

Virginia's Healthcare Response to Sexual Assault

Guidelines for the Acute Care of Adult and Post-Pubertal Adolescent Sexual Assault Patients

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COMMONWEALTH of VIRGINIA

Office of the Governor

Marilyn B. Tavenner
Secretary of Health and Human Resources

November 2, 2009

To Virginia's Healthcare Professionals and Community Partners:

It is my pleasure to present to you "*Guidelines for the Acute Care of Adult and Post-Pubertal Adolescent Sexual Assault Patients* in Virginia."

In 2007, the Governor's Commission on Sexual Violence recommended that a state level, multidisciplinary advisory group be convened to promote a consistent healthcare response to victims of sexual assault. Subsequently, a dedicated team of healthcare providers, criminal justice professionals, sexual assault victim advocates, and survivors of sexual assault worked to commence this effort. These guidelines are the culmination of their effort and incorporate recommendations from professionals across Virginia, as well as information from current guidelines from relevant state and national resources.

This document is a useful tool for healthcare professionals and their community partners striving to provide high quality care for victims of sexual assault. In addition to providing practical guidance to those delivering direct care to patients, these guidelines will also be a valuable resource to healthcare facilities in the development of facility policies.

While these guidelines were developed specifically for healthcare professionals and facilities, we know that the healthcare sector is just one component of a comprehensive response to sexual violence. In 2009, the Virginia General Assembly passed legislation requiring the Commonwealth's Attorneys to establish a multidisciplinary response to criminal sexual assault. It is my hope that these guidelines will be a valuable part of our statewide efforts to establish coordinated, collaborative, and compassionate responses to sexual violence in every community in Virginia.

Sincerely,

A handwritten signature in black ink, reading "Marilyn B. Tavenner".

Marilyn B. Tavenner

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Guidelines for the Acute Care of
Adult and Post-Pubertal Adolescent
Sexual Assault Patients

Available online at www.sexualanddomesticviolencevirginia.org

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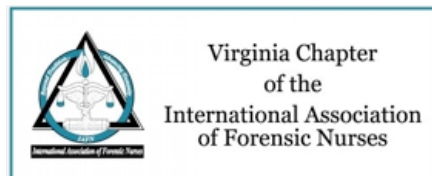
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Virginia Department of Health
Virginia Department of Health Professions
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Virginia Association of Free Clinics
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This document provides guidance for compassionate and effective care for adult and post-pubertal adolescent sexual assault patients. It does not represent the only medically or legally acceptable response to any sexual assault patient or establish a legal or medical standard of care, and deviation from this document does not necessarily represent a breach of a standard of care. The ultimate judgment regarding a healthcare provider's recommendation on a course of action for a patient must be made by the clinician in light of all the circumstances presented. This document does not supersede clinician judgment, facility policies, state and federal laws, or guidelines issued by the Virginia Department of Criminal Justice Services and Department of Forensic Science for conducting forensic examinations.

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Introduction

The Need for Healthcare Guidelines

Virginia law enforcement agencies received reports of 5,009 forcible sex offenses in 2007 (Virginia Uniform Crime Reporting Program, 2008). The actual number of assaults is thought to be much higher, as reporting rates for sexual assault are relatively low (Rand, 2007). The 12-month incidence of sexual violence among adults in Virginia is estimated to be 2.4 percent, and the lifetime prevalence is 28 percent for adult women and 13 percent for adult men (Virginia Sexual Violence State Plan Advisory Board, 2006). Nationally, 1 in 1,000 persons were victims of rape or sexual assault in 2007 (Rand, 2007).

Clinical guidelines and protocols for the healthcare of sexual assault patients have been issued by national medical, criminal justice, and victim services organizations (AAP, 2008; ACEP, 2002; ACOG, 1997, 1999; AHRQ, 2003; AMA, 1995; Office on Violence Against Women, 2004), providing fairly uniform recommendations for the necessary components of comprehensive medical-forensic care. However, research suggests that the healthcare received by sexual assault patients is inconsistent and often does not adhere to national guidelines (Amey and Bishai, 2002; Campbell, 2006; Campbell and Bybee, 1997; Campbell et al., 2006; Rovi and Shimoni, 2002; Straight and Heaton, 2007). Data from Virginia reflect these national findings (Plichta et al., 2006) and support the need for a consistent approach to caring for sexual assault patients across the Commonwealth.

The Governor's Commission on Sexual Violence recommended in November 2007 that the Secretaries of Health and Human Services and Public Safety convene a multidisciplinary body to develop a statewide model of care for the acute healthcare response to sexual violence. Subsequently, the Virginia Department of Criminal Justice Services awarded funding to the Virginia Sexual and Domestic Violence Action Alliance (VSDVAA) and the Virginia Chapter of the International Association of Forensic Nurses (VA-IAFN) to facilitate this effort. Throughout 2008 and 2009, VSDVAA and VA-IAFN worked with a multidisciplinary, interagency Advisory Board and Working Group to develop this document. (See Appendix 1 for more information about the development of this document.)

Goal:
Sexual assault patients in Virginia will receive a consistently high quality of healthcare in all facilities providing treatment, regardless of the circumstances of the assault or the patient's involvement with the criminal justice system.

The goal of this initiative is for sexual assault patients to receive a consistently high quality of healthcare in all facilities providing treatment, regardless of the circumstances of the assault or the patient's involvement with the criminal justice system. Nearly two decades ago, a similar initiative laid the groundwork for a consistent approach to caring for sexual assault patients in Virginia's hospitals, with the publication in 1990 of "Virginia's Hospital Protocol For the Treatment of Sexual Assault Victims." This new document replaces that protocol. It incorporates current guidelines from national medical and criminal justice organizations for the management of sexual assault patients and the collection of forensic evidence. This document also expands the focus to encompass healthcare settings other than hospitals; an emergency room is not always the first stop for a person who has been sexually assaulted. Healthcare providers in a variety of settings must be prepared to care for sexual assault patients.

Data on Virginia's Healthcare Response to Sexual Assault

Plichta et al. (2006) are the first to systematically study the services offered to sexual assault patients by emergency departments in Virginia. (No published data are available on the acute care received by sexual assault patients in other healthcare settings in Virginia.) While nearly all of their respondents routinely offered

sexual assault patients testing and treatment for sexually transmitted infections and pregnancy tests, some aspects of recommended medical care—notably emergency contraception and HIV testing¹—were offered less consistently (87% and 82% respectively). Among emergency departments that provided forensic examinations for sexual assault patients, only 66 percent performed all of the recommended components of the forensic exam. While many components of the exam were conducted by at least 90 percent of respondents, only 78 percent of respondents reported that they obtained written consent from the sexual assault patient or photographically documented injuries. Services that support the emotional well-being and comfort of sexual assault patients, such as the presence of a sexual assault crisis center advocate or providing clean clothes and a place to shower after a forensic exam, were offered by only 60 to 80 percent of emergency departments. Fewer than half of Virginia’s emergency departments regularly trained new staff in caring for sexual assault patients, and very few (13%) provided such training for existing staff.

These gaps are particularly noteworthy in light of evidence that provider education and the quality of medical and forensic services have significant effects on patient outcomes, on the likelihood of participation in the criminal justice process, and on the quality of forensic evidence collected (Campbell, Patterson, and Lichty, 2005; Campbell et al., 2006; Nugent-Borakove et al., 2006; Plichta et al., 2006; Sievers, Murphy and Miller, 2003). Anecdotal evidence from healthcare providers, law enforcement officials, and crisis center advocates from around the Commonwealth suggests continued inconsistency in access to trained medical personnel and emergency departments equipped to conduct forensic examinations, often resulting in delays in medical care and evidence collection, poorer quality evidence, and increased trauma to the patient.

Use of This Document

This document addresses the healthcare response to sexual assault at all levels of the system—community, healthcare facility, and individual providers—by providing:

Community-Level

Recommendations that promote institutionalized linkages among stakeholders for greater collaboration and sharing of resources.

Facility-Level

Guidance for healthcare facilities in establishing policies that institutionalize system-level relationships and support the provision of high quality medical and forensic services to sexual assault patients.

Individual-Level

Tools for clinicians who directly deliver care to patients in the acute period after a sexual assault. Practice guidelines and algorithms outline major process steps and provide guidance on performing these steps in a manner that minimizes further trauma to the patient and maximizes the probability of collecting and preserving evidence for potential use in the legal system.

As indicated by the title, this document provides guidelines for the care of adult and post-pubertal adolescent sexual assault patients only. Pre-pubertal children who have been sexually abused are emotionally as well as physically different from older sexual assault patients and require pediatric medical, forensic, and psychological services. Although guidelines for caring for post-pubertal adolescent sexual assault patients are similar to those for adults, special consideration must be given to issues related to mandatory reporting, consent, and confidentiality. Please see page 6 for a discussion of special considerations for using this document with post-pubertal adolescents.

Application in Different Settings and Communities

This is not a document about forensic nursing programs. Not all communities or facilities can sustain forensic nursing programs. These guidelines are intended to assist healthcare facilities in all communities

¹ The study was conducted prior to the enactment of Virginia’s opt-out screening process for HIV in 2008.

and regions of Virginia in developing policies for managing sexual assault patients—whether they provide sexual assault examinations on-site or transfer sexual assault patients to other facilities.

Sexual assault patients may present to a variety of healthcare settings, most commonly, but certainly not limited to, hospital emergency departments. In some communities, Forensic Nurse Examiner/Sexual Assault Nurse Examiner programs operate independently of the hospital. Other healthcare facilities that may provide care in the immediate period after a sexual assault include local health department clinics, free clinics, urgent care clinics, military hospitals or clinics, student health centers, and private practices. This document was written to be useful for different types of healthcare facilities. Although specific guidelines may be more relevant to some facilities than others, the overarching elements of a compassionate and effective healthcare response are the same regardless of where the care is provided.

The guidelines presented in this document are goals that all healthcare facilities should work toward and should be able to achieve. In many cases, the precise manner in which these goals are met (e.g., assisting sexual assault patients with transportation, coordinating a response by the local sexual assault crisis center, providing training to healthcare providers) will depend on available resources and community-level factors. Some goals may take more time to achieve than others, but they are all achievable.

In addition to the guidelines, the document identifies best practices. The best practices are ideal elements of a model healthcare response to sexual assault that, unlike the guidelines, may not be feasible for all facilities or communities.

This document provides:

- **Guidance for healthcare facilities** developing or enhancing policies for the provision of medical and forensic services to adult and post-pubertal adolescent patients reporting sexual assault.
- **Guidelines and tools for clinicians** providing care to adult and post-pubertal adolescent sexual assault patients.

This document ***DOES NOT***:

- Apply to pre-pubertal children.
- Impose a set of mandates or replace clinician judgment and healthcare facility policies.
- Represent the only medically or legally acceptable response to any sexual assault patient or establish a legal or medical standard of care.
- Supplant guidelines issued by the Departments of Criminal Justice Services and Forensic Science related to forensic exams and Physical Evidence Recovery Kits (PERK).

Overarching Issues

Several broad concepts are at the heart of a model healthcare response to sexual assault and guided the development of this document:

- Patient-centered care (see sidebar)
- Informed choice
- Competent, comprehensive, and ethical practice
- Consistency and continuity of care
- Accountability
- Recognition of forensic services as a critical healthcare service

Healthcare for sexual assault patients serves multiple purposes and must meet the needs of both patients and the criminal justice system. These needs may converge or conflict at various points in the healthcare process.

Sexual assault patients have acute and long-term medical and emotional needs, including:

- Competent and comprehensive examination and treatment, regardless of their legal choices.
- Continuity of care and access to appropriate follow-up services.
- Feeling safe, respected, and in control.
- Privacy.

Privacy issues are important in all healthcare interactions, but may have particular importance for the safety and emotional well-being of sexual assault patients. Healthcare providers must take care to protect personal health information in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and state privacy laws.

The needs of the **criminal justice system** center on obtaining quality evidence that can be used in a courtroom setting, including access to effective forensic services, preservation and documentation of the chain of custody, and support for sexual assault patients to enable their participation in the criminal justice system.

This document provides a framework and guidelines for the critical role of the healthcare sector in meeting the needs of sexual assault patients and the criminal justice system, with a focus on the acute healthcare setting. The community response to sexual assault is most effective when all stakeholders share an understanding of the roles of different responders (e.g., healthcare, law enforcement, advocacy), strive for consistency in fulfilling these roles, and recognize the obligation to provide high quality medical care and access to forensic services to sexual assault patients.

Patient-centered care is respectful of and responsive to the needs and preferences of individual patients.

Sexual assault patients have experienced severe physical and emotional trauma. Patient-centered care for sexual assault patients acknowledges the impact of violence and victimization on patients, and practices and policies are adapted accordingly.

Common reactions to trauma include:

- Loss of a sense of safety and control,
- Difficulty processing information,
- Inability to manage feelings,
- Difficulty filtering external and internal stimuli,
- Difficulty with transition, and
- Disruptions in memory.

These reactions may be exacerbated by healthcare settings and/or procedures. Everybody responds differently to sexual violence, so the needs of sexual assault patients will vary. Healthcare providers should be aware of the common effects of sexual trauma and modify practices as necessary to minimize re-traumatizing the patient.

Fundamental Criteria

The practice guidelines provided in this document are organized around four *fundamental criteria for a model healthcare response to sexual assault*.

I. The physical and emotional needs of sexual assault patients are recognized and addressed to minimize additional trauma. (page 9)

This section focuses on **PATIENT CARE PRIORITIES**:

- Addressing physical and emotional trauma throughout the healthcare visit
- Addressing safety, privacy, and physical comfort needs
- Coordination with sexual assault crisis centers to provide emotional support and other assistance

II. Healthcare facilities treating sexual assault patients establish and promote a patient-centered model of care. (page 13)

This section focuses on **PROVIDER RESPONSIBILITIES**:

- Utilizing providers with training in caring for sexual assault patients
- Respect for patient autonomy
- Providing information and obtaining consent
- Accommodating the individual needs of patients

III. Healthcare facilities provide medical services to sexual assault patients and promote a continuum of care through planning for and/or providing follow-up services, regardless of the time elapsed since the assault or whether a forensic exam is performed. (page 17)

This section focuses on **MEDICAL SERVICES**:

- Medical screening
- Testing and treatment for STIs/HIV
- Emergency contraception
- Toxicology testing
- Discharge instructions, referrals, and follow-up services

IV. Healthcare facilities support the provision of competent, high quality forensic services to sexual assault patients. (page 19)

This section focuses on **FORENSIC SERVICES**:

- Collecting and preserving forensic evidence and maintaining chain of custody
- Preparation of facilities and providers to provide quality forensic services
- Collaboration and coordination in the community response to sexual assault

Special Considerations for Post-Pubertal Adolescent Sexual Assault Patients

This document is intended for use with post-pubertal adolescents as well as adults. Caring for adolescent sexual assault patients requires special attention to issues related to mandatory reporting, consent, and confidentiality. This section highlights key points to be considered when using this document with post-pubertal adolescents.

Discussions with healthcare providers around Virginia suggest that interpretation of state laws on mandatory reporting and minors' consent may vary across local agencies and healthcare facilities. Healthcare facilities should ensure that their policies provide adequate guidance to providers in complying with Virginia laws for all of these issues. (Note: References to state law are in italics.)

Mandated Reporting Requirements

Healthcare providers are required to report sexual abuse of a child under the age of 18, per § 63.2-1509 of the Code of Virginia.

See Appendix 6 for the text of laws that specify reporting requirements and define reportable abuse. Healthcare providers should follow their facilities' policies about reporting sexual abuse of children and inform adolescent patients of those policies.

Consent

Per § 54.1-2969 of the Code of Virginia:

- *A minor has the right to consent to or refuse testing and treatment for sexually transmitted infections (STIs), including HIV prophylaxis, without parental consent or notification.*
- *A minor has the right to consent to or refuse emergency contraception without parental consent or notification.*
- *Results of pregnancy tests, STI screening, and drug/alcohol screening may not be released to a parent/guardian without the patient's consent.*

See Appendix 5 for the text of this law. Providers should follow their facilities' policies about minors' consent to treatment when determining if forensic evaluation can be conducted without parental consent/notification or other legal alternative. No forensic patient, regardless of age, should be forced or coerced to have a forensic exam.

Confidentiality

- Parents or other family members may provide crucial emotional support for the adolescent patient and should be contacted as soon as possible with patient consent.
- Healthcare providers should accommodate patients' requests to have a personal support person in the room during an examination. However, family members or other support persons should not be in the examination room if the healthcare provider has reason to suspect that their presence may be harmful to the patient or to the examination process.

