.

One should recognize that evidence might be present beyond 72 hours after the assault and up to 110 hours after the assault in post-pubertal patients. If the last alleged sexual contact was within 110 hours of presentation and the patient is an adolescent, then a complete history, physical examination and rape kit should be done in the PED. In recent history, 72 hours after the sexual assault has been considered a guideline to use as an outside limit for obtaining evidence for the sexual assault evidence collection kit, but recent research and evidence analysis indicate that some evidence may be available beyond this time period in adult patients. **In any case, regardless of the time frame of when**

the assault occurred, one should collect the clothing worn at the time of the assault, especially if it has not been washed, as the timeframe for degradation of evidence can be considerably longer than 110 hours for fabrics.

If the last alleged sexual contact was within 24 hours of presentation and the patient is prepubertal, then a complete history, physical examination should be done in the PED. A rape kit may need to be performed depending on the history, physical examination, including an examination of the body using the Blue Maxx light. This light is carried by the Sexual Assault Nurse Examiner's (SANE's) who may be on duty at the time of patient presentation and is also stored in Kirsten Bechtel's locker (#24). There is also a Blue Maxx in the safe in the ED break room (code #0543). Any clothing worn at the time of last sexual contact should be collected regardless of whether a rape kit is done.

Indications for doing a rape kit in a prepubertal child:
1-There is physical examination evidence of genital trauma or a sexually transmitted infection (STI).
2-With examination of the skin with the Blue Maxx, there is material that fluoresces that is suggestive of biological fluids that could identify a perpetrator.
3-Child is unable to give a history of the sexual assault to any professional (Social work, police DCF) and there is evidence of either condition 1 or 2 above.

In children and adolescents who will require a forensic interview in the Child Sexual Abuse clinic, please try to obtain minimal facts as to the nature of the abuse/assault
Who did it?
Where on the body did it happen**?**
When did it happen?

Parents/guardians/caregivers can be asked:
Is there/was there genital bleeding?
Is the child in pain/was in pain?
When did it occur?
When was the last time the child was around the person you think did it or could have done it?

In many instances of **child** sexual abuse the history from the non-offending caregiver will provide enough information about the nature of the abuse/assault for you to do an adequate medical evaluation. **In addition, only one provider should obtain the history to avoid multiple questioners asking the history. If this is the case please call the on-call DART attending to discuss what questions can be asked (688-2468).**

Collecting forensic evidence in a prepubertal child can be very traumatic. If it is likely that collecting the evidence from the genital orifices would cause pain and distress in the child, one can consider just doing the Blue Light examination and

collecting the child's clothing. This thought process must be documented in the medical record.

3-**Who should do the examination?** If the patient is prepubertal and requires a rape kit, please consult one of the SANE's who may be working in the PED. If a SANE is not available, please contact Kirsten Bechtel MD (203-654-0105) as to the extent of the examination when possible. Prepubertal children who are anxious or uncooperative with the examination can be referred to the Child Sexual Abuse Clinic after consultation with the DART service (688-2468).

If the patient is an adolescent and requires a rape kit, then one of the SANE's can be consulted to perform the examination with a resident, fellow or attending. If it is a prepubertal child with genital injuries that are bleeding, painful or may require examination under anesthesia, then please consult the Pediatric Surgery Service and the DART service (203-688-2468) as to the best method of safely examining the child and collecting forensic evidence. If it is a female adolescent patient with genital injuries that result in bleeding and may require surgical repair, please consult the Gynecology resident to perform the examination and collect forensic evidence for the rape kit.

If there are any questions at all regarding the physical examination and collecting forensic evidence, please contact Kirsten Bechtel (203-654-0105).

Please discuss case with all treating ED team members (clinician, nurse, SANE, social worker) before proceeding with the patient's evaluation so delineation of medical duties can be determined before evaluation.

