

INFORMATION PERTAINING TO ASSAULT & KIT TRACKING FORM FORM 2A PROVIDER SEXUAL CRIME REPORT

FAX FORM 2A ONLY

Per MGL C.112, S. 12A 1/2

K

A. PATIENT INFORMATION: <i>Name, address and other identifying information should not be written on this anonymous form.</i>					
1. Age: _____		2. Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Male to Female <input type="checkbox"/> Female to Male			
3. Race: <input type="checkbox"/> White <input type="checkbox"/> Black/African Am <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Am Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Other: _____					
4. Date of Assault (e.g., 01/01/2000): _____			5. Approx. Time of Assault: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM		
6. City/Town of Assault: _____		State: _____		Neighborhood: _____	
7. Specific surroundings at time of Assault: <input type="checkbox"/> House/Apartment <input type="checkbox"/> Outdoors <input type="checkbox"/> College/University <input type="checkbox"/> Hotel/Motel <input type="checkbox"/> Unsure <input type="checkbox"/> Other (specify) _____ Correctional Facility (Check One): <input type="checkbox"/> Prison <input type="checkbox"/> Jail <input type="checkbox"/> DYS					
8. Date of hospital exam (e.g., 01/01/2000): _____			9. Time of hospital exam: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM		
10. Hospital providing service: _____		Affix kit number label here on both white and yellow copies.			
11. Exam completed by: <input type="checkbox"/> MA SANE <input type="checkbox"/> SANE-A <input type="checkbox"/> OTHER _____					
B. ASSAILANT(S) INFORMATION: <i>Did the patient voluntarily report any of the following relationships with the assailant(s)?</i>					
12. Total number of assailants: _____ Unsure: <input type="checkbox"/>					
13. Assailant(s) relationship to patient and gender of assailant (m/f) (If >1 assailant, designate relationship of each).					
	# Male	# Female		# Male	# Female
<input type="checkbox"/> Parent/ Step-parent	_____	_____	<input type="checkbox"/> Boy/ girlfriend	_____	_____
<input type="checkbox"/> Spouse/ live-in partner	_____	_____	<input type="checkbox"/> Ex-boy/ girlfriend	_____	_____
<input type="checkbox"/> Ex-Spouse/ live-in partner	_____	_____	<input type="checkbox"/> Date	_____	_____
<input type="checkbox"/> Parent's live-in partner	_____	_____	<input type="checkbox"/> Acquaintance	_____	_____
<input type="checkbox"/> Other relative	_____	_____	<input type="checkbox"/> Friend	_____	_____
<input type="checkbox"/> Stranger	_____	_____	<input type="checkbox"/> Unknown	_____	_____
			<input type="checkbox"/> Other (specify): _____	_____	_____
C. WEAPONS/ FORCE USED: <i>(Check all that apply as per patient report and/or physical findings).</i>					
14. <input type="checkbox"/> Unknown		<input type="checkbox"/> Hitting		<input type="checkbox"/> Hold Down/Body Weight	
<input type="checkbox"/> Verbal threats		<input type="checkbox"/> Burns		<input type="checkbox"/> Blunt Object	
<input type="checkbox"/> Strangulation		<input type="checkbox"/> Gun		<input type="checkbox"/> Alcohol	
<input type="checkbox"/> Bites		<input type="checkbox"/> Knife		<input type="checkbox"/> Drugs	
				<input type="checkbox"/> Chemical(s) (pepper spray, mace, etc.)	
				<input type="checkbox"/> Restraints (ropes, ties, cords, etc.)	
				<input type="checkbox"/> Other physical force Describe: _____	
				<input type="checkbox"/> Other weapons Describe: _____	
D. ACTS DESCRIBED BY THE PATIENT:					
<i>Was there penetration, however slight, of:</i>					
15. Vagina <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/> Attempt <input type="checkbox"/> Yes <input type="checkbox"/> N/A		BY <input type="checkbox"/> Penis <input type="checkbox"/> Finger <input type="checkbox"/> Tongue <input type="checkbox"/> Object/Other: _____			
16. Anus <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/> Attempt <input type="checkbox"/> Yes		BY <input type="checkbox"/> Penis <input type="checkbox"/> Finger <input type="checkbox"/> Tongue <input type="checkbox"/> Object/Other: _____			
17. Mouth <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/> Attempt <input type="checkbox"/> Yes		BY <input type="checkbox"/> Penis <input type="checkbox"/> Finger <input type="checkbox"/> Tongue <input type="checkbox"/> Object/Other: _____			
18. Did ejaculation occur? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNSURE <input type="checkbox"/> N/A					
19. Did assailant(s) use a condom? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNSURE <input type="checkbox"/> N/A					
20. Any injuries to patient resulting in bleeding? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNSURE					
If yes, specify: _____					
21. Any injuries to assailant(s) resulting in bleeding? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNSURE					
If yes, specify: _____					
E. CASE STATUS AT TIME OF THE EXAM					
22a. Evidence Collection Kit completed?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
22b. Toxicology Kit completed?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
23. Reported to police?		<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, specify police dept.: _____</i>			
24. DCF Involved?		<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, describe status: _____</i>			
25. Restraining order in place before assault?		<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, date and court location: _____</i>			
26. Restraining order filed after assault?		<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, date and court location: _____</i>			
F. MANDATORY REPORTING					
27. 19A Elder Abuse Report		<input type="checkbox"/> Yes <input type="checkbox"/> No			
28. 51A Child Abuse Report		<input type="checkbox"/> Yes <input type="checkbox"/> No			
29. 19C Disabled Persons Report		<input type="checkbox"/> Yes <input type="checkbox"/> No			
30. 12A Weapon Report		<input type="checkbox"/> Yes <input type="checkbox"/> No			
31. 70E Emergency Contraception Administered		<input type="checkbox"/> Yes <input type="checkbox"/> Not indicated <input type="checkbox"/> Declined <input type="checkbox"/> Not offered			
G. KIT TRACKING INFORMATION					
32. Name of Police Department notified for pick up and transport of Evidence: _____					
33. Date notified: _____ Time notified: _____					

FAX this report to:

Massachusetts Executive Office of Public Safety-Research and Policy Analysis Unit

JUNE 2014

FAX: 617-725-0260 AND: Local public safety authority

RETAIN WHITE COPY OF FORM 2A AND 2B FOR HOSPITAL RECORDS

RETURN YELLOW COPY OF FORM 2A AND 2B TO STEP 1 ENVELOPE