- Healthcare providers should respect patients' wishes about notifying family members and schools unless facility policies require otherwise.
- Providers should inform adolescent sexual assault patients about the facility's policies requiring parental notification.²
- Providers should inform patients that if they are covered by a parent's health insurance, any services paid for by that health insurance policy might become known to the policy holder.

² For example, under federal Family Educational Rights and Privacy Act regulations, educational institutions may disclose information to parents "to protect the health or safety of the student or other individuals."

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Practice Guidelines

As noted in the introduction, the resources held by or available to healthcare facilities vary considerably. The guidelines that follow are *goals that all healthcare facilities should work toward and should be able to achieve*.

Best practices, on the other hand, are *ideal elements of a model healthcare response to sexual assault, but may not be feasible for all facilities or communities*. For the purposes of this document, “best practices” do not necessarily represent “evidence-based practices” as defined by current scientific literature; for many practices, no scientific evidence base currently exists.

Note: The practice guidelines that follow are not intended as a chronological representation of all of the steps involved in providing medical and forensic services to sexual assault patients. For a condensed, step-by-step guide, please refer to the Algorithms.

Patient Care Priorities

I. The physical and emotional needs of sexual assault patients are recognized and addressed to minimize additional trauma.

- A. Healthcare facility policies and procedures recognize that sexual assault patients present an emergency medical condition and make provisions in the triage and/or intake process.

Important points:

- Not all patients who have been sexually assaulted will identify themselves as sexual assault patients. Healthcare facilities should have procedures in place for identifying possible cases of sexual assault.
- Sexual assault patients may not have visible physical injuries.
- The severity of their psychological trauma may not be initially apparent.
- Physical evidence can be destroyed or contaminated if collection is delayed.
- Wait times should be minimized to reduce posttraumatic stress and preserve forensic evidence, as well as to ensure that serious physical injuries are attended to in a timely manner.

- B. The privacy and safety needs of sexual assault patients are recognized and accommodated to whatever extent feasible.

- i. Sexual assault patients are provided a private area and recognized as emergent or urgent patients when assigning priority for treatment areas.

Best Practice: Following triage and intake processes, sexual assault patients are taken immediately to a private treatment area.

- ii. Healthcare personnel take precautions to ensure that discussions with and about sexual assault patients are held privately, and avoid identifying them as sexual assault patients in a public setting.

- C. The healthcare facility contacts the local sexual assault crisis center (if it is not already involved) to coordinate response by an advocate to offer on-site support, crisis intervention, and advocacy services to the sexual assault patient. (See Appendix 8.)
- i. The healthcare provider offers the services of the responding sexual assault crisis advocate to the sexual assault patient and, if requested, introduces the advocate as soon as possible and preferably prior to any further examination after the medical screening examination.
 - ii. The sexual assault patient's identifying information and personal health information are not released to the advocate without the patient's consent.
 - iii. The healthcare facility and local sexual assault crisis center have a mutually agreed upon written protocol for requesting a sexual assault crisis advocate, taking into account local factors such as travel time to the facility.

Best Practices:

A cooperative agreement formally establishes a relationship between the healthcare facility and the local sexual assault crisis center and addresses the scope and limits of confidentiality, including legal and ethical access to patient information, in order to expedite sexual assault patients' access to advocacy and support services.

A hospital-based advocate trained in sexual assault crisis services is available 24/7 to provide support services to sexual assault patients throughout the medical and/or forensic examinations and to coordinate discharge and follow-up services.³

- D. Throughout a sexual assault patient's stay in the healthcare facility, the number of healthcare providers caring for the patient is limited.
- E. Whenever feasible, one person is designated to stay with the sexual assault patient throughout his or her healthcare visit. Efforts are made to avoid leaving the sexual assault patient alone.
- F. Medical and forensic processes are coordinated or integrated whenever possible to minimize repetition of questions or procedures⁴ and reduce the burden on the sexual assault patient.
- i. If the sexual assault patient chooses to report to law enforcement, the healthcare provider and law enforcement personnel coordinate their information needs. (See the "best practice" under B on page 13.)
 - ii. The healthcare provider clarifies at the outset of a forensic exam what evidence needs to be collected based on the history provided by the patient.
- G. Representatives of law enforcement are not in the room during an exam.
- H. If desired by the sexual assault patient, an advocate is present during the initial history and throughout the medical and/or forensic exam for emotional support of the patient.
- I. The healthcare provider accommodates sexual assault patients' requests to have a personal support person (e.g., spouse or partner, relative, friend) in the room during the exam, unless responders believe the presence of that person could be harmful to the patient or to the exam process.

³ A hospital-based advocate is not a replacement for a crisis center advocate but coordinates and works with the crisis center advocate to meet the needs of the patient in the best manner given the facility's and community's resources.

⁴ For example, blood drawn for medical purposes should be collected at the same time as blood drawn for forensic purposes in order to minimize patient discomfort. However, medical specimens and documentation done for clinical purposes should be kept separate from forensic specimens and documentation.

Healthcare providers should be aware that the support person accompanying the patient (e.g., spouse or partner, family member, personal care assistant) may be a threat or harmful to the patient. For example, the support person may be the perpetrator of the assault, or their anger may prevent them from being emotionally supportive.

Healthcare providers and facilities should establish a plan for identifying immediate safety risks to patients, for talking to and treating sexual assault patients when the perpetrator may be present, and for safely removing a person who obstructs or interferes with the provision of medical and/or forensic services or whose presence is considered harmful to the patient.

- J. The healthcare provider limits the number of people in the room during the exam (other than the patient-requested support person, advocate, and interpreter, if necessary). If additional healthcare providers are needed, the healthcare provider seeks permission from the patient before admitting them to the room.
- K. The healthcare provider conducts a safety assessment and, if indicated, develops a safety plan to address identified risks in consultation with the sexual assault patient.⁵ (See Appendix 4.)
- L. After the forensic examination (if performed), the sexual assault patient is offered an opportunity to shower or wash up, change clothes, get food and drink, and make phone calls.⁵

Best Practices:

A specific area of the facility is designated for sexual assault patients to privately shower or wash and attend to physical comfort needs.

The healthcare facility has identified internal and/or external resources to assist patients with personal care needs (e.g., clean clothes) and transportation. Healthcare providers are aware of these resources and know how to access them.

- M. The sexual assault patient is assisted with transportation home or to another location.⁵

⁵ The healthcare facility can work with the local sexual assault crisis center to conduct safety assessment and planning, to provide clean clothes and comfort items (or to assist sexual assault patients in bringing their own change of clothes to the healthcare facility), and to assist with transportation needs.

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Provider Responsibilities

II. Healthcare facilities treating sexual assault patients establish and promote a patient-centered model of care.

- A. Acute care facilities have designated licensed clinical practitioners who have received training in caring for sexual assault patients. The designated provider is assigned to the case as soon as possible after a sexual assault patient presents or is identified.

Healthcare facilities may wish to collaborate with local sexual assault crisis centers to establish core competencies and provide training and ongoing continuing education for providers who care for sexual assault patients. See Appendix 10 for further guidance and recommended training content.

Best Practice: Healthcare facilities staff or contract with Forensic Nurses and/or Sexual Assault Nurse Examiners (FNE and/or SANE) to provide medical and forensic services to sexual assault patients.

- B. Healthcare providers are knowledgeable about resources available within their facility and in the community to respond to the needs of sexual assault patients (e.g., sexual assault crisis center, law enforcement agencies, victim/witness programs, mental health and social services, hospital-based social services).

Best Practice: Healthcare facilities collaborate with local law enforcement agencies, the local sexual assault crisis center, emergency medical services, and other first responders to develop and maintain written protocols for the community's medical and forensic response to sexual assault. This coordinated, multidisciplinary approach ideally is established through a Sexual Assault Response Team (SART) that facilitates victims' access to comprehensive acute and follow-up care, promotes collaboration, and leverages resources in the community's response to sexual assault. SARTs should include, at a minimum, sexual assault victim advocates, law enforcement, providers of healthcare and forensic services, and prosecutors.⁶

- C. Providers understand that reporting sexual assault is not mandatory except in cases involving children under the age of 18, aged or incapacitated patients, or injuries from certain weapons. (See Appendix 6.)
 - i. Healthcare providers inform sexual assault patients of the healthcare facility's policies on mandatory reporting and reporting sexual assault to law enforcement, including what patient information, if any, is released to law enforcement.
- D. Healthcare providers inform sexual assault patients that they may receive medical care regardless of their decision to have contact with law enforcement, report the assault, or have evidence collected.
- E. Healthcare providers explain to sexual assault patients their options regarding contact with law enforcement and provide information about the reporting process to help patients make informed decisions about whether or not to report the assault to law enforcement.⁷
 - i. Healthcare providers ask sexual assault patients if they would like law enforcement to be contacted.

⁶ Chapter 817 of the 2009 Virginia Acts of Assembly requires Commonwealth's Attorneys to establish multidisciplinary sexual assault response teams that meet at least annually.

⁷ In some cases, nonmedical information, such as options for involvement with the criminal justice system and the benefits and consequences of various choices, may be provided by an advocate or other appropriate professional. Healthcare providers nevertheless should be knowledgeable about this information and able to ensure that it is conveyed to sexual assault patients.

- ii. Healthcare providers inform sexual assault patients that delays in reporting or talking to law enforcement, especially extended delays, can result in loss of evidence and may affect the ability of the criminal justice system to investigate and prosecute a case.
- iii. Healthcare providers inform sexual assault patients that they are not required to participate in the criminal justice system or cooperate with law enforcement authorities in order to be provided with a forensic examination (per §19.2-165.1(B) of the Code of Virginia).
- iv. Healthcare providers inform sexual assault patients that if they are not yet prepared to report the assault or release identifying information, the Physical Evidence Recovery Kit (PERK) may be released to local law enforcement, the Division of Consolidated Laboratory Services (DCLS), or another appropriate agency that is able to maintain chain of custody and preserve and protect patients' right to privacy. (DCLS will store PERKs for only 120 days. See Appendix 19.)

(Also see Forensic Services guidelines on page 19.)

Best Practices:

Written policies designate who is responsible for informing patients about the facility's policies on reporting sexual assaults and the patient's options for medical and forensic services and involvement with law enforcement.

Healthcare providers or designees⁷ provide this information in writing and allow patients time to consider their options before making decisions.

- F. Healthcare providers inform sexual assault patients of the medical care/treatments and forensic services that are available, including the unique purposes of medical and forensic examinations.
 - i. At the outset of the medical and forensic exam and throughout the examination process, the benefits and consequences of all choices are fully explained to sexual assault patients, including the medical and forensic implications of declining a medical exam, a forensic exam, or a component of either exam.
- G. Healthcare providers inform sexual assault patients that they may stop the medical or forensic exam at any time or decline specific components of the exam. Before beginning the exam and before each procedure during the exam, the healthcare provider explains each procedure and seeks permission from the patient before proceeding.
- H. Healthcare facilities have guidelines for consistency in obtaining the necessary consents. Written policies address the assessment of patients' decision-making capacity.
- I. Facility personnel are knowledgeable about available resources for accommodating sexual assault patients with cognitive or physical disabilities, and the healthcare facility has a plan in place to ensure that necessary equipment and resources are accessible in a timely manner. As soon as is practicable, personnel arrange for necessary services or equipment.
- J. Facility personnel are knowledgeable about resources for serving sexual assault patients who have limited English proficiency or are deaf or hard of hearing, and are able to access interpretive services in a timely manner. (See Appendix 9.)

Best Practice: Healthcare facilities maintain access to professional interpreting services for patients who are deaf or hard of hearing and for patients with limited English proficiency. Ideally, interpretation is provided in person by a qualified interpreter with training in the medical and legal language used in examining sexual assault patients.

- K. Healthcare providers recognize that the cultural perspective and experiences of both patients and providers may affect patient-provider interactions.

- i. Healthcare providers are sensitive and responsive to the needs and concerns of individual patients, taking into consideration factors like immigration status, age, sex, gender identity, sexual orientation, cognitive and physical abilities, ethnicity and culture. (See Appendix 9.)

Guidelines for Billing and Payment Information

- Healthcare providers should inform sexual assault patients that services billed to a health insurance plan may become known to the policy holder (e.g., spouse, domestic partner, parent). If the patient does not want services billed to health insurance, other options should be discussed.
- Billing policies and procedures for forensic examinations should comply with the guidelines issued by the Sexual Assault Forensic Exam (SAFE) Payment Program, a division of Virginia's Criminal Injuries Compensation Fund (CICF). (See Appendix 16.)
- Healthcare providers should be familiar with the billing process in order to provide accurate information to sexual assault patients about payment for forensic and medical services and privacy of billing information:
 - Forensic examinations are paid for by the Commonwealth of Virginia if conducted within guidelines issued by the SAFE Payment Program. Guidelines and eligible costs are subject to change due to budgetary discretion. *(At the time of publication of this document, the SAFE Payment Program pays for forensic exams conducted within 72 hours of the sexual assault unless the provider can show good cause for performing the exam after 72 hours. See Appendix 16.)*
 - It is the responsibility of the provider to seek reimbursement by the SAFE Payment Program within one year of the date of service. The examiner must complete the Request for Payment Form (see Appendix 16) and submit with an itemized detailed bill.
 - Adult patients are not required to report the crime to law enforcement in order for the SAFE Payment Program to pay for the forensic examination.
 - Costs for the treatment of injuries, as well as any expense incurred that is not part of a forensic evidentiary examination, are not eligible for payment by the SAFE Payment Program. However, the patient may be eligible for compensation for medical costs and fees, as well as other crime-related expenses, through application to CICF. Information and forms for CICF may be found online at <http://www.cicf.state.va.us>.
 - The patient must report the crime to law enforcement and cooperate with all investigation and prosecution efforts in order to be eligible for compensation of crime-related expenses.

Best Practice: Healthcare facilities provide victims of crime with written information on Virginia's Criminal Injuries Compensation Fund to facilitate access to information on financial assistance that may be available.

Information about applying for compensation may be provided by an advocate or other appropriate professional. Healthcare providers, however, should be knowledgeable about this information and ensure that it is conveyed to sexual assault patients. The CICF publication "Notice Regarding Payment of Your Sexual Assault Examination" may assist providers in explaining payment information. (See Appendix 17.)

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Medical Services

III. Healthcare facilities provide medical services to sexual assault patients and promote a continuum of care through planning for and/or providing follow-up services, regardless of the time elapsed since the assault or whether a forensic exam is performed.

- A. Qualified medical personnel conduct a medical screening of every sexual assault patient presenting to an emergency department, in accordance with facility policy and Emergency Medical Treatment and Labor Act (EMTALA) requirements.
 - i. All sexual assault patients are medically screened for acute medical conditions and mental health needs and stabilized prior to undergoing a forensic exam.
 - ii. If a sexual assault patient is transferred to another facility for forensic services, the initial receiving facility provides screening and stabilization for acute medical conditions and mental health needs prior to transfer.
- B. The healthcare facility maintains written protocols for the medical treatment of sexual assault patients, including provisions for emergency contraception, testing and treatment of sexually transmitted infections (STIs), and other medical concerns.
- C. Female sexual assault patients are informed of options regarding pregnancy testing and emergency contraception. If indicated, the healthcare provider writes a prescription for emergency contraception.
Best Practice: The healthcare facility administers emergency contraception on-site.
- D. Healthcare providers inform sexual assault patients of options regarding testing and treatment for gonorrhea, chlamydia, trichomonas, syphilis, and hepatitis. The healthcare provider provides testing and/or medications in accordance with CDC guidelines. (See Appendix 7.)
- E. Healthcare providers inform sexual assault patients of the facility's HIV screening policies⁸ and the risks of HIV transmission from sexual assault.
- F. Healthcare providers assess sexual assault patients for risk of HIV transmission and, if warranted and with patient consent, immediately start post-exposure prophylaxis in accordance with CDC guidelines. (See Appendix 7.)
- G. Healthcare providers inform sexual assault patients that tests will not determine if HIV or other STIs were transmitted during the sexual assault, but that the tests may assist in interpretation of forensic findings, and screening for unrecognized STIs is optimal for patients' health.
- H. Facilities that do not have the capacity to provide appropriate HIV and STI follow-up services coordinate with and/or refer to an outside agency to provide those services.
- I. Toxicology testing of sexual assault patients is done only when deemed medically necessary or in cases of suspected alcohol- and/or drug-facilitated sexual assault. When toxicology testing is warranted:
 - i. Patients are informed about the purposes of the testing, the drugs that will be detected, and the scope of confidentiality of results.
 - ii. Consent is obtained for the testing and distinguishes between testing done for clinical purposes and for evidentiary purposes.
- J. The healthcare provider explains the need for follow-up medical care and discusses referral options (e.g., private physicians, local health department clinics, free clinics) with sexual assault patients.