Documentation

History

1-If the history and physical examination and the rape kit is done in the PED, then one uses the "State of Connecticut Sexual Assault Form", which is found in the rape kit, for PED documentation. At present, this form CANNOT be scanned in to the EPIC PED medical record. One can use the SA templates (.KAB SA Template) to document the entire history, physical examination, evaluation and treatment in the EPIC medical record. The first page (duplicate with yellow copy) of the "State of Connecticut Sexual Assault Form" should be completed legibly and the yellow copy placed in a sealed envelope on the back of the rape kit.

2-If the physician obtains the history about the alleged sexual abuse or sexual assault, direct quotes from the patient and parent/guardian should be used for documentation. One should also use open-ended questions such as "Why did you come to the Emergency Department?" and "Can you tell me what happened?" when obtaining the history.

A history of prostitution or Human Trafficking should be obtained especially if there is a large age or developmental discrepancy between the patient and perpetrator; if there were multiple perpetrators; if the patient is homeless or

ran away from home. In cases of suspected Human Trafficking/Prostitution DCF should be notified.

3-Especially in cases of Human Trafficking ask about substance use, either voluntary or forced; ask about methods of use (snorting, injection) and any withdrawal symptoms (diarrhea, diaphoresis, tremors, etc.).

Physical and Laboratory Evaluation

1-If unable to do a physical examination due to fear or lack of cooperation on the patient's part, then defer the examination in the ED and refer the patient to the Sexual Abuse Clinic for an examination. **Do not force the examination**. Please contact the DART attending on call (688-2468) in such cases.

2-In situations where a physical examination is paramount, such as a history of severe genital pain or bleeding, inability to urinate or defecate, then utilize the services of the child life therapists. Sedation may be required in rare cases. The type of sedation and time of administration should be clearly documented in the medical record. Any sedation should be done after a history has been obtained from the child.

3-For adolescent female patients:

a. Not all adolescent females may have had either prior consensual sexual activity or a prior pelvic examination with a speculum. These questions should be asked before doing a GU examination.
b. If a patient is not able to tolerate a speculum or bimanual examination, **do not force them to do so.**
c. An external examination of the genitalia and blind vaginal swabs can be obtained for the rape kit.
d. Adolescent patients for whom a speculum examination should be considered are those with vaginal bleeding without external genital trauma, or those who are unable to urinate or defecate. One may consider the use of sedation or an examination under anesthesia for these patients in conjunction with the Pediatric Surgical Service (prepubertal) and Gynecology service (pubertal).

4-When documenting the physical examination, refrain from using the term "intact" to describe the anatomy of the hymen. Instead use terms such as "no interruptions in the edge of the hymen" or "v-shaped interruption of the hymen at 6:00."

5-For male patients:

a. Only swabs from the anus for GC culture and for the forensic kits need to be obtained if there was such contact.
b. Do not obtain urethral swabs-urine can be obtained for GC and Chlamydia if the patient is symptomatic (i.e. dysuria, genital discharge) or if there was a history of genital contact with the perpetrator's mouth or genitalia.

6-Special considerations for Victims of Human Trafficking

a. Assess for signs of physical abuse
b. Assess for signs of medical neglect, nutritional status
c. Check for tattoos and other 'markings'

7-**Forensic evidence collection** should be done in adolescents with a history of sexual abuse or assault that occurred within 72 hours of PED presentation. Forensic evidence collection should be considered in prepubertal children if the last contact was within 24 hours of PED presentation. The clothing worn at the time of last contact should be collected regardless of the time of PED presentation, as this will most likely be the source of forensic evidence in this group of patients. If the child has bathed and changed clothes, or if an examination with the Blue Maxx does not reveal substances that fluoresce, the yield of evidence that may identify a perpetrator is substantially decreased-this should be documented in the medical record. Any area of fluorescence should be swabbed, labeled appropriately and placed in the Rape Kit.

The Blue Maxx can be found in the locked closet in the administrative office suite (1-2-3 code).

A focused rape kit can be collected. This is the collection of evidence from parts of the victim's body in which there was contact with the perpetrator's body, based on the history from the patient and physical examination findings (evidence of genital trauma due to contact with the perpetrator's body).