⁸ Virginia has adopted the "opt-out" screening process for HIV, effective July 1, 2008. Virginia statute (§32.1-37.2) requires that, prior to HIV testing, a healthcare provider tells the patient that the test is planned, provides information about the test, and advises the patient that he or she has a right to decline the test.

- K. Oral and written discharge instructions include a summary of the exam and care provided (e.g., tests conducted, medication prescribed or provided, treatment received), medication doses to be taken, and follow-up appointments needed or scheduled.

Best Practices:

A sexual assault crisis center advocate and a FNE/SANE provide the sexual assault patient with a detailed discharge plan that will aid the patient's primary care physician in following up in accordance with CDC recommendations.

Written discharge plans for sexual assault patients include specific information about follow-up medical, legal, and counseling services, including contact names, phone numbers, and addresses.

- L. The healthcare provider provides sexual assault patients with referrals to community resources (e.g., sexual assault crisis center, victim/witness program, mental health/counseling centers, resources for follow-up and/or primary medical care).⁹ Information about follow-up resources is regularly updated.

Best Practices:

The healthcare provider or other designated provider (e.g., hospital-based advocate or sexual assault crisis center advocate) calls sexual assault patients (with patient consent) within 72 hours of discharge to encourage follow-up with appropriate medical, legal, and counseling services. Healthcare facilities work collaboratively with local sexual assault crisis centers to coordinate this follow-up contact.

The healthcare facility works collaboratively with providers to promote access to follow-up medical care and counseling services.

⁹ Healthcare providers may work with an advocate or other appropriate professional to provide sexual assault patients with referrals to community resources.

Forensic Services

IV. Healthcare facilities support the provision of competent, high quality forensic services to sexual assault patients.

- A. Healthcare providers and facilities providing forensic services are knowledgeable about Physical Evidence Recovery Kit (PERK) procedures, documentation of injuries, preservation of evidence, and the local jurisdiction's current procedures for transporting and storing evidence in a manner that preserves chain of custody. (See Appendix 14.)

Best Practice: The discharge plan identifies any follow-up needed to document injuries (for example, progression of bruising). (See Appendix 13.)

- B. Forensic exams are conducted in accordance with Virginia's PERK instructions by a healthcare provider who has been trained in conducting forensic exams and maintaining chain of custody.
- C. Healthcare facilities that provide forensic exams have identified a minimum standard of training for providers conducting forensic exams and have designated healthcare providers who have received the necessary training. (See Appendix 10.)
- D. Facilities without providers trained to conduct forensic exams have written protocols for transferring sexual assault patients to a facility with a Forensic Nurse Examiner/Sexual Assault Nurse Examiner program in a manner that minimizes time delays and loss of evidence.

Best Practice: At least one healthcare facility in every community or region maintains a Forensic Nurse Examiner/Sexual Assault Nurse Examiner program to provide 24/7 medical and forensic services on-site or through an on-call program.

- E. Healthcare facilities that provide forensic exams have plans in place to ensure the availability of the necessary equipment. (See Appendix 15.)
- F. Healthcare providers inform sexual assault patients who request forensic exams to what agency the forensic evidence will be released and what information, including identifying patient information, will be released for the purposes of transporting and storing the forensic evidence (PERKs).

Best Practice: Healthcare facilities establish written policies to ensure that sexual assault patients requesting forensic services are informed of facility policies on releasing patient information and evidence to law enforcement, the Division of Consolidated Laboratory Services, or other appropriate agency.

- G. Healthcare providers do not release identifying patient information, including evidence collected during a forensic exam, to law enforcement without the patient's written consent unless mandated by law.

Best Practice: Healthcare facilities, in collaboration with local law enforcement, establish written protocols for the release of forensic evidence that are compliant with §19.2-165.1 (B) of the Virginia Code (see Appendix 18) and ensure that patient information, including evidence collected during a forensic exam, will not be released to law enforcement without patient consent unless mandated by law.

- H. Healthcare facilities have established procedures for submitting PERKs to the Division of Consolidated Laboratory Services or other appropriate agency for cases in which the sexual assault patient is not yet prepared to report the assault or release identifying information to law enforcement, and law enforcement will not accept and store the PERK without personal identifying information. (See Appendix 19.)

Important note: The Division of Consolidated Laboratory Services is intended to be used for temporary storage of PERKs when local law enforcement will not accept and store evidence from non-reported assaults without the patient's name. Evidence should be released to local law enforcement for temporary storage if local law enforcement will accept evidence without a report or the patient's name. Communities are encouraged to establish local mechanisms for temporarily storing evidence from non-reported sexual assaults that both preserve the chain of custody and respect patients' right to privacy.

Special Considerations for Emergency Medical Services

This document addresses the care of sexual assault patients in hospitals and other healthcare facilities. However, the practices of emergency medical personnel responding to and transporting sexual assault patients significantly affect both the patients' emotional well-being and the preservation of forensic evidence. The following guidelines will assist EMS agencies in providing sensitive care, complying with jurisdictional policies, and preserving forensic evidence.

Emergency medical services personnel (e.g., paramedics and emergency medical technicians) responding to a person who is known or suspected to have been sexually assaulted should:

- Assess the safety needs of the patient at the scene (e.g., offenders may be present).
- Provide only those services necessary for medical stabilization.
- Identify an appropriate receiving facility and notify the facility that a sexual assault patient is in route.
- Request that the receiving facility call the local sexual assault crisis center and a healthcare provider who has been designated to provide medical-forensic services for sexual assault patients.
- Give consideration to privacy issues when transmitting identifying patient information.
- Notify law enforcement ONLY if requested by the patient or mandated by law.

All emergency medical personnel should receive training on responding to sexual assault patients, evidence preservation, and Virginia's reporting requirements. Emergency medical personnel should know which healthcare facilities have been designated or have the staffing to perform forensic examinations.

Algorithms

The preceding practice guidelines are organized around four broad criteria for a model healthcare response to sexual assault, and many of the guidelines apply to multiple steps in the process of caring for sexual assault patients.

The following algorithms present key components of that process in chronological order, providing a step-by-step overview of the management of sexual assault patients in an acute healthcare setting.

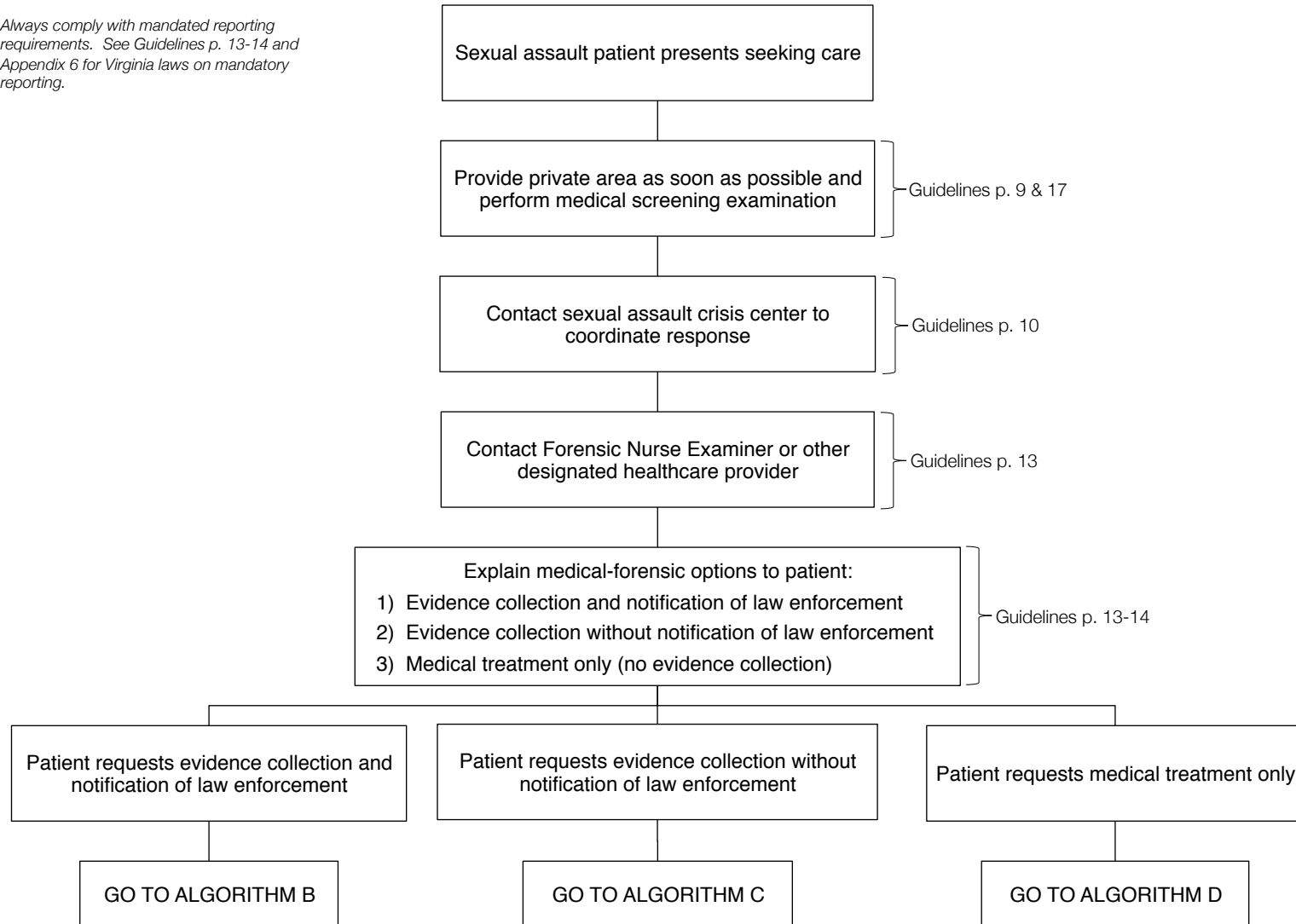
Algorithm A: Patient Seeks Care	page 23
Algorithm B: Evidence Collection AND Notification of Law Enforcement	page 25
Algorithm C: Evidence Collection WITHOUT Notification of Law Enforcement	page 27
Algorithm D: Medical Treatment Only (No Evidence Collection).....	page 29

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Medical-Forensic Management of Adult and Post-Pubertal Adolescent Sexual Assault Patients

ALGORITHM A: Patient Seeks Care

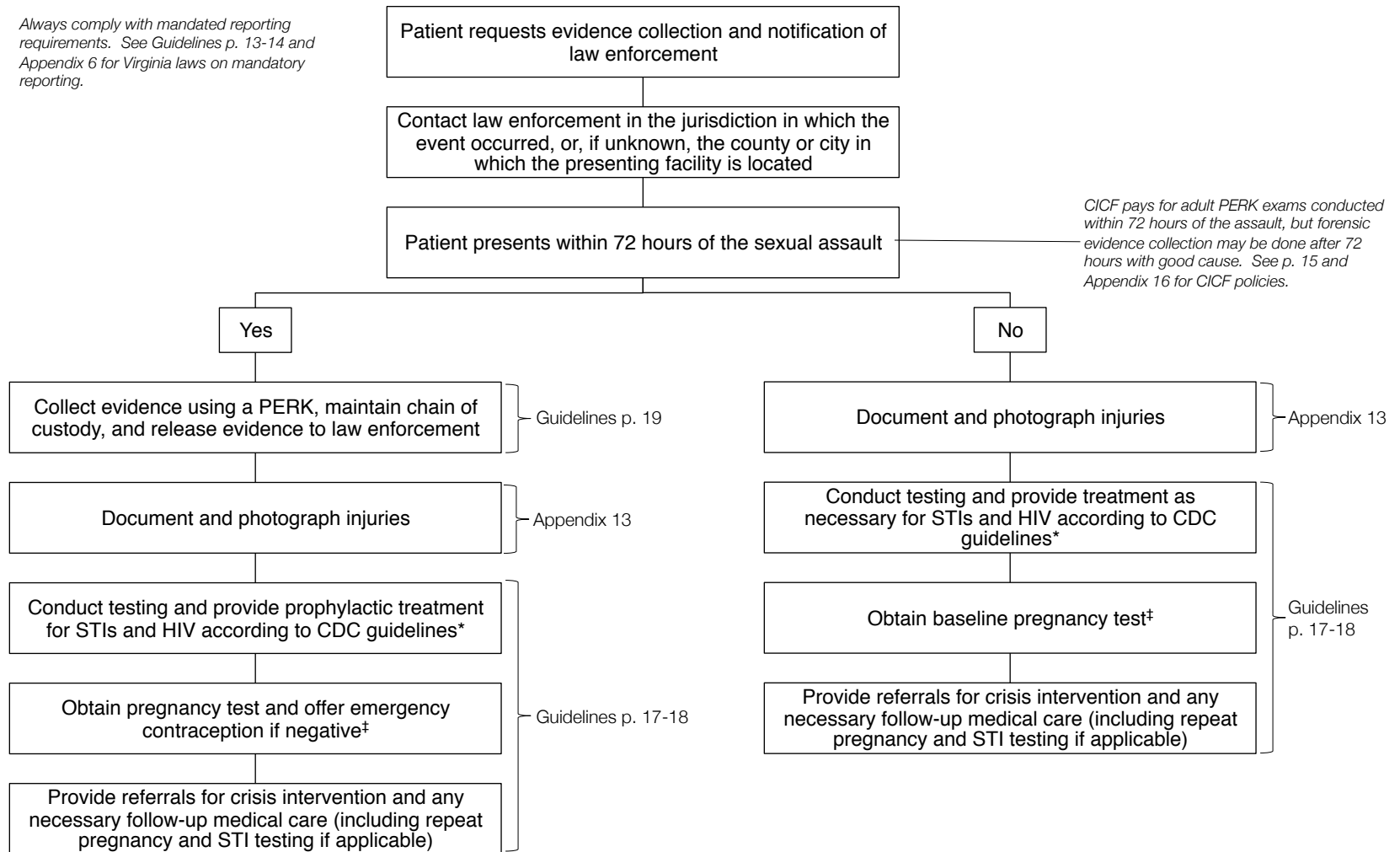
Always comply with mandated reporting requirements. See Guidelines p. 13-14 and Appendix 6 for Virginia laws on mandatory reporting.



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ALGORITHM B: Evidence Collection AND Notification of Law Enforcement

Always comply with mandated reporting requirements. See Guidelines p. 13-14 and Appendix 6 for Virginia laws on mandatory reporting.



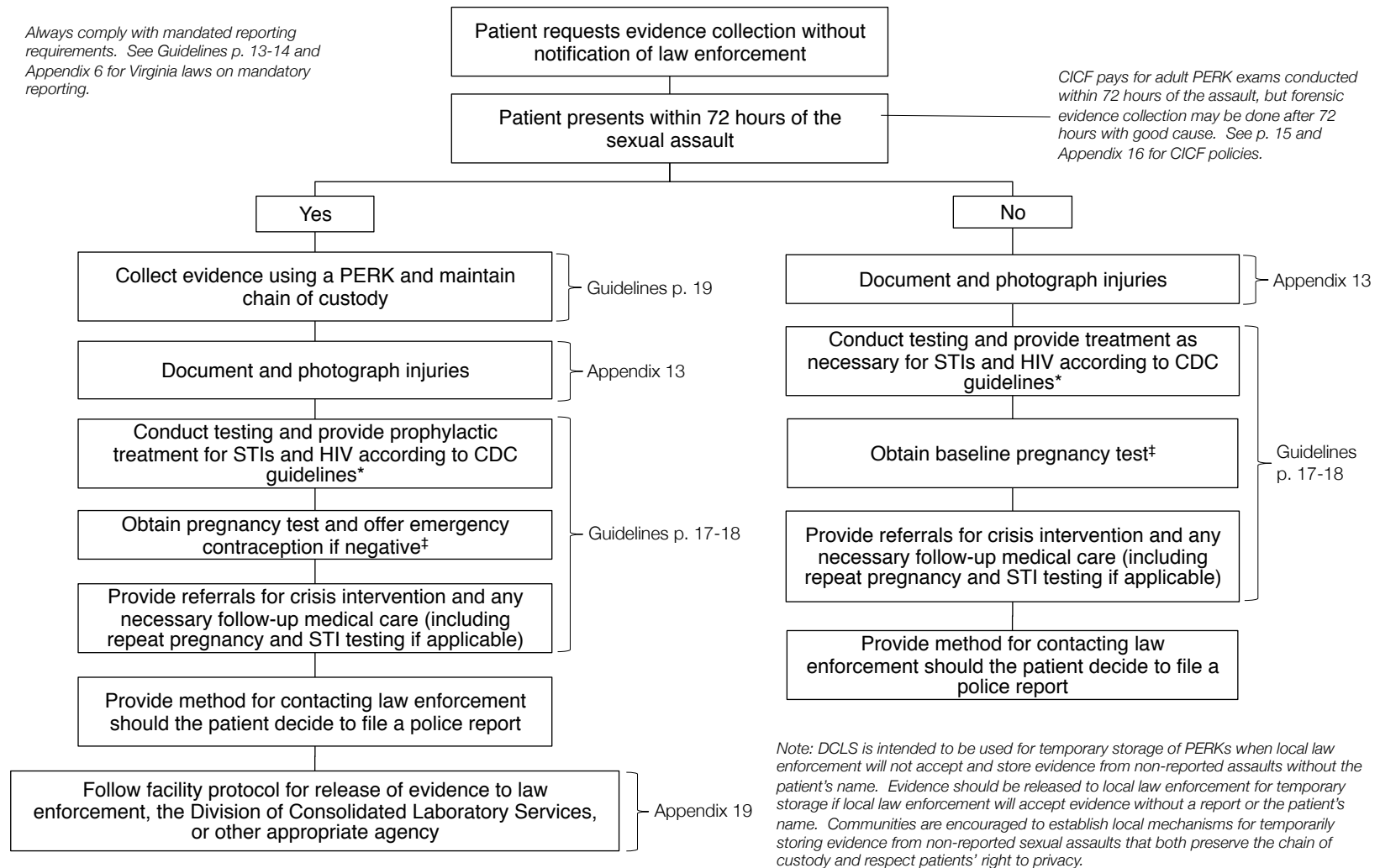
*STIs recommended for testing and treatment: gonorrhea, chlamydia, trichomonas, syphilis, hepatitis, and HIV. Note that CDC recommends consulting with a pediatric HIV specialist prior to the initiation of HIV PEP in children under the age of 16. See Appendix 7.

‡At the time of publication, FDA-approved emergency contraceptive pills are approved for use up to 72 hours after unprotected intercourse. Some clinical guidelines recommend use of emergency contraception up to 120 hours after unprotected intercourse (ACOG, 2005; WHO, 2007). Patients should be informed that the efficacy of emergency contraceptive pills diminishes with time since unprotected intercourse.

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ALGORITHM C: Evidence Collection WITHOUT Notification of Law Enforcement

Always comply with mandated reporting requirements. See Guidelines p. 13-14 and Appendix 6 for Virginia laws on mandatory reporting.



*STIs recommended for testing and treatment: gonorrhea, chlamydia, trichomonas, syphilis, hepatitis, and HIV. Note that CDC recommends consulting with a pediatric HIV specialist prior to the initiation of HIV PEP in children under the age of 16. See Appendix 7.

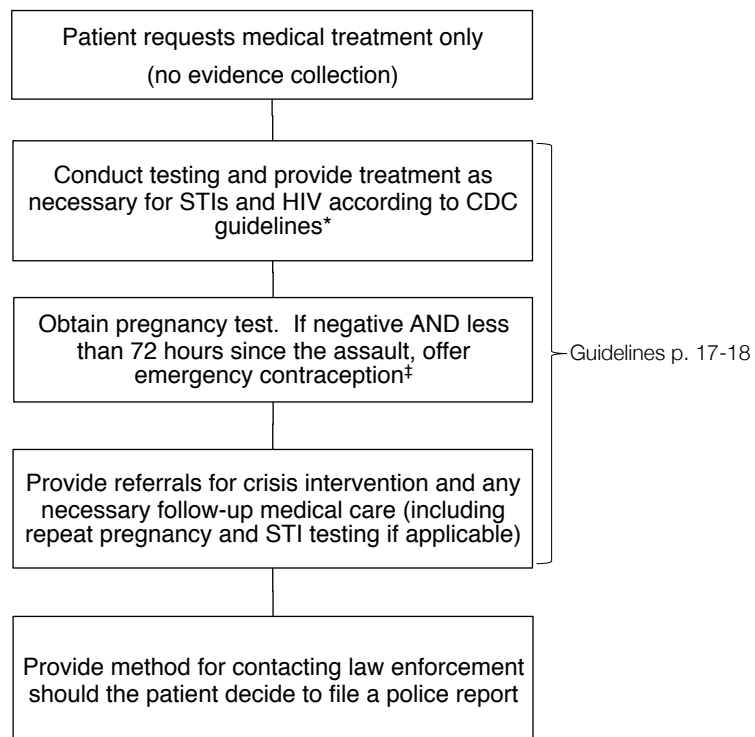
†At the time of publication, FDA-approved emergency contraceptive pills are approved for use up to 72 hours after unprotected intercourse. Some clinical guidelines recommend use of emergency contraception up to 120 hours after unprotected intercourse (ACOG, 2005; WHO, 2007). Patients should be informed that the efficacy of emergency contraceptive pills diminishes with time since unprotected intercourse.

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Medical-Forensic Management of Adult and Post-Pubertal Adolescent Sexual Assault Patients

ALGORITHM D: Medical Treatment Only (No Evidence Collection)

Always comply with mandated reporting requirements. See Guidelines p. 13-14 and Appendix 6 for Virginia laws on mandatory reporting.



*STIs recommended for testing and treatment: gonorrhea, chlamydia, trichomonas, syphilis, hepatitis, and HIV. Note that CDC recommends consulting with a pediatric HIV specialist prior to the initiation of HIV PEP in children under the age of 16. See Appendix 7.

†At the time of publication, FDA-approved emergency contraceptive pills are approved for use up to 72 hours after unprotected intercourse. Some clinical guidelines recommend use of emergency contraception up to 120 hours after unprotected intercourse (ACOG, 2005; WHO, 2007). Patients should be informed that the efficacy of emergency contraceptive pills diminishes with time since unprotected intercourse.

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Appendices

Appendices are provided as reference resources only; they do not represent guidelines written and approved by the Working Group and Advisory Board.

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Appendix 1: Development of This Document

In its 2007 final report to Governor Timothy Kaine, the Commission on Sexual Violence recommended that the Secretaries of Health and Human Services and Public Safety convene a multidisciplinary body to develop a statewide model of care for the acute healthcare response to sexual violence. As a result, the Virginia Department of Criminal Justice Services awarded funding to the Virginia Sexual and Domestic Violence Action Alliance (VSDVAA) and the Virginia Chapter of the International Association of Forensic Nurses (VA-IAFN) to collaboratively facilitate the development of this model of care. The project partners established a multidisciplinary, interagency Advisory Board and Working Group made up of experts representing key stakeholders in the healthcare response to sexual assault—healthcare providers, healthcare facilities, law enforcement and criminal justice agencies, advocates, and survivors of sexual assault. The Advisory Board and Working Group were charged with developing and reviewing content and advising the project partners on dissemination of the document. These committees lent critical expertise to the project and continue to play a vital role in the ongoing effort to implement a consistent, statewide healthcare response to sexual assault. Membership lists are provided in Appendix 2.

As a first step in the development of this document, project partners gathered information on current practices in communities around Virginia. Telephone surveys of local health department clinics, free clinics, and urgent care clinics provided information about what typically happens when sexual assault patients present to non-hospital facilities, particularly with regard to policies and procedures for referring sexual assault patients to emergency rooms. Telephone interviews with emergency room nurses provided detailed information about current practice in emergency departments both with and without Forensic Nurse Examiner/Sexual Assault Nurse Examiner programs. Project partners also held in-person forums with healthcare providers and representatives of law enforcement, the criminal justice system, local sexual assault crisis centers, and university and military sexual assault programs. The information gathered from all of these sources was invaluable to the development of this document.

Numerous other resources were consulted in the preparation of this document, including protocols and standards of care developed by other states, national guidelines for the treatment and examination of sexual assault patients, and published medical and scientific literature on the healthcare response to sexual assault. A full reference list is provided in Appendix 20.

Two statewide review processes provided opportunities for all interested stakeholders to comment on drafts. Healthcare providers were asked to provide feedback on a preliminary draft in February 2009. A revised draft was disseminated in June 2009 to a wide range of stakeholder groups:

- Emergency department physicians and nurses
- Forensic nurses
- Adolescent health and women's health providers
- Hospital administrators
- Rural healthcare providers
- Public health and "safety net" providers
- State health, criminal justice, and law enforcement agencies and professional organizations
- Crisis centers and sexual assault program directors
- Victim/Witness programs
- Mental health and counseling providers
- Sexual Assault Response Teams

The draft was revised based on reviewers' feedback, and the Advisory Board and Working Group approved a final document in November 2009.

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Appendix 2: Advisory Board and Working Group Members

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Appendix 3: Glossary

Best Practice

For the purposes of this document, best practices are ideal elements of a model healthcare response to sexual assault that may not be feasible for all facilities or communities. Best practices do not necessarily represent evidence-based practices as defined by the scientific literature; for many practices, no scientific evidence base currently exists.

Forensic Nurse Examiner (FNE)

(See also *Sexual Assault Nurse Examiner*.) The International Association of Forensic Nurses defines forensic nursing as “the application of nursing science to public or legal proceedings; the application of the forensic aspects of health care combined with the bio-psycho-social education of the registered nurse in the scientific investigation and treatment of trauma and/or death of victims and perpetrators of abuse, violence, criminal activity and traumatic accidents. The forensic nurse provides direct services to individual clients, consultation services to nursing, medical and law related agencies, and expert court testimony in areas dealing with trauma and/or questioned death investigative processes, adequacy of services delivery, and specialized diagnoses of specific conditions as related to nursing.” (<http://www.iafn.org>)

Licensed Clinical Practitioner

For the purposes of this document, “licensed clinical practitioner” refers to a person who by education, training, and licensure is qualified to provide healthcare. Preferably, a practitioner providing medical or forensic examinations for sexual assault patients will be an Advanced Practice Nurse, Doctor of Medicine, Doctor of Osteopathic Medicine, Physician Assistant, or Registered Nurse.

Patient-Centered Care

The Institute for Family-Centered Care identifies four principles of patient-centered care: Dignity and respect, information sharing, participation, and collaboration. (<http://www.familycenteredcare.org>)

Patient-centered care is one of six dimensions of quality healthcare identified by the Institute of Medicine. The IOM defines patient-centered as “providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.” (Committee on Quality of Health Care in America, Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. National Academy Press, Washington DC; 2001.)

PERK, or Physical Evidence Recovery Kit

The Physical Evidence Recovery Kit contains instructions and other materials used to collect and preserve forensic evidence from sexual assault patients. PERKs are provided free of charge by the Department of Forensic Science.

Qualified Interpreter

As defined by the Americans With Disabilities Act, a qualified interpreter is one “who is able to interpret effectively, accurately and impartially both receptively and expressively, using any necessary specialized vocabulary.” The U.S. Office of Minority Health’s National Standards on Culturally and Linguistically Appropriate Services (CLAS) state that “health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff.” Further CLAS guidance states that “bilingual clinicians and other staff who communicate directly with patients/consumers in their preferred language must demonstrate a command of both English and the target language that includes knowledge and facility with the terms and concepts relevant to the type of encounter.” Use of untrained interpreters, including family members, is associated with poorer clinical outcomes and lower quality of healthcare and may raise privacy issues. In cases of sexual assault, the choice of interpreter may be particularly important to ensure the comfort of the sexual assault patient disclosing sensitive information. Interpreters should be familiar with the medical and legal terminology used

in the examination of sexual assault patients to ensure the accuracy of information for both clinical and evidentiary purposes.

Qualified Medical Personnel

Under the federal Emergency Medical Treatment and Labor Act (EMTALA), qualified medical personnel are practitioners formally certified by a hospital as being qualified to perform initial medical screening examinations in an emergency department. Qualified medical personnel do not have to be physicians, but designated non-physician practitioners must be identified in hospital by-laws or similar rules and regulations that are approved by the hospital's governing body.

Sexual Assault

For the purposes of this document, sexual assault refers to any sexual contact without mutual consent or for which the victim is unable to give consent due to age or physical or mental incapacity. The term "sexual assault" may refer to a range of criminal sex acts including, but not limited to, rape, sexual battery, forcible sodomy, and object sexual penetration.

Sexual Assault Crisis Center

Sexual assault crisis centers provide advocacy and counseling services to victims in the immediate aftermath of an assault and throughout their emotional and physical recovery. See Appendix 8 for information about the services provided by local sexual assault crisis centers and contact information for accredited centers in Virginia.

Sexual Assault Nurse Examiner (SANE)

(See also Forensic Nurse Examiner.) Sexual Assault Nurse Examiners are forensic nurses who have received specialized education to perform sexual assault examinations. The SANE-A credential indicates professional certification for sexual assault nurse examiners of adults and adolescents. The SANE-P credential indicates certification for sexual assault nurse examiners who care for pediatric/adolescent populations.

Sexual Assault Response Team

As defined by the National Sexual Violence Resource Center, "a Sexual Assault Response Team (SART) is a multidisciplinary interagency team of individuals working collaboratively to provide services for the community by offering specialized sexual assault intervention services. Teams are specialized to fit the needs of each community and generally have goals of increasing reporting and conviction of sexual assaults and countering the experience of sexual trauma with a sensitive and competent response. Typically, teams consist of key responders such as advocates, law enforcement officers, forensic examiners (e.g.; SANE/SAFE/FNE), crime lab personnel, and prosecutors." (<http://nsvrc.org>)

Victim/Witness Program

The Victim/Witness Program provides support, information, and referrals to assist victims and witnesses throughout their participation in the criminal justice system. Programs are administered locally through the Office of the Commonwealth's Attorney and at some colleges and universities. Services for victims typically include assistance with applications to the Criminal Injuries Compensation Fund, help in obtaining protective orders, information about the status of the case and the criminal justice process, preparation for court appearances, and referrals to other community resources as needed. The Department of Criminal Justice Services publishes a list of Victim/Witness Programs and other local, state, and federal victim assistance programs and agencies (<http://www.dcjs.virginia.gov/victims/documents/victimAssistanceDirectory.pdf>).

Appendix 4: Considerations for Safety Assessment

Appendices are provided as reference resources only; they do not represent guidelines written and approved by the Working Group and Advisory Board.

Most sexual assaults are committed by perpetrators known to the victim (Rand, 2007). Determining whether the sexual assault patient is returning to a safe environment and providing assistance or referrals to ensure the patient's safety is an important component of the healthcare response to sexual assault. For example, a support person, family member, or personal care assistant who accompanies the patient may or may not be a safe person for the patient. Consideration should be given to crisis intervention needs of the patient as well as to threats of harm from others.

The *National Protocol for Sexual Assault Medical Forensic Examinations* offers the following guidance for assisting sexual assault patients in safety assessment and planning prior to discharge:

“Jurisdictional and exam site policies should be in place to facilitate this process. Assist patients in developing a post-exam plan that addresses their physical safety and emotional well-being. Screen for domestic and dating violence and other forms of abuse. Assist patients in considering things such as:

- 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.)
- 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.)
- Are they eligible for protection orders? (Provide information and help obtain if desired.)
- Is there a need for enhanced security measures? (Discuss options and help obtain if desired.)
- If they feel unsafe, what will they do to get help? (Discuss options and help them develop a plan.)

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.”

(Office on Violence Against Women. *A National Protocol for Sexual Assault Medical Forensic Examinations*. U.S. Department of Justice; 2004, p. 114.)

The Family Violence Prevention Fund recommends the following questions for assessment of the immediate safety of victims of intimate partner violence:

- Are you in immediate danger?
- Is your partner at the health facility now?
- Do you want to (or have to) go home with your partner?
- Do you have somewhere safe to go?
- Have there been threats or direct abuse of the children (if s/he has children)?
- Are you afraid your life may be in danger?
- Has the violence gotten worse or is it getting scarier? Is it happening more often?
- Has your partner used weapons, alcohol or drugs?
- Has your partner ever held you or your children against your will?

- Does your partner ever watch you closely, follow you or stalk you?
- Has your partner ever threatened to kill you, him/herself or your children?

(The Family Violence Prevention Fund. *National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Healthcare Settings*. 2004, p. 14. www.endabuse.org/userfiles/file/Consensus.pdf)

Resources for patient education and safety planning materials

The *National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Healthcare Settings* includes a section entitled “Safety Plan and Discharge Instructions.” The brochure “Planning for Your Safety,” published by the Virginia Sexual and Domestic Violence Action Alliance, may be helpful for sexual assault patients who are dealing with intimate partner violence (www.vsdvalliance.org).

Appendix 5: Authority to Consent to Medical Treatment of Minors

The following statute from the Code of Virginia is current at the time of publication of this document but may change in the future.

§ 54.1-2969. Authority to consent to surgical and medical treatment of certain minors.