If there is a history of drug or alcohol facilitated sexual assault, in which the victim gives a history of "blacking out" or cannot remember all the details of the contact, then the entire rapc kit should be completed. In addition, the patient can be offered the collection of the Forensic Toxicology kit to look for illicit substances not captured on the hospital toxicology laboratory screening (see page 13).

8-**STI collection** (which should be collected after swabs for forensic evidence have been obtained) should be done in the following patients:

a. Adolescents with Tanner Stage 3 or greater
b. Pre-adolescents with a history of vaginal or penile discharge or evidence of such on physical examination
c. Pre-adolescents with evidence of genital trauma
d. **Urine for GC and Chlamydia by NAAT can be obtained instead of performing swab testing**.
e. Serum for HIV EIA, VDRL, and Hepatitis panel should be considered in these patients as well.

9-**STI prophylaxis** should be offered to all adolescents (Tanner Stage 3 or greater) at the time of evaluation:

a. **Ceftriaxone 250 mg IM and Azithromycin 1 gm PO**

b. Doxycycline 100 mg PO BID x 7 days should be given to adolescents who are thought to also have Pelvic Inflammatory Disease (PID).
c. Consider inpatient treatment of PID for any adolescent with a history of sexual assault and evidence of PID on physical examination (cervical motion tenderness and bilateral adnexal tenderness, with/without fever and lower abdominal tenderness)
d. STI prophylaxis is not needed in prepubertal children, unless there are symptoms or signs of an STI on physical examination (genital discharge, perineal lesions suggestive of herpes simplex or human papillomavirus infection).

If you are considering treating a prepubertal patient for a suspected STI after STI testing has been obtained, please consult with the DART service FIRST (203-688-2468). It is rare that prepubertal children have STI's such as N. gonorrheae or C. trachomatis after sexual abuse/assault, and any positive NAAT needs to be confirmed with a second test in this population.

10-Pregnancy screening and prophylaxis

a**. Ulipristal (Ella) 30 mg tablet can be given as a single dose in the PED after urine pregnancy test is confirmed as negative. This can be given up to 120 hours after the assault.**
b. Zofran may be needed as pregnancy prophylaxis can cause nausea and vomiting. It may be necessary to provide another dose of Ulipristal (Ella) for use at home in case the patient vomits the second dose at home. Please give a prescription for Zofran 4 mg tablets along with the pregnancy prophylaxis.
c. Patients should be told that they will get their menses within 3 weeks of taking pregnancy prophylaxis and that menses will be heavier than usual. All patients should have a repeat pregnancy test if they do not get their menses within 3 weeks.
d. Patients are also at an increased risk of pregnancy if they have future consensual sexual intercourse and do not use contraception. Patients should be told to use contraception in the future to prevent pregnancy, preferably a long term form as an IUD or Implanon. They be referred to the Family Planning Clinic (737-4665) or the Women's Center (688-4101).

Considerations for Emergency Contraception with respect to patient BMI

What	Dose	How long postcoital	Decreasing effectiveness with time?	BMI issues
No treatment	-	-	-	-
Levonorgestrel (Plan B)	1.5 mg one time dose	72 hours	Yes	Not very effective for BMI >25

Ulipristal acetate (ella)	30 mg one time dose	120 hours	NO	Not very effective for BMI >30
Copper T 380A IUD (ParaGard)	One device, inserted	120 hours	NO	None

11-Immunizations

a. Hepatitis B prophylaxis (HBIG and HB vaccine) should be considered in those who are not immunized and sexual assault with contact with a high-risk perpetrator (known Hepatitis infection, IV drug use, HIV disease).
b. If patient has been vaccinated and the perpetrator is not high-risk, then titers for Hepatitis B and C can be drawn to confirm immune status. In those not immune, then HBIG and HB vaccine should be given. This can be done within a week of the last contact in those who have been sexually assaulted.
c. Tetanus toxoid should be given for those patients who have not had a tetanus booster within the past 5 years and who have abrasions or lacerations.