A. Whenever any minor who has been separated from the custody of his parent or guardian is in need of surgical or medical treatment, authority commensurate with that of a parent in like cases is conferred, for the purpose of giving consent to such surgical or medical treatment, as follows:

1. Upon judges with respect to minors whose custody is within the control of their respective courts.
2. Upon local directors of social services or their designees with respect to (i) minors who are committed to the care and custody of the local board by courts of competent jurisdiction, (ii) minors who are taken into custody pursuant to § 63.2-1517, and (iii) minors who are entrusted to the local board by the parent, parents or guardian, when the consent of the parent or guardian cannot be obtained immediately and, in the absence of such consent, a court order for such treatment cannot be obtained immediately.
3. Upon the Director of the Department of Corrections or the Director of the Department of Juvenile Justice or his designees with respect to any minor who is sentenced or committed to his custody.
4. Upon the principal executive officers of state institutions with respect to the wards of such institutions.
5. Upon the principal executive officer of any other institution or agency legally qualified to receive minors for care and maintenance separated from their parents or guardians, with respect to any minor whose custody is within the control of such institution or agency.
6. Upon any person standing in loco parentis, or upon a conservator or custodian for his ward or other charge under disability.

B. Whenever the consent of the parent or guardian of any minor who is in need of surgical or medical treatment is unobtainable because such parent or guardian is not a resident of the Commonwealth or his whereabouts is unknown or he cannot be consulted with promptness reasonable under the circumstances, authority commensurate with that of a parent in like cases is conferred, for the purpose of giving consent to such surgical or medical treatment, upon judges of juvenile and domestic relations district courts.

C. Whenever delay in providing medical or surgical treatment to a minor may adversely affect such minor's recovery and no person authorized in this section to consent to such treatment for such minor is available within a reasonable time under the circumstances, no liability shall be imposed upon qualified emergency medical services personnel as defined in § 32.1-111.1 at the scene of an accident, fire or other emergency, a licensed health professional, or a licensed hospital by reason of lack of consent to such medical or surgical treatment. However, in the case of a minor 14 years of age or older who is physically capable of giving consent, such consent shall be obtained first.

D. Whenever delay in providing transportation to a minor from the scene of an accident, fire or other emergency prior to hospital admission may adversely affect such minor's recovery and no person authorized in this section to consent to such transportation for such minor is available within a reasonable time under the circumstances, no liability shall be imposed upon emergency medical services personnel as defined in § 32.1-111.1, by reason of lack of consent to such transportation. However, in the case of a minor 14 years of age or older who is physically capable of giving consent, such consent shall be obtained first.

E. A minor shall be deemed an adult for the purpose of consenting to:

1. Medical or health services needed to determine the presence of or to treat venereal disease or any infectious or contagious disease that the State Board of Health requires to be reported;
2. Medical or health services required in case of birth control, pregnancy or family planning except for the purposes of sexual sterilization;

3. Medical or health services needed in the case of outpatient care, treatment or rehabilitation for substance abuse as defined in [§ 37.2-100](#); or

4. Medical or health services needed in the case of outpatient care, treatment or rehabilitation for mental illness or emotional disturbance.

A minor shall also be deemed an adult for the purpose of accessing or authorizing the disclosure of medical records related to subdivisions 1 through 4.

F. Except for the purposes of sexual sterilization, any minor who is or has been married shall be deemed an adult for the purpose of giving consent to surgical and medical treatment.

G. A pregnant minor shall be deemed an adult for the sole purpose of giving consent for herself and her child to surgical and medical treatment relating to the delivery of her child when such surgical or medical treatment is provided during the delivery of the child or the duration of the hospital admission for such delivery; thereafter, the minor mother of such child shall also be deemed an adult for the purpose of giving consent to surgical and medical treatment for her child.

H. Any minor 16 years of age or older may, with the consent of a parent or legal guardian, consent to donate blood and may donate blood if such minor meets donor eligibility requirements. However, parental consent to donate blood by any minor 17 years of age shall not be required if such minor receives no consideration for his blood donation and the procurer of the blood is a nonprofit, voluntary organization.

I. Any judge, local director of social services, Director of the Department of Corrections, Director of the Department of Juvenile Justice, or principal executive officer of any state or other institution or agency who consents to surgical or medical treatment of a minor in accordance with this section shall make a reasonable effort to notify the minor's parent or guardian of such action as soon as practicable.

J. Nothing in subsection G shall be construed to permit a minor to consent to an abortion without complying with [§ 16.1-241](#).

K. Nothing in subsection E shall prevent a parent, legal guardian or person standing in loco parentis from obtaining (i) the results of a minor's nondiagnostic drug test when the minor is not receiving care, treatment or rehabilitation for substance abuse as defined in [§ 37.2-100](#) or (ii) a minor's other health records, except when the minor's treating physician or the minor's treating clinical psychologist has determined, in the exercise of his professional judgment, that the disclosure of health records to the parent, legal guardian, or person standing in loco parentis would be reasonably likely to cause substantial harm to the minor or another person pursuant to subsection B of [§ 20-124.6](#).

Appendix 6: Mandated Reporting Laws

This Appendix includes the following statutes from the Code of Virginia:

§ 63.2-1509. Physicians, nurses, teachers, etc., to report certain injuries to children; penalty for failure to report (p. 35)

§ 63.2-100. Definitions ("Abused or neglected child") (p. 37)

§ 54.1-2967. Physicians and others rendering medical aid to report certain wounds (p. 37)

§ 63.2-1606. Protection of aged or incapacitated adults; mandated and voluntary reporting (p. 38)

Healthcare facilities and jurisdictions may have their own policies regarding mandated reporting, but these are the relevant state codes. These laws are current at the time of publication of this document but may change in the future.

§ 63.2-1509. Physicians, nurses, teachers, etc., to report certain injuries to children; penalty for failure to report.

A. The following persons who, in their professional or official capacity, have reason to suspect that a child is an abused or neglected child, shall report the matter immediately to the local department of the county or city wherein the child resides or wherein the abuse or neglect is believed to have occurred or to the Department's toll-free child abuse and neglect hotline:

1. Any person licensed to practice medicine or any of the healing arts;
2. Any hospital resident or intern, and any person employed in the nursing profession;
3. Any person employed as a social worker;
4. Any probation officer;
5. Any teacher or other person employed in a public or private school, kindergarten or nursery school;
6. Any person providing full-time or part-time child care for pay on a regularly planned basis;
7. Any mental health professional;
8. Any law-enforcement officer or animal control officer;
9. Any mediator eligible to receive court referrals pursuant to § 8.01-576.8;
10. Any professional staff person, not previously enumerated, employed by a private or state-operated hospital, institution or facility to which children have been committed or where children have been placed for care and treatment;
11. Any person associated with or employed by any private organization responsible for the care, custody or control of children;
12. Any person who is designated a court-appointed special advocate pursuant to Article 5 (§ 9.1-151 et seq.) of Chapter 1 of Title 9.1;
13. Any person, over the age of 18 years, who has received training approved by the Department of Social Services for the purposes of recognizing and reporting child abuse and neglect;
14. Any person employed by a local department as defined in § 63.2-100 who determines eligibility for public assistance; and
15. Any emergency medical services personnel certified by the Board of Health pursuant to § 32.1-111.5, unless such personnel immediately reports the matter directly to the attending physician at the hospital to which the child is transported, who shall make such report forthwith.

This subsection shall not apply to any regular minister, priest, rabbi, imam, or duly accredited practitioner of

any religious organization or denomination usually referred to as a church as it relates to (i) information required by the doctrine of the religious organization or denomination to be kept in a confidential manner or (ii) information that would be subject to § 8.01-400 or 19.2-271.3 if offered as evidence in court.

If neither the locality in which the child resides nor where the abuse or neglect is believed to have occurred is known, then such report shall be made to the local department of the county or city where the abuse or neglect was discovered or to the Department's toll-free child abuse and neglect hotline.

If an employee of the local department is suspected of abusing or neglecting a child, the report shall be made to the court of the county or city where the abuse or neglect was discovered. Upon receipt of such a report by the court, the judge shall assign the report to a local department that is not the employer of the suspected employee for investigation or family assessment. The judge may consult with the Department in selecting a local department to respond to the report or the complaint.

If the information is received by a teacher, staff member, resident, intern or nurse in the course of professional services in a hospital, school or similar institution, such person may, in place of said report, immediately notify the person in charge of the institution or department, or his designee, who shall make such report forthwith.

The initial report may be an oral report but such report shall be reduced to writing by the child abuse coordinator of the local department on a form prescribed by the Board. Any person required to make the report pursuant to this subsection shall disclose all information that is the basis for his suspicion of abuse or neglect of the child and, upon request, shall make available to the child-protective services coordinator and the local department, which is the agency of jurisdiction, any information, records, or reports that document the basis for the report. All persons required by this subsection to report suspected abuse or neglect who maintain a record of a child who is the subject of such a report shall cooperate with the investigating agency and shall make related information, records and reports available to the investigating agency unless such disclosure violates the federal Family Educational Rights and Privacy Act (20 U.S.C. § 1232g). Provision of such information, records, and reports by a health care provider shall not be prohibited by § 8.01-399. Criminal investigative reports received from law-enforcement agencies shall not be further disseminated by the investigating agency nor shall they be subject to public disclosure.

B. For purposes of subsection A, "reason to suspect that a child is abused or neglected" shall include (i) a finding made by an attending physician within seven days of a child's birth that the results of a blood or urine test conducted within 48 hours of the birth of the child indicate the presence of a controlled substance not prescribed for the mother by a physician; (ii) a finding by an attending physician made within 48 hours of a child's birth that the child was born dependent on a controlled substance which was not prescribed by a physician for the mother and has demonstrated withdrawal symptoms; (iii) a diagnosis by an attending physician made within seven days of a child's birth that the child has an illness, disease or condition which, to a reasonable degree of medical certainty, is attributable to in utero exposure to a controlled substance which was not prescribed by a physician for the mother or the child; or (iv) a diagnosis by an attending physician made within seven days of a child's birth that the child has fetal alcohol syndrome attributable to in utero exposure to alcohol. When "reason to suspect" is based upon this subsection, such fact shall be included in the report along with the facts relied upon by the person making the report.

C. Any person who makes a report or provides records or information pursuant to subsection A or who testifies in any judicial proceeding arising from such report, records, or information shall be immune from any civil or criminal liability or administrative penalty or sanction on account of such report, records, information, or testimony, unless such person acted in bad faith or with malicious purpose.

D. Any person required to file a report pursuant to this section who fails to do so within 72 hours of his first suspicion of child abuse or neglect shall be fined not more than \$500 for the first failure and for any subsequent failures not less than \$100 nor more than \$1,000.

§ 63.2-100. Definitions.

As used in this title, unless the context requires a different meaning:

"Abused or neglected child" means any child less than 18 years of age:

1. Whose parents or other person responsible for his care creates or inflicts, threatens to create or inflict, or allows to be created or inflicted upon such child a physical or mental injury by other than accidental means, or creates a substantial risk of death, disfigurement, or impairment of bodily or mental functions, including but not limited to, a child who is with his parent or other person responsible for his care either (i) during the manufacture or attempted manufacture of a Schedule I or II controlled substance, or (ii) during the unlawful sale of such substance by that child's parents or other person responsible for his care, where such manufacture, or attempted manufacture or unlawful sale would constitute a felony violation of [§ 18.2-248](#);
2. Whose parents or other person responsible for his care neglects or refuses to provide care necessary for his health. However, no child who in good faith is under treatment solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination shall for that reason alone be considered to be an abused or neglected child. Further, a decision by parents who have legal authority for the child or, in the absence of parents with legal authority for the child, any person with legal authority for the child, who refuses a particular medical treatment for a child with a life-threatening condition shall not be deemed a refusal to provide necessary care if (i) such decision is made jointly by the parents or other person with legal authority and the child; (ii) the child has reached 14 years of age and is sufficiently mature to have an informed opinion on the subject of his medical treatment; (iii) the parents or other person with legal authority and the child have considered alternative treatment options; and (iv) the parents or other person with legal authority and the child believe in good faith that such decision is in the child's best interest. Nothing in this subdivision shall be construed to limit the provisions of [§ 16.1-278.4](#);
3. Whose parents or other person responsible for his care abandons such child;
4. Whose parents or other person responsible for his care commits or allows to be committed any act of sexual exploitation or any sexual act upon a child in violation of the law;
5. Who is without parental care or guardianship caused by the unreasonable absence or the mental or physical incapacity of the child's parent, guardian, legal custodian or other person standing in loco parentis; or
6. Whose parents or other person responsible for his care creates a substantial risk of physical or mental injury by knowingly leaving the child alone in the same dwelling, including an apartment as defined in [§ 55-79.2](#), with a person to whom the child is not related by blood or marriage and who the parent or other person responsible for his care knows has been convicted of an offense against a minor for which registration is required as a violent sexual offender pursuant to [§ 9.1-902](#).

If a civil proceeding under this title is based solely on the parent having left the child at a hospital or rescue squad, it shall be an affirmative defense that such parent safely delivered the child to a hospital that provides 24-hour emergency services or to an attended rescue squad that employs emergency medical technicians, within 14 days of the child's birth. For purposes of terminating parental rights pursuant to [§ 16.1-283](#) and placement for adoption, the court may find such a child is a neglected child upon the ground of abandonment.

§ 54.1-2967. Physicians and others rendering medical aid to report certain wounds.

Any physician or other person who renders any medical aid or treatment to any person for any wound which such physician or other person knows or has reason to believe is a wound inflicted by a weapon specified in [§ 18.2-308*](#) and which wound such physician or other person believes or has reason to believe was not self-inflicted shall as soon as practicable report such fact, including the wounded person's name and address, if known, to the sheriff or chief of police of the county or city in which treatment is rendered. If such medical aid or treatment is rendered in a hospital or similar institution, such physician or other person rendering such

medical aid or treatment shall immediately notify the person in charge of such hospital or similar institution, who shall make such report forthwith.

Any physician or other person failing to comply with this section shall be guilty of a Class 3 misdemeanor. Any person participating in the making of a report pursuant to this section or participating in a judicial proceeding resulting therefrom shall be immune from any civil liability in connection therewith, unless it is proved that such person acted in bad faith or with malicious intent.

***The relevant section of § 18.2-308 lists the following types of weapons:**

(i) any pistol, revolver, or other weapon designed or intended to propel a missile of any kind by action of an explosion of any combustible material; (ii) any dirk, bowie knife, switchblade knife, ballistic knife, machete, razor, slingshot, spring stick, metal knucks, or blackjack; (iii) any flailing instrument consisting of two or more rigid parts connected in such a manner as to allow them to swing freely, which may be known as a nun chahka, nun chuck, nunchaku, shuriken, or fighting chain; (iv) any disc, of whatever configuration, having at least two points or pointed blades which is designed to be thrown or propelled and which may be known as a throwing star or oriental dart; or (v) any weapon of like kind as those enumerated in this subsection

§ 63.2-1606. Protection of aged or incapacitated adults; mandated and voluntary reporting.

A. Matters giving reason to suspect the abuse, neglect or exploitation of adults shall be reported immediately upon the reporting person's determination that there is such reason to suspect. Medical facilities inspectors of the Department of Health are exempt from reporting suspected abuse immediately while conducting federal inspection surveys in accordance with § 1864 of Title XVIII and Title XIX of the Social Security Act, as amended, of certified nursing facilities as defined in § 32.1-123. Reports shall be made to the local department or the adult protective services hotline in accordance with requirements of this section by the following persons acting in their professional capacity:

1. Any person licensed, certified, or registered by health regulatory boards listed in § 54.1-2503, with the exception of persons licensed by the Board of Veterinary Medicine;
2. Any mental health services provider as defined in § 54.1-2400.1;
3. Any emergency medical services personnel certified by the Board of Health pursuant to § 32.1-111.5;
4. Any guardian or conservator of an adult;
5. Any person employed by or contracted with a public or private agency or facility and working with adults in an administrative, supportive or direct care capacity;
6. Any person providing full, intermittent or occasional care to an adult for compensation, including but not limited to, companion, chore, homemaker, and personal care workers; and
7. Any law-enforcement officer.

B. The report shall be made in accordance with subsection A to the local department of the county or city wherein the adult resides or wherein the adult abuse, neglect or exploitation is believed to have occurred or to the adult protective services hotline. Nothing in this section shall be construed to eliminate or supersede any other obligation to report as required by law. If a person required to report under this section receives information regarding abuse, neglect or exploitation while providing professional services in a hospital, nursing facility or similar institution, then he may, in lieu of reporting, notify the person in charge of the institution or his designee, who shall report such information, in accordance with the institution's policies and procedures for reporting such matters, immediately upon his determination that there is reason to suspect abuse, neglect or exploitation. Any person required to make the report or notification required by this subsection shall do so either orally or in writing and shall disclose all information that is the basis for the suspicion of adult abuse, neglect or exploitation. Upon request, any person required to make the report shall make available to the adult protective services worker and the local department investigating the reported case of adult abuse, neglect or exploitation any information, records or reports which document the basis for the report. All persons required to report suspected adult abuse, neglect or exploitation shall cooperate with

the investigating adult protective services worker of a local department and shall make information, records and reports which are relevant to the investigation available to such worker to the extent permitted by state and federal law. Criminal investigative reports received from law-enforcement agencies shall not be further disseminated by the investigating agency nor shall they be subject to public disclosure; such reports may, however, be disclosed to the Adult Fatality Review Team as provided in [§ 32.1-283.5](#) and, if reviewed by the Team, shall be subject to all of the Team's confidentiality requirements.

C. Any financial institution staff who suspects that an adult has been exploited financially may report such suspected exploitation to the local department of the county or city wherein the adult resides or wherein the exploitation is believed to have occurred or to the adult protective services hotline. For purposes of this section, financial institution staff means any employee of a bank, savings institution, credit union, securities firm, accounting firm, or insurance company.

D. Any person other than those specified in subsection A who suspects that an adult is an abused, neglected or exploited adult may report the matter to the local department of the county or city wherein the adult resides or wherein the abuse, neglect or exploitation is believed to have occurred or to the adult protective services hotline.

E. Any person who makes a report or provides records or information pursuant to subsection A, C or D, or who testifies in any judicial proceeding arising from such report, records or information, or who takes or causes to be taken with the adult's or the adult's legal representative's informed consent photographs, video recordings, or appropriate medical imaging of the adult who is subject of a report shall be immune from any civil or criminal liability on account of such report, records, information, photographs, video recordings, appropriate medical imaging or testimony, unless such person acted in bad faith or with a malicious purpose.

F. An employer of a mandated reporter shall not prohibit a mandated reporter from reporting directly to the local department or to the adult protective services hotline. Employers whose employees are mandated reporters shall notify employees upon hiring of the requirement to report.

G. Any person 14 years of age or older who makes or causes to be made a report of adult abuse, neglect, or exploitation that he knows to be false shall be guilty of a Class 4 misdemeanor. Any subsequent conviction of this provision shall be a Class 2 misdemeanor.

H. Any person who fails to make a required report or notification pursuant to subsection A shall be subject to a civil penalty of not more than \$500 for the first failure and not less than \$100 nor more than \$1,000 for any subsequent failures. Civil penalties under subdivision A 7 shall be determined by a court of competent jurisdiction, in its discretion. All other civil penalties under this section shall be determined by the Commissioner or his designee. The Board shall establish by regulation a process for imposing and collecting civil penalties, and a process for appeal of the imposition of such penalty pursuant to [§ 2.2-4026](#) of the Administrative Process Act.

I. Any mandated reporter who has reasonable cause to suspect that an adult died as a result of abuse or neglect shall immediately report such suspicion to the appropriate medical examiner and to the appropriate law-enforcement agency, notwithstanding the existence of a death certificate signed by a licensed physician. The medical examiner and the law-enforcement agency shall receive the report and determine if an investigation is warranted. The medical examiner may order an autopsy. If an autopsy is conducted, the medical examiner shall report the findings to law enforcement, as appropriate, and to the local department or to the adult protective services hotline.

J. No person or entity shall be obligated to report any matter if the person or entity has actual knowledge that the same matter has already been reported to the local department or to the adult protective services hotline.

K. All law-enforcement departments and other state and local departments, agencies, authorities and institutions shall cooperate with each adult protective services worker of a local department in the detection, investigation and prevention of adult abuse, neglect and exploitation.

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Appendix 7: CDC Guidelines for Screening and Treatment of Sexually Transmitted Infections in Adult/Adolescent Sexual Assault Patients

The following is an excerpt from the 2006 Sexually Transmitted Diseases Treatment Guidelines issued by the Centers for Disease Control and Prevention [MMWR 2006;55(No. RR-#). Accessed online at <http://www.cdc.gov/std/treatment/2006/toc.htm>]. These CDC guidelines are current at the time of publication of this document but may change in the future. Up-to-date guidelines should always be used.

The excerpt from the CDC guidelines are followed on page 54 by additional guidance on HIV PEP consultation for pregnant women and patients under the age of 16.

Sexual Assault and STDs Adults and Adolescents

The recommendations in this report are limited to the identification, prophylaxis, and treatment of sexually transmitted infections and conditions commonly identified in the management of such infections. The documentation of findings, collection of nonmicrobiologic specimens for forensic purposes, and the management of potential pregnancy or physical and psychological trauma are beyond the scope of this report. Examinations of survivors of sexual assault should be conducted by an experienced clinician in a way that minimizes further trauma to the survivor. The decision to obtain genital or other specimens for STD diagnosis should be made on an individual basis. Care systems for survivors should be designed to ensure continuity (including timely review of test results), support adherence, and monitor for adverse reactions to any therapeutic or prophylactic regimens prescribed at initial examination. Laws in all 50 states strictly limit the evidentiary use of a survivor's previous sexual history, including evidence of previously acquired STDs, as part of an effort to undermine the credibility of the survivor's testimony. Evidentiary privilege against revealing any aspect of the examination or treatment is enforced in the majority of states. In unanticipated, exceptional situations, STD diagnoses may later be accessed, and the survivor and clinician may opt to defer testing for this reason. However, collection of specimens at initial examination for laboratory STD diagnosis gives the survivor and clinician the option to defer empiric prophylactic antimicrobial treatment. Among sexually active adults, the identification of sexually transmitted infection after an assault might be more important for the psychological and medical management of the patient than for legal purposes because the infection could have been acquired before the assault.

Trichomoniasis, BV, gonorrhea, and chlamydial infection are the most frequently diagnosed infections among women who have been sexually assaulted. Because the prevalence of these infections is high among sexually active women, their presence after an assault does not necessarily signify acquisition during the assault. A postassault examination is, however, an opportunity to identify or prevent sexually transmitted infections, regardless of whether they were acquired during an assault. Chlamydial and gonococcal infections in women are of particular concern because of the possibility of ascending infection. In addition, HBV infection might be prevented by postexposure administration of hepatitis B vaccine. Reproductive-aged female survivors should be evaluated for pregnancy, if appropriate.

Evaluation for Sexually Transmitted Infections Initial Examination

An initial examination should include the following procedures:

Testing for *N. gonorrhoeae* and *C. trachomatis* from specimens collected from any sites of penetration or attempted penetration.

Culture or FDA-cleared nucleic acid amplification tests for either *N. gonorrhoeae* or *C. trachomatis*. NAAT offer the advantage of increased sensitivity in detection of *C. trachomatis*.

Wet mount and culture of a vaginal swab specimen for *T. vaginalis* infection. If vaginal discharge, malodor, or itching is evident, the wet mount also should be examined for evidence of BV and candidiasis.

Collection of a serum sample for immediate evaluation for HIV, hepatitis B, and syphilis (see Sexual Assault, sections Prophylaxis, Risk for Acquiring HIV Infection, and Follow-Up Examination After Assault).

Follow-Up Examinations

After the initial postassault examination, follow-up examinations provide an opportunity to 1) detect new infections acquired during or after the assault; 2) complete hepatitis B immunization, if indicated; 3) complete counseling and treatment for other STDs; and 4) monitor side effects and adherence to postexposure prophylactic medication, if prescribed.

Examination for STDs should be repeated within 1–2 weeks of the assault. Because infectious agents acquired through assault might not have produced sufficient concentrations of organisms to result in positive test results at the initial examination, testing should be repeated during the follow-up visit, unless prophylactic treatment was provided. If treatment was provided, testing should be conducted only if the survivor reports having symptoms. If treatment was not provided, follow-up examination should be conducted within 1 week to ensure that results of positive tests can be discussed promptly with the survivor and that treatment is provided. Serologic tests for syphilis and HIV infection should be repeated 6 weeks, 3 months, and 6 months after the assault if initial test results were negative and infection in the assailant could not be ruled out (see Sexual Assaults, Risk for Acquiring HIV Infection).

Prophylaxis

Many specialists recommend routine preventive therapy after a sexual assault because follow-up of survivors of sexual assault can be difficult. The following prophylactic regimen is suggested as preventive therapy:

Postexposure hepatitis B vaccination, without HBIG, should adequately protect against HBV infection.

Hepatitis B vaccination should be administered to sexual assault victims at the time of the initial examination if they have not been previously vaccinated. Follow-up doses of vaccine should be administered 1–2 and 4–6 months after the first dose.

An empiric antimicrobial regimen for chlamydia, gonorrhea, trichomonas, and BV.

EC should be offered if the postassault could result in pregnancy in the survivor.

Recommended Regimens

Ceftriaxone 125 mg IM in a single dose

PLUS

Metronidazole 2 g orally in a single dose

PLUS

Azithromycin 1 g orally in a single dose

OR

Doxycycline 100 mg orally twice a day for 7 days

For patients requiring alternative treatments, refer to the sections in this report relevant to the specific agent. The efficacy of these regimens in preventing infections after sexual assault has not been evaluated. Clinicians should counsel patients regarding the possible benefits and toxicities associated with these treatment regimens; gastrointestinal side effects can occur with this combination. Providers might also consider anti-emetic medications, particularly if EC also is provided.

Other Management Considerations

At the initial examination and, if indicated, at follow-up examinations, patients should be counseled regarding 1) symptoms of STDs and the need for immediate examination if symptoms occur and 2) abstinence from sexual intercourse until STD prophylactic treatment is completed.

Risk for Acquiring HIV Infection

HIV seroconversion has occurred in persons whose only known risk factor was sexual assault or sexual abuse, but the frequency of this occurrence is probably low. In consensual sex, the risk for HIV transmission from vaginal intercourse is 0.1%–0.2% and for receptive rectal intercourse, 0.5%–3% (219). The risk for HIV transmission from oral sex is substantially lower. Specific circumstances of an assault might increase risk for HIV transmission (e.g., trauma, including bleeding) with vaginal, anal, or oral penetration; site of exposure to ejaculate; viral load in ejaculate; and the presence of an STD or genital lesions in the assailant or survivor.

Postexposure therapy with zidovudine was associated with a reduced risk for acquiring HIV in a study of health-care workers who had percutaneous exposures to HIV-infected blood (220). On the basis of these results and the results of animal studies, PEP has been recommended for health-care workers who have occupational exposures to HIV (207). These findings have been extrapolated to other types of HIV exposure, including sexual assault (58). If HIV exposure has occurred, initiation of PEP as soon as possible after the exposure likely increases benefit. Although a definitive statement of benefit cannot be made regarding PEP after sexual assault, the possibility of HIV exposure from the assault should be assessed at the time of the postassault examination. The possible benefit of PEP in preventing HIV infection also should be discussed with the assault survivor if risk exists for HIV exposure from the assault.

The likelihood of the assailant having HIV, any exposure characteristics that might increase the risk for HIV transmission, the time elapsed after the event, as well as potential benefits and risks the PEP are all factors that will impact the medical recommendation for PEP and impact the assault survivor's acceptance of that recommendation (58). Determination of assailant's HIV status at the time of the assault examination will usually be impossible. Therefore, the health-care provider should assess any available information concerning HIV-risk behaviors of the assailant(s) (e.g., a man who has sex with other men and injecting-drug or crack cocaine use), local epidemiology of HIV/AIDS, and exposure characteristics of the assault. When an assailant's HIV status is unknown, factors that should be considered in determining whether an increased risk for HIV transmission exists include 1) whether vaginal or anal penetration occurred; 2) whether ejaculation occurred on mucous membranes; 3) whether multiple assailants were involved; 4) whether mucosal lesions are present in the assailant or survivor; and 5) other characteristics of the assault, survivor, or assailant that might increase risk for HIV transmission.

If PEP is offered, the following information should be discussed with the patient: 1) the unproven benefit and known toxicities of antiretrovirals; 2) the close follow-up that will be necessary; 3) the benefit of adherence to recommended dosing; and 4) the necessity of early initiation of PEP to optimize potential benefits (as soon as possible after and up to 72 hours after the assault). Providers should emphasize that PEP appears to be well-tolerated in both adults and children and that severe adverse effects are rare. Clinical management of the survivor should be implemented according to the following guidelines (58). Specialist consultation on PEP regimens is recommended if HIV exposure during the assault was possible and if PEP is being considered. The sooner PEP is initiated after the exposure, the higher the likelihood that it will prevent HIV transmission, if HIV exposure occurred; however, distress after an assault also might prevent the survivor from accurately weighing exposure risks and benefits of PEP and making an informed decision to start PEP. If use of PEP is judged to be warranted, the survivor should be offered a 3–5-day supply of PEP with a follow-up visit scheduled for additional counseling after several days.

Recommendations for Postexposure Assessment of Adolescent and Adult Survivors Within 72 hours of Sexual Assault[†]

Assess risk for HIV infection in the assailant.

Evaluate characteristics of the assault event that might increase risk for HIV transmission.

Consult with a specialist in HIV treatment, if PEP is being considered.

If the survivor appears to be at risk for HIV transmission from the assault, discuss antiretroviral prophylaxis, including toxicity and lack of proven benefit.

If the survivor chooses to start antiretroviral PEP (58), provide enough medication to last until the next return visit; reevaluate the survivor 3–7 days after initial assessment and assess tolerance of medications.

If PEP is started, perform CBC and serum chemistry at baseline (initiation of PEP should not be delayed, pending results).

Perform HIV antibody test at original assessment; repeat at 6 weeks, 3 months, and 6 months.

[†]Assistance with postexposure prophylaxis decisions can be obtained by calling the National Clinician's Post-Exposure Prophylaxis Hotline (PEPLINE), telephone: 888-448-4911.

Additional Guidance:**HIV PEP Consultation for Pregnant Women and Patients <16 Years Old**

The U.S. Public Health Service recommends consulting a pediatric HIV specialist prior to the initiation of HIV PEP in children under the age of 16 (CDC, 2005). If specialized consultation is unavailable immediately, and the results of the HIV risk assessment warrant the initiation of HIV PEP, the patient should be started on antiretroviral medications and provided with a sufficient quantity to last until such time as expert consultation can be arranged (Havens and AAP Committee on Pediatric AIDS, 2003).

Special consideration also should be given to the initiation of HIV PEP in pregnant women. Specialists in HIV and obstetrics should be consulted before initiating HIV PEP in pregnant women. Current recommendations regarding the use of HIV PEP during pregnancy are based on the premise that therapies shown to be beneficial to women should not be withheld during pregnancy unless the risk of adverse effects to either the mother or fetus outweighs potential benefits. As a result, pregnancy is not a contraindication to the use of antiretroviral medications. However, special attention needs to be given to the selection and dosing of HIV PEP medications and potential short- and long-term effects of antiretroviral medications on the fetus and newborn (Panel on Antiretroviral Guidelines for Adults and Adolescents, 2008).

References:

Centers for Disease Control and Prevention. *Antiretroviral Postexposure Prophylaxis After Sexual, Injection-Drug Use, or Other Nonoccupational Exposure to HIV in the United States: Recommendations from the U.S. Department of Health and Human Services*. MMWR 2005;54(No. RR-2).

Havens PL and American Academy of Pediatrics Committee on Pediatric AIDS. Postexposure prophylaxis in children and adolescents for nonoccupational exposure to human immunodeficiency virus. *Pediatrics*. 2003;111:1475-1489.

Panel on Antiretroviral Guidelines for Adults and Adolescents. *Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents*. Department of Health and Human Services. November 3, 2008; 1-139.

Appendix 8: Local Sexual Assault Crisis Centers

Sexual assault crisis centers offer numerous services to victims in the immediate aftermath of an assault and throughout their emotional and physical recovery. While healthcare providers and law enforcement personnel may be compassionate and supportive, their primary duty is not to provide emotional support to sexual assault patients.

Local sexual assault crisis centers provide:

- Emotional support during the medical and forensic exam processes.
- Crisis intervention and longer-term counseling services.
- Information about sexual assault patients' options for involvement with law enforcement; forensic and medical services; and follow-up medical, counseling, and legal services.
- Advocacy for needs identified by the sexual assault patient and for a coordinated response by all of the professionals involved.
- Assistance with safety assessment and planning.
- Assistance with logistical and physical comfort needs (e.g., transportation to and from the exam site, clean clothing and toiletries).

The Virginia Sexual and Domestic Violence Action Alliance has developed an accreditation process for Virginia's sexual assault crisis centers to ensure consistency across localities in the services available to victims of sexual assault, the infrastructure of sexual violence agencies, and the training of professionals and volunteers who work with victims. Accreditation criteria are available at www.vsdvalliance.org/accreditation.html.