12-**HIV screening and prophylaxis**

a. **Screening**: The risk of HIV infection in children and adolescents after sexual abuse or sexual assault is quite low (1:2000 or less). When possible, HIV screening in the PED should be considered in the following cases

1-Genital-genital contact with/without contact with semen or blood, or genital/genital contact with an unknown perpetrator
2-Mucosal or skin trauma to the genitalia (abrasions or lacerations)
3-Contact with a high risk perpetrator (known HIV disease, intravenous drug use, history of hepatitis)
4-High patient or parental anxiety about contracting HIV

b**. Appropriate screening for HIV should include HIV EIA**
c. If consultation is needed regarding HIV screening or questions about prophylaxis, one can page the Pediatric ID fellow at 1-860-588-0841.
d. **Prophylaxis can be offered to patients in whom HIV screening is done**. It should be given within 48 hours of assault. If the patient and family decline HIV prophylaxis, this should be documented in the medical record. If prophylaxis is provided, the following should be used:

a. **Esentress (raltegravir) 400 mg PO BID for 28 days**
b. **Truvada tablets (200 mg emtricitabine and 300 mg tenofovir): 1 tablet once a day for 28 days**

5) If prophylaxis is prescribed, baseline LFT's and CBC should be considered.
6) If prophylaxis is prescribed solely for patient or parental anxiety about contracting HIV, the patient and family should be

clearly counseled as the risk of significant side effects is probably greater than the likelihood of contracting HIV from the sexual abuse or assault.

7)**Side effects from prophylaxis include**:

a)Headache, dyspepsia, nausea, vomiting, diarrhea, abdominal pain, anorexia, malaise, dizziness, constipations, myalgia, insomnia, paresthesias, kidney stones, lactic acidosis, hepatotoxicity

b)3TC:Nausea, diarrhea, skin rash, pancreatitis, peripheral neuropathy, hepatitis, anemia, thrombocytopenia

c)Nelfinavir: Nausea, vomiting, diarrhea, headache, abdominal pain, skin rashes

8)**For patients who cannot swallow pills and require liquid medications**:

a) Truvada comes in liquid preparation, but it is difficult to find; the pills can be crushed and put in food, liquid

b) **THE LIQUID PREPARATIONS OF THESE HIV PROPHYLAXIS MEDICATIONS ARE USUALLY ONLY AVAILABLE AT THE MEDICAL CENTER PHARMACY ON PARK STREET (**53 PARK ST 203-777-7809)

c)**If you are prescribing HIV prophylaxis for a prepubertal patient, please consult with the ID fellow on call.**

For those patients who cannot afford to pay for HIV PEP, contact Social Work to get a compassionate prescription request from pharmacy. They can get up to 3 days of HIV PEP from the Park Street Walgreens.

Psychosocial evaluation

1-Patients who have been sexually assaulted are at high risk for psychiatric disturbance in the 6- month period following the assault. The social worker will assess the patient for new and current psychiatric conditions, and make appropriate ED consultations for acute psychiatric evaluation and for outpatient care if no such acute evaluation is necessary.

2-In most cases of Human Trafficking, an acute psychiatric evaluation should be done in the ED, either by Child Psychiatry (patient younger than 16 years old) or by the CIU (patient older than 16 years old).

3-Please contact the social worker prior to discharging the patient from the ED to insure that all appropriate evaluations have taken place and a safe disposition for the patient has been determined, especially in cases of Human Trafficking.

Follow-up

1-**Medical evaluation in the Child Sexual Abuse Clinic:**

A. A forensic interview and medical evaluation in the Child Sexual Abuse Clinic can be helpful in the following situations:

i. Preverbal child

ii. Last contact with alleged perpetrator more than 72 hours prior to Emergency Department presentation

iii. Inability to perform genital examination due to child's anxiety

iv. When it is not clear that sexual abuse has occurred (confusing statements by child; parental concern that sexual abuse occurred but without history of statements by child suggesting such; child who has history of sexualized behaviors but no statements suggestive of sexual abuse)

v.Re-examination of injuries

vi. Concern about possible abnormalities detected on genital examination. These patients should be seen as soon as possible tin the Sexual Abuse Clinic.

vii. When the primary care provider cannot be contacted to insure follow-up of medical testing and psychosocial referrals or if the patient goes to the Pediatric Primary Care Center (PCC).

viii. When DCF has been notified, as in a case of suspected Child Sexual Abuse or Human Trafficking.