Every healthcare facility should identify the nearest sexual assault crisis center(s) and keep its contact information readily available. Certified crisis centers are listed by city and county on the following pages. This list is provided by the Virginia Sexual and Domestic Violence Action Alliance (www.vsdvalliance.org; 804-377-0336) and is current as of May 2009.

Virginia Family Violence and Sexual Assault Hotline: 1-800-838-8238

Sexual Assault Crisis Centers in Virginia, by County/City Served

County/City	Sexual Assault Crisis Center	Hotline Phone	Business Phone	Street Address/PO Box	City	Zip
Accomack Co.	Center for Sexual Assault Survivors	1.800.838.8238	757.599.9844	11030 Warwick Blvd.	Newport News	23601
Albemarle Co.	Sexual Assault Resource Agency	434.977.7273	434.295.7273	PO Box 6880	Charlottesville	22906
Alexandria	Alexandria SARA Program	703.683.7273	703.838.4911	421 King Street Suite 400	Alexandria	22314
Alleghany Co.	Safehome Systems	540.965.3237	540.965.3237	102 East Hawthorne Street PO Box 748	Covington	24426-1619
Amelia Co.	Southside Center for Violence Prevention	1.888.819.2926	434.292.1077	PO Box 563	Farmville	23901
Amherst Co.	Sexual Assault Response Program - Crisis Line of Central VA	434.947.7273	434.947.7422	PO Box 3074	Lynchburg	24503
Appomattax Co.	Sexual Assault Response Program - Crisis Line of Central VA	434.947.7273	434.947.7422	PO Box 3074	Lynchburg	24503
Arlington Co.	Arlington County Violence Intervention	703.228.4848	703.228.1515	3033 Wilson Blvd Suite 500 A	Arlington	22201
Ashland	Hanover Safe Place	804.752.2702	804.752.2728	629A N Washington Hwy	Ashland	23005
Augusta	New Directions	540.886-6800 1-800-56-HAVEN	540.885.7273	PO Box 3069	Staunton	24402-3069
Bath Co.	Safehome Systems	540.965.3237	540.965.3237	102 East Hawthorne Street PO Box 748	Covington	24426-1619
Bedford	Sexual Assault Response Program - Crisis Line of Central VA	434.947.7273	434.947.7422	PO Box 3074	Lynchburg	24503
Bland Co.	Family Resource Center, Inc.	1.800.613.6145.	276.625.0219	PO Box 612	Wytheville	24382-0612
Botetourt	Sexual Assault Response & Awareness	540-981-9352	540.345.7273	Blue Ridge Behavioral Health 3517 Brandon Ave. SW	Roanoke	24016
Bristol	The Crisis Center	276.466.2312	276.466.2218	PO Box 642	Bristol	24203

Virginia Family Violence and Sexual Assault Hotline: 1-800-838-8238

Sexual Assault Crisis Centers in Virginia, by County/City Served

County/City	Sexual Assault Crisis Center	Hotline Phone	Business Phone	Street Address/PO Box	City	Zip
Brunswick Co.	Southside Center for Violence Prevention	1.888.819.2926	434.292.1077	PO Box 563	Farmville	23901
Brunswick Co.	Family Violence Prevention (CSU-FVPP)	800.383.8238	804-348-0100	420 South Main Street	Emporia	23847
Buchanan Co.	Family Crisis Support Services	877.348.3416	276.679.7240	PO Box 692	Norton	24273
Buchanan Co.	People, Inc.	877.697.9444	276.935-4747	1173 W. Main Street	Abingdon	24210
Buckingham Co.	Southside Center for Violence Prevention	1.888.819.2926	434.292.1077	PO Box 563	Farmville	23901
Buena Vista	Project Horizon	540.463.2594	540.463.7861	120 Varner Lane	Lexington	24450
Campbell	Sexual Assault Response Program - Crisis Line of Central VA	434.947.7273	434.947.7422	PO Box 3074	Lynchburg	24503
Caroline Co.	Rappahannock Council Against Sexual Assault	540.371.1666	540.371.6771	2601 Princess Anne St Suite 102	Fredericksburg	22401
Carroll Co.	Family Resource Center, Inc.	1.800.613.6145.	276.625.0219	PO Box 612	Wytheville	24382-0612
Charles City Co.	Project Hope at Quin Rivers	877.966.4357	804.966.5020	104 Roxbury Industrial Center	Charles City	23030-2310
Charles City Co.	Laurel Shelter	804.694.5890	804.694.5552	PO Box 23	Gloucester	23061-2102
Charles City Co.	Avalon: A Center For Women And Children	757.258.5051	757.258.5022	PO Box 1079	Williamsburg	23187-1079
Charlotte Co.	Southside Center for Violence Prevention	1.888.819.2926	434.292.1077	PO Box 563	Farmville	23901
Charlottesville	Sexual Assault Resource Agency	434.977.7273	434.295.7273	PO Box 6880	Charlottesville	22906
Chesapeake	Response Sexual Assault Support Services of YWCA	757.622.4300	757.623.2115	5215 Colley Ave	Norfolk	23508

Virginia Family Violence and Sexual Assault Hotline: 1-800-838-8238

Sexual Assault Crisis Centers in Virginia, by County/City Served

County/City	Sexual Assault Crisis Center	Hotline Phone	Business Phone	Street Address/PO Box	City	Zip
Chesterfield Co.	YWCA Women's Advocacy Program	804.796.3066	804.643.6761	6 North 5th Street	Richmond	23219
Clarke Co.	Laurel Center, Inc.	540.667.6466	540.667.6160	PO Box 14	Winchester	22604-0014
Clifton Forge/Covington	Safehome Systems	540.965.3237	540.965.3237	102 East Hawthorne Street PO Box 748	Covington	24426-1619
Craig Co.	Sexual Assault Response & Awareness	540-981-9352	540.345.7273	Blue Ridge Behavioral Health 3517 Brandon Ave. SW	Roanoke	24016
Culpeper	Services to Abused Families (SAFE)	800.825.8876	540.825.8891	PO Box 402	Culpeper	22701
Cumberland Co.	Southside Center for Violence Prevention	1.888.819.2926	434.292.1077	PO Box 563	Farmville	23901
Danville	Domestic Violence Emergency Services (DOVES)	434.791.1400	434.799.3683	PO Box 2381	Danville	24541-0381
Dickenson Co.	Family Crisis Support Services	877.348.3416	276.679.7240	PO Box 692	Norton	24273
Dinwiddie Co.	The James House Intervention/Prevention Services	804.458.2840	804.458.2704	1016 Maplewood Avenue	Hopewell	23860
Emporia	Family Violence Prevention (CSU-FVPP)	800.383.8238	804-348-0100	420 South Main Street	Emporia	23847
Essex Co.	The Haven Shelter & Services, Inc.	800.224.2836	804.333.1099	PO Box 1267	Warsaw	22572-0713
Fairfax Co.	Fairfax Victim Assistance Network (VAN)	703.360.7273	703.324-7000	14150 Parkeast Circle Ste 200	Alexandria	22309
Fauquier Co.	Services to Abused Families (SAFE)	800.825.8876	540.825.8891	PO Box 402	Culpeper	22701
Floyd Co.	Women's Resource Center of the New River Valley	540.639.1123	540.639.9592	PO Box 477	Radford	24143
Fluvanna Co.	Sexual Assault Resource Agency	434.977.7273	434.295.7273	PO Box 6880	Charlottesville	22906

Virginia Family Violence and Sexual Assault Hotline: 1-800-838-8238

Sexual Assault Crisis Centers in Virginia, by County/City Served

County/City	Sexual Assault Crisis Center	Hotline Phone	Business Phone	Street Address/PO Box	City	Zip
Frederick	Laurel Center, Inc.	540.667.6466	540.667.6160	PO Box 14	Winchester	22604-0014
Fredericksburg	Rappahannock Council Against Sexual Assault	540.371.1666	540.371.6771	2601 Princess Anne St Suite 102	Fredericksburg	22401
Front Royal	Harmony Place (formerly Warren Co. Council on Domestic Violence)	540.635.9062	540.635.9194	PO Box 1831	Warren	22630
Galax City	Family Resource Center, Inc.	276.236.0364	276.625.0219	PO Box 612	Wytheville	24382-0612
Giles Co.	Women's Resource Center of the New River Valley	540.639.1123	540.639.9592	PO Box 477	Radford	24143
Gloucester	Laurel Shelter	804.694.5890	804.694.5552	PO Box 23	Gloucester	23061-2102
Goochland Co.	YWCA Women's Advocacy Program	804.634.0888	804.643.6761	6 North 5th Street	Richmond	23219
Grayson Co.	Family Resource Center, Inc.	1.800.613.6145	276.625.0219	PO Box 612	Wytheville	24382-0612
Greene Co.	Sexual Assault Resource Agency	434.977.7273	434.295.7273	PO Box 6880	Charlottesville	22906
Greensville Co.	Family Violence Prevention (CSU-FVPP)	800.383.8238	804.348.0100	420 South Main Street	Emporia	23847
Halifax Co.	Domestic Violence Emergency Services (DOVES)	434.791.1400	434.799.3683	PO Box 2381	Danville	24541-0381
Hampton	Center for Sexual Assault Survivors	1.800.838.8238	757.599.9844	11030 Warwick Blvd.	Newport News	23606
Hanover Co.	Hanover Safe Place	804.752.2702	804.752.2728	629A N Washington Hwy	Ashland	23005
Harrisonburg	The Collins Center	540.434.2272	540.432.6430	PO Box 1473	Harrisonburg	22803
Henrico Co.	YWCA Women's Advocacy Program	804.634.0888	804.643.6761	6 North 5th Street	Richmond	23219
Henry Co.	Citizens Against Family Violence	276.632.8701	276.632.8701	PO Drawer 352	Martinsville	24114-0352

Virginia Family Violence and Sexual Assault Hotline: 1-800-838-8238

Sexual Assault Crisis Centers in Virginia, by County/City Served

County/City	Sexual Assault Crisis Center	Hotline Phone	Business Phone	Street Address/PO Box	City	Zip
Highland Co.	Safehome Systems	540.965.3237	540.965.3237	102 East Hawthorne Street PO Box 748	Covington	24426-1619
Highland Co.	New Directions	540.886-6800 1-800-56-HAVEN	540.885.7273	PO Box 3069	Staunton	24402-3069
Isle of Wight Co.	Center for Sexual Assault Survivors	1.800.838.8238	757.599.9844	11030 Warwick Blvd.	Newport News	23606
James City Co.	Avalon: A Center For Women And Children	757.258.5051	757.258.5022	PO Box 1079	Williamsburg	23187-1079
King & Queen Co.	Project Hope at Quin Rivers	877.966.4357	804.966.5020	104 Roxbury Industrial Center	Charles City	23030-2310
King George Co.	Rappahannock Council Against Sexual Assault	540.371.1666	540.371.6771	2601 Princess Anne St Suite 102	Fredericksburg	22401
King William Co.	Project Hope at Quin Rivers	877.966.4357	804.966.5020	104 Roxbury Industrial Center	Charles City	23030-2310
Lancaster Co.	The Haven Shelter & Services, Inc.	804.224.2836	804.333.1099	PO Box 1267	Warsaw	22572-0713
Lee Co.	The Crisis Center	276.466.2312	276.466.2218	PO Box 642	Bristol	24203
Lee Co.	Family Crisis Support Services	877.348.3416	276.679.7240	PO Box 692	Norton	24273
Leesburg	Loudoun Citizens for Social Justice (formerly Loudoun Abused Women's Shelter)	703.777.6552	703.771.3398	105 East Market Street	Leesburg	20176
Lexington	Project Horizon	540.463.2594	540.463.7861	120 Varner Lane	Lexington	24450
Loudoun Co.	Loudoun Citizens for Social Justice (formerly Loudoun Abused Women's Shelter)	703.777.6552	703.771.3398	105 East Market Street	Leesburg	20176
Louisa Co.	Sexual Assault Resource Agency	434.977.7273	434.295.7273	PO Box 6880	Charlottesville	22906

Virginia Family Violence and Sexual Assault Hotline: 1-800-838-8238

Sexual Assault Crisis Centers in Virginia, by County/City Served

County/City	Sexual Assault Crisis Center	Hotline Phone	Business Phone	Street Address/PO Box	City	Zip
Luray	Council on Domestic Violence for Page Co.	540.743.4414	540.743.4414	216 West Main Street	Luray	22835-1235
Madison Co.	Services to Abused Families (SAFE)	540.825.8876	540.825.8837	PO Box 402	Culpeper	22701
Martinsville	Citizens Against Family Violence	276.632.8701	276.632.8701	PO Drawer 352	Martinsville	24114-0352
Mathews Co.	Laurel Shelter	804.694.5890	804.694.5552	PO Box 23	Gloucester	23061-2102
Middlesex Co.	Laurel Shelter	804.694.5890	804.694.5552	PO Box 23	Gloucester	23061-2102
Montgomery Co.	Women's Resource Center of the New River Valley	540.639.1123	540.639.9592	PO Box 477	Radford	24143
Nelson Co.	Sexual Assault Resource Agency	434.977.7273	434.295.7273	PO Box 6880	Charlottesville	22906
New Kent Co.	Project Hope at Quin Rivers	877.966.4357	804.966.5020	104 Roxbury Industrial Center	Charles City	23030-2310
Newport News	Center for Sexual Assault Survivors	1.800.838.8238	757.599.9844	11030 Warwick Blvd.	Newport News	23606
Norfolk	Response Sexual Assault Support Services of YWCA	757.622.4300	757.623.2115	5215 Colley Ave	Norfolk	23508
North Tazewell Co.	Family Crisis Services	276.979.8959	276.988.5583	PO Box 188	N. Tazewell	24630
Northampton Co.	Center for Sexual Assault Survivors	1.800.838.8238	757.599.9844	11030 Warwick Blvd.	Newport News	23606
Northumberland Co.	The Haven Shelter & Services, Inc.	804.224.2836	804.333.1099	PO Box 1267	Warsaw	22572-0713
Orange	Services to Abused Families (SAFE)	540.825.8876	540.825.8837	PO Box 402	Culpeper	22701
Page Co.	Council on Domestic Violence for Page Co.	540.743.4414	540.743.4414	216 West Main Street	Luray	22835-1235

Virginia Family Violence and Sexual Assault Hotline: 1-800-838-8238

Sexual Assault Crisis Centers in Virginia, by County/City Served

County/City	Sexual Assault Crisis Center	Hotline Phone	Business Phone	Street Address/PO Box	City	Zip
Patrick Co.	Citizens Against Family Violence	276.632.8701	276.632.8701	PO Drawer 352	Martinsville	24114-0352
Pittsylvania Co.	Domestic Violence Emergency Services (DOVES)	434.791.1400	434.799.3683	PO Box 2381	Danville	24541-0381
Poquoson	Center for Sexual Assault Survivors	1.800.838.8238	757.599.9844	11030 Warwick Blvd.	Newport News	23606
Portsmouth	Response Sexual Assault Support Services of YWCA	757.622.4300	757.623.2115	5215 Colley Ave	Norfolk	23508
Prince George Co.	The James House Intervention/Prevention Services	804.458.2840	804.458.2704	1016 Maplewood Avenue	Hopewell	23860
Prince William Co.	Sexual Assault Victims Advocacy Services (SAVAS)	703.368.4141	703.497.1192	PO Box 4783	Woodbridge	22194
Pulaski Co.	Women's Resource Center of the New River Valley	540.639.1123	540.639.9592	PO Box 477	Radford	24143
Radford	Women's Resource Center of the New River Valley	540.639.1123	540.639.9592	PO Box 477	Radford	24143
Rappahannock	Services to Abused Families (SAFE)	540.825.8876	540.825.8837	PO Box 402	Culpeper	22701
Richmond	YWCA Women's Advocacy Program	804.634.0888	804.643.6761	6 North 5th Street	Richmond	23219
Richmond Co.	The Haven Shelter & Services, Inc.	804.224.2836	804.333.1099	PO Box 1267	Warsaw	22572-0713
Roanoke	Sexual Assault Response & Awareness	540.981.9352	540.345.7273	Blue Ridge Behavioral Health 3517 Brandon Ave. SW	Roanoke	24016
Rockbridge Co.	Project Horizon	540.463.2594	540.463.7861	120 Varner Lane	Lexington	24450
Rockingham Co.	The Collins Center	540.434.2272	540.432.6430	PO Box 1473	Harrisonburg	22803
Russell Co.	Family Crisis Services	276.979.8959	276.988.5583	PO Box 188	N. Tazewell	24630
Scott Co.	The Crisis Center	276.466.2312	276.466.2218	PO Box 642	Bristol	24203

Virginia Family Violence and Sexual Assault Hotline: 1-800-838-8238

Sexual Assault Crisis Centers in Virginia, by County/City Served

County/City	Sexual Assault Crisis Center	Hotline Phone	Business Phone	Street Address/PO Box	City	Zip
Shenandoah Co.	Response	540.459.5161	540.459-5599	PO Box 287	Woodstock	22664-0287
Smyth Co.	Family Resource Center, Inc.	1.800.613.6145	276.625.0219	PO Box 612	Wytheville	24382-0612
Southampton Co.	Center for Sexual Assault Survivors	1.800.838.8238	757.599.9844	11030 Warwick Blvd.	Newport News	23606
Spotsylvania Co.	Rappahannock Council Against Sexual Assault	540.371.1666	540.371.6771	2601 Princess Anne St Suite 102	Fredericksburg	22401
Stafford Co.	Rappahannock Council Against Sexual Assault	540.371.1666	540.371.6771	2601 Princess Anne St Suite 102	Fredericksburg	22401
Suffolk	Response Sexual Assault Support Services of YWCA	757.622.4300	757.623.2115	5215 Colley Ave	Norfolk	23508
Surry Co.	The James House Intervention/Prevention Services	804.458.2840	804.458.2704	1016 Maplewood Avenue	Hopewell	23860
Sussex Co.	Family Violence Prevention (CSU-FVPP)	800.383.8238	804.348.0100	420 South Main Street	Emporia	23847
Virginia Beach	Response Sexual Assault Support Services of YWCA	757.622.4300	757.623.2115	5215 Colley Ave	Norfolk	23508
Washington Co.	The Crisis Center	276.466.2312	276.466.2218	PO Box 642	Bristol	24203
Westmoreland Co.	The Haven Shelter & Services, Inc.	804.224.2836	804.333.1099	PO Box 1267	Warsaw	22572-0713
Williamsburg	Avalon: A Center For Women And Children	757.258.5051	757.258.5022	PO Box 1079	Williamsburg	23187-1079
Winchester	Laurel Center, Inc.	540.667.6466	540.667.6160	PO Box 14	Winchester	22604-0014
Wise Co.	The Crisis Center	276.466.2312	276.466.2218	PO Box 642	Bristol	24203
Wytheville Co.	Family Resource Center, Inc.	276.228.8431	276.625.0219	PO Box 612	Wytheville	24382-0612

Virginia Family Violence and Sexual Assault Hotline: 1-800-838-8238

Sexual Assault Crisis Centers in Virginia, by County/City Served

County/City	Sexual Assault Crisis Center	Hotline Phone	Business Phone	Street Address/PO Box	City	Zip
York Co.	Avalon: A Center For Women And Children	757.258.5051	757.258.5022	PO Box 1079	Williamsburg	23187-1079
York Co.	Center for Sexual Assault Survivors	1.800.838.8238	757.599.9844	11030 Warwick Blvd.	Newport News	23606

Appendix 9: Developing Policies and Practices That Support Linguistic Accessibility and Cultural Proficiency of Services

Appendices are provided as reference resources only; they do not represent guidelines written and approved by the Working Group and Advisory Board.

Guidance for Policy Development and Assessment of Practices

The following questions are offered as a starting point for considering the linguistic accessibility and cultural proficiency of healthcare facility policies and practices. For a more comprehensive and structured analysis of policies and practices, refer to the list of assessment tools provided below.

- Does the facility collect data on the cultural, linguistic, and demographic characteristics of patients, and is that data used in planning and decision making?
- Do the written policies of the facility explicitly address the needs of diverse patient populations—and are the policies reflected in practices?
 - Are the needs of diverse patient populations addressed in policies and procedures for treating sexual assault patients?
 - Do policies and procedures address multiple dimensions of diversity, such as immigration status, age, sex, gender identity, sexual orientation, cognitive and physical abilities, ethnicity and culture?
 - Are practices and policies responsive to different circumstances of sexual assault (e.g., assault of prostitutes, males assaulted by an intimate partner)?
- Does the facility maintain written policies and procedures for translation and interpretation services—and are they reflected in practices?
 - Is there a written procedure for identifying patients who need interpretation and translation services?
 - Do interpreters have training in medical and forensic terminology?
 - Are there mechanisms in place to evaluate the quality and effectiveness of interpreter services?
- Are consent forms and patient information materials understandable to patients with limited English proficiency or low literacy levels?
- Is there a mechanism in place to evaluate patient satisfaction?
- Does the facility partner with community organizations to develop patient services and/or to provide staff training on topics relevant to the patient populations served?
- Does the organization's leadership demonstrate a commitment to culturally competent care and allocate resources accordingly?
- Is there a training plan for cultural competency? If so, is it based on an assessment of the cultural competency skills and training needs of staff?
- Does the facility have policies for recruitment and retention of personnel who are culturally and linguistically representative of the patient populations served?

Assessment and Policy Development Tools for Healthcare Providers and Facilities

A hospital self-assessment tool is included in The Joint Commission's 2008 report *One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations*. The assessment tool is available online and as a Word document at http://www.jointcommission.org/PatientSafety/HLC/self_assessment_tool.htm.

Healthcare Language Services Implementation Guide. Developed by the Office of Minority Health, U.S. DHHS. <https://hclsig.thinkculturalhealth.org/user/home.rails>

The Diversity and Cultural Proficiency Assessment Tool for Leaders. Developed by the American College of Healthcare Executives, American Hospital Association, Institute for Diversity in Health Management, and National Center for Healthcare Leadership. <http://www.aha.org/aha/content/2004/pdf/diversitytool.pdf>

Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile. Developed by the Health Resources and Services Administration, U.S. DHHS. <http://www.hrsa.gov/culturalcompetence/indicators/>

The Cultural Competence Self Assessment Protocol for Health Care Organizations and Systems. Developed by Dennis Andrulis, Thomas Delbanco, Laura Avakian and Yoku Shaw-Taylor. <http://erc.msh.org/provider/andrulis.pdf>

Cultural and Linguistic Competency Policy Assessment. Developed by the National Center for Cultural Competence at Georgetown University. <http://www.clcpa.info>

Cultural Competence Health Practitioner Assessment. Developed by the National Center for Cultural Competence at Georgetown University. <http://www11.georgetown.edu/research/gucchd/nccc/features/CCHPA.html>

For a list of additional resources, see “Promoting Effective Communication—Language Access Services in Health Care.” *Joint Commission Perspectives*, 2008, Volume 28, Issue 2. http://www.jointcommission.org/NR/rdonlyres/ACAFA57F-5F50-427A-BB98-73431D68A5E4/0/Perspectives_Article_Feb_2008.pdf

Online Training Resources

Resources for training and education on cultural and linguistic competence in healthcare are numerous, and most healthcare facilities incorporate cultural competency to some degree in their training and continuing education programs for employees. A comprehensive list of available resources is beyond the scope of this document. The following resources are cited because they provide free, web-based, multimedia training modules for healthcare providers.

Cross-Cultural Health Care – Case Studies. Developed by the Pediatric Pulmonary Center grantees of the Maternal and Child Health Bureau, HRSA, U.S. DHHS. See in particular the “Diane Mathis” case study on an emergency department patient with limited English proficiency. http://support.mchtraining.net/national_ccce/

Cultural Competency Curriculum Modules developed by the Office of Minority Health, U.S. DHHS. <http://www.thinkculturalhealth.org/>

The Joint Commission and U.S. DHHS Regulatory Standards and Reports

The Joint Commission 2009 Requirements Related to the Provision of Culturally and Linguistically Appropriate Health Care. http://www.jointcommission.org/PatientSafety/HLC/HLC_Joint_Commission_Standards.htm

Joint Commission on Accreditation of Healthcare Organizations. Promoting Effective Communication: Language Access Services in Health Care. *Joint Commission Perspectives*, February 2008, Volume 28, Issue 2, pp. 8-11.

Office of Minority Health, U.S. Department of Health and Human Services. *National Standards for Culturally and Linguistically Appropriate Services in Health Care*. (2001). <http://www.omhrc.gov/assets/pdf/checked/finalreport.pdf>

Office of Minority Health National Culturally and Linguistically Appropriate Services (CLAS) Standards

Crosswalked to The Joint Commission 2009 Standards for Hospitals, Ambulatory, Behavioral Health, Long Term Care, and Home Care. <http://www.jointcommission.org/NR/rdonlyres/02E99D6E-E4EA-4F6A-A31F-4A10CAE691DC/0/2009OMHJCCLASXwalkHAP.pdf>

Wilson-Stronks A, Lee KK, Cordero CL, Kopp AL, Galvez E. *One Size Does Not Fit All: Meeting the Health Care Needs of Diverse Populations*. Oakbrook Terrace, IL: The Joint Commission; 2008. http://www.jointcommission.org/PatientSafety/HLC/one_size_meeting_need_of_diverse_populations.htm

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Appendix 10: Training of Healthcare Providers

Appendices are provided as reference resources only; they do not represent guidelines written and approved by the Working Group and Advisory Board.

The Need for Training

Emergency departments in Virginia recognize a need for better training of staff on caring for patients presenting for treatment after sexual assault. In a recent study, more than one-third rated their training of staff as “fair or poor,” and fewer than half regularly provided training on sexual violence to new or current staff members (Plichta et al., 2006). Newer data from an informal survey of Virginia hospitals suggest that training may have become more accessible, but a number of facilities identify the need and desire for more training (unpublished data, Virginia Hospital and Healthcare Association, 2009).

Proper training and clinical preparation of providers who care for sexual assault patients is essential to minimize retraumatization. The psychological distress caused by sexual assault may be exacerbated and reinforced by the physically and emotionally invasive interview and examination procedures that are necessary components of the medical-forensic process. Additionally, training for providers who conduct forensic examinations is critical to ensure the proper collection and preservation of evidence that may form the basis for prosecution of suspects.

Other healthcare personnel who interact with or oversee the management of sexual assault patients also will benefit from training. Because sexual assault patients’ emotional and physical injuries may not be readily apparent, and physical evidence may be lost if examination is delayed, registration and intake personnel need to be familiar with this document and understand the importance of their role in the response to sexual assault.

An effective healthcare response to sexual assault rests not only on the preparation of individual providers, but on the readiness of the healthcare facility and the community-level system as well. Training for healthcare facility administrators and clinical managers will equip them to draw on the elements of a model healthcare response to sexual assault as they make staffing decisions, develop policies, and establish collaborative relationships with other stakeholders and responders in the community.

Recommended Content of Training

At a minimum, the preparation of healthcare professionals involved in the care of adult and post-pubertal adolescent sexual assault patients should include training on the content of this document.

National medical and criminal justice organizations recommend additional topic areas for training clinicians to provide medical care to sexual assault patients and conduct forensic examinations.¹ Suggested broad topic areas include:

- The dynamics and effects of sexual violence
- Jurisdictional laws
- Elements of a coordinated community response to sexual assault

¹ See, for example, the section on “Minimum Core Content” in *Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient*, American College of Emergency Physicians (1999); “Components of a Thorough Training Curriculum” in *Intimate Partner Violence and Sexual Assault: A Guide to Training Materials and Programs for Health Care Providers*, National Center for Injury Prevention and Control, CDC (1998); “Preparing Your Practice” in *National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings*, The Family Violence Prevention Fund (2004); *A National Protocol for Sexual Assault Medical Forensic Examinations*, Office on Violence Against Women, U.S. Department of Justice (2004); *National Training Standards for Sexual Assault Medical Forensic Examiners*, Office on Violence Against Women, U.S. Department of Justice (2006).

- Patient-centered, compassionate care
In addition to the guidelines in this document, this topic could include:
 - Objectivity and sensitivity in verbal and written communication
 - Caring for sexual assault patients from specific populations (e.g., male, lesbian, gay, bisexual, transgender, elderly, people with disabilities, cultural groups, people with limited English proficiency)
 - Adapting examination procedures to the needs of the patient and the circumstances of the assault
 - Community resources for sexual assault patients' emotional support, advocacy, crisis intervention, and follow-up services
- Medical forensic history, examination, and documentation
In addition to the guidelines in this document, this topic could include:
 - Documentation of findings for evidentiary purposes, including the importance of neutrality and objectivity (See Appendix 13 for guidance on documentation issues)
 - Forensic photography
 - Procedures and equipment for evidence collection and preservation (including use of Virginia's Physical Evidence Recovery Kit)
 - Maintaining chain of custody and transferring evidence to law enforcement
- Interpreting physical and/or anogenital findings
- Testifying in court

Training Mechanisms and Resources

Healthcare facilities should incorporate the response to sexual assault into ongoing training and continuing education opportunities for providers. Facilities may wish to collaborate with local sexual assault crisis centers to develop and provide training. Educational opportunities also may be available from the Virginia Chapter of the International Association of Forensic Nurses (<http://www.va-iafn.org>).

A multi-media, interactive "Virtual Practicum" for medical and forensic management of the sexual assault patient is available for purchase from the International Association of Forensic Nurses (<http://www.iafn.org>). Developed by Dartmouth Medical School's Interactive Media Lab for the Office of Violence Against Women in the U.S. Department of Justice, the practicum is based on the *National Protocol for Sexual Assault Medical Forensic Examinations*. This resource is appropriate for any healthcare professional that provides care for sexual assault patients, in addition to those preparing for certification as Sexual Assault Nurse Examiners.

Appendix 11: Virginia Forensic Nurse Examiner Programs By Region

The following list of Forensic Nurse Examiner Programs is accurate as of May 2009. The Virginia Chapter of the International Association of Forensic Nurses maintains this directory, and it is available online at <http://va-iafn.org/Directory.html>.

Virginia Forensic Nurse Examiner Programs By Region (Northern, Tidewater, Western, Central)

NORTHERN REGION

INOVA Fairfax Hospital Sexual Assault Nurse Examiners

INOVA Fairfax Hospital
3300 Gallows Road
Falls Church, VA 22042

Contact: Sue Brown, PhDc, MSN, RN, SANE-A, SANE-P, CFN
Phone: 703.776.3505
Fax: 703.776.3821
Suzanne.Brown@inova.org

Services Available:

- Adult Sexual Assault
- Domestic Violence - Appointments only with approval
- Child Sexual Abuse - Acute and Chronic
- Child Physical Abuse - Appointments only with approval
- Elder Abuse
- Felonious Assault

Special Services:

- FNE On-Call 24 hours a day
- Scheduled appointments available
- Colposcopy evaluation

Potomac Hospital Sexual Assault Nurse Examiners

Potomac Hospital
2300 Orbitz Blvd
Woodbridge, VA 22191

Contact: Rhonda Boyett, RN
Phone: 703.670.1363
Fax: 703.670.2642

Services Available:

- Adult Sexual Assault

Special Services:

- FNE On-Call 24 hours a day
- Colposcopy evaluation

Warren Memorial Sexual Assault Nurse Examiners

Warren Memorial Hospital
1000 Shenandoah Ave
Front Royal, VA 22630

Contact: Jackie Stone O'Donnell, MSN, RN
Phone: 540.636.0334
Fax: 540.636.0247
jackieo@shentel.net

Services Available:

- Adult Sexual Assault
- Domestic Violence
- Child Physical Abuse
- Elder Abuse
- Felonious Assault

Special Services:

- FNE On-Call 24 hours a day
- Medscope evaluation

Winchester Medical Center Forensic Nurse Examiners

Winchester Medical Center
1840 Amherst Street
Winchester, VA 22601

Contact: Cyndi Leahy, RN, SANE-A
Phone: 540.536.4147
Fax: 540.536.4188

Services Available:

- Adult Sexual Assault
- Domestic Violence
- Child Sexual Abuse - Acute and Chronic
- Child Physical Abuse
- Elder Abuse
- Felonious Assault

Special Services:

- FNE On-Call 24 hours a day
- Scheduled appointments available
- Colposcopy evaluation

TIDEWATER REGION

Chesapeake Forensic Specialists LLC

Chesapeake Forensic Specialists LLC
1101 Madison Plaza Suite 103
Chesapeake, VA 23320

Contact: Connie Andrews, RN, SANE-A
Phone: 757.446.0048 (pager), 757.398.5105 (answering service)
Fax: 757.398.5105

Services Available:

- Adult and adolescent sexual assault care
- Domestic violence
- Elder abuse

- Disabled
 - Suspect
 - Follow-up assessment
- Special Services:
- 24-7 on-call
 - Colposcopic assessment and photographic documentation
 - Will travel to offsite

Riverside Regional Medical Center Sexual Assault Nurse Examiners

Riverside Regional Medical Center
500 J. Clyde Morris Blvd
Newport News, VA 23601

Contact: Sandi Reinholdt, RN, SANE-A, SANE-P
Phone: 757.594.3983
Fax: 757.594.2366
Sandra.Reinholdt@rivhs.com

Services Available:

- Adult Sexual Assault
- Domestic