B. **Please note that the Child Sexual Abuse Clinic does not provide ongoing psychological counseling or family therapy, but is a resource for such services and can provide referrals**.

C. **Please notify the Sexual Abuse Clinic Intake Social Worker at 688-2392 for all referrals to the Child Sexual Abuse Clinic. The ED social worker should make this phone call for referral**

2-Follow-up with the primary care provider:

A. The primary care provider can be helpful to coordinate referrals and to offer support to the family. If the examination was completed in the PED and if the primary care provider is willing to re-examine the child and provide follow-up of STI testing and Hepatitis immunization, then referral to the Child Sexual Abuse Clinic may not be necessary, provided that Mental Health referrals have been provided by the ED social worker.

3-Rape crisis center volunteers can be very helpful to the patient and family in terms of any mental health or legal assistance or in cases where the adolescent is homeless. Please give families the brochure for the Women and Families Center on discharge (in Room 12 closet).

Tips on Completing the Rape (Forensic) Kit

1-First complete the information on the outside of the kit (patient name, unit number, name of examiner and assisting nurse/tech). Inform the patient what the examination entails, obtain his/her verbal consent and allow them to have a support person (preferably of the same gender) in the room during the examination. Tell the patient that after the examination, blood will be drawn. To identify each label you can print labels from EPIC and then sign your name with the time on each envelope. If evidence was not collected for that particular envelope please print why the evidence was not collected (e.g. patient did not scratch alleged perpetrator).

2- Using the "State of Connecticut Sexual Assault Medical Report" form, fill in the history of assault and significant past medical history. Complete duplicate form and put yellow copy in the envelope on the back of the kit and **seal the envelope with a moistened 4x4-DO NOT LICK THE ENVELOPE.**

3- Now proceed to the physical examination, forensic evidence and STI collection:

> **Step 1**: Have the patient undress over two large pieces of paper that are in the Rape Kit; if not available, use 2 bed sheets. Wrap the outer clothing in the top sheet and use the second sheet to wrap the wrapped clothing. Place in paper bag; staple the bag and complete the outer label.
>
> > **Note**: If there are stains on the clothing, use a piece of paper to cover the stain, then fold the clothing.
> >
> > **Note:** Place underwear in a separate small white bag, placing paper over stains, label and seal the white bag, and then place in the brown paper bag with the rest of the clothes.
>
> **Step 2**: Examine the skin for any body fluids, which contain flavenoids that will appear bright yellow or orange with the Blue Maxx light (which is carried by the SANE's and is also locked in Kirsten Bechtel's locker #24). Any substance that fluoresces should be swabbed with a saline-moistened cotton swab from **Envelope 7.** Dry the swabs as best as possible and place back in the paper packets, labeling the outside with the location of the area that was swabbed. You may need more than one cotton swab packet. All packets should be placed in **Envelope 7.**
>
> **Note: To seal the envelopes in the Rape Kit, use moistened gauze. DO NOT LICK THE ADHESIVE ON THE ENVELOPE.**
>
> **Step 3: Complete Envelope 4 ONLY if the patient scratched the alleged perpetrator and has sufficiently long natural fingernails.**
>
> **Step 4:** Complete Envelope 5 by GENTLY plucking 20 head hairs close to the scalp. Look carefully for any trauma to the head.
>
> **Step 5: Complete Envelopes 6 ONLY if there was oral-genital contact or if there are bite marks on the patient, or if the patient bit the alleged perpetrator.**

Step 6: Examine the chest, abdomen and extremities, noting any injuries

Step 7: Proceed to the GU examination. Note Tanner stage and the presence of any external injuries or lesions.

a. Inspect the perineum with the Blue Maxx; any substance that fluoresces can be swabbed with a saline-moistened cotton swab, placed in its packet and then placed in an envelope or in **Envelope 7** if not previously used. Any areas that are swabbed due to fluorescence with the Blue Maxx should be documented on the person figure on the outside of Envelope 7. If multiple swabs are placed in Envelope 7 please document on the outside of the paper swab packet the location from which it was obtained.
b. Complete **Envelopes 8 and 9,** but clip for pubic hair-do not pull.
c. Complete **Envelope 10** as directed, using a moistened cotton swab to swab the perineum.
d. **Envelope 11** should only be completed for girls Tanner stage 3 or greater. A speculum is not needed to obtain these samples, especially in adolescents who have not had a prior speculum examination. Blind vaginal swabs are adequate for both the Rape Kit.
e. Complete **Envelope 12** if there was a history of anal-genital contact. STI swabs can be taken from the anus after the swabs from the Rape Kit have been collected.
f. Any foreign bodies (tampons, condoms) found on GU examination can be placed in **Envelope 2**.

Step 8: Allow the patient to dress and inform them of the blood draw. Red and purple top tubes from **Envelope 3**, as well as 2 red tops for HIV EIA, VDRL and Hepatitis panel, need to be obtained by venipuncture. Remember that the STI testing goes to the hospital laboratory and not in the Rape Kit.

Step 9: **Complete pages 2-5 of the Sexual Assault Report** and place the yellow copy of page 1 in the envelope on the back of the kit. The white copies of pages 1-5 can be scanned by the BA into Lynx. Seal the kit. If detectives are not available to pick up the kit, contact the security personnel in the triage area of the Adult ED so the kit can be stored in the locked refrigerator in the AED triage security office. Any person who handles the kit needs to write their name on the chain of possession section of the outside of the kit.

Evaluation for "Date Rape" Drugs

If the patient presents with altered mental status, memory loss, impaired motor skills, one should be concerned about concomitant ethanol or drug use either voluntarily by the patient or given to the patient by the perpetrator without the patient's knowledge or consent. Most often ethanol is used to facilitate a sexual assault. In rare cases, GHB or Rohypnol may be given, which are not detected by the standard toxicology screen used by the hospital. If there is a concern that drugs were given to the patient to facilitate a sexual assault, a toxicology screen (blood and urine) should be sent to the hospital laboratory. In addition, to detect GHB and Rohypnol, a separate forensic toxicology kit is available and should be kept with the Rape Kit so it can be given to detectives. Consent to obtain this testing should be documented in the medical record.

1-If assault occurred within 72 hours of ED presentation, collect blood and urine samples.
2-If the assault occurred more than 72 hours before ED presentation, then no testing is done.

Collection procedure

1: **Blood**: Collect 10 cc in 2 gray top tubes. Label each tube with the patient's name, date of birth, date of collection, and the initial of the person who obtained the blood. Place in the toxicology kit.
2: **Urine**: Collect 30 cc of a mid-stream urine sample into a sterile container. Label the container in the manner described above. Place in the toxicology kit and seal the kit.
3-**If no toxicology kit is available**, the collect 2 gray top tubes for blood and the urine and put these samples in a stapled biohazard bag, with a patient ID label on the front. Store the kit with the rape kit, either in the Adult ED triage security office refrigerator or hand to the detective, documenting name and badge number in the medical record.

Patient Disposition

Once the examination is completed, be sure that all referrals to the Child Sexual Abuse Clinic, the Sexual Assault Crisis Service and mental health providers have been done and given to the parent/guardian. The primary care provider must also be notified. One can use the discharge instruction sheet in the Rape Kit for all medications and referrals.

Prepared by:
Kirsten Bechtel MD
Karen Santucci MD
Carl Baum MD
December 21, 2003
Revised 8/26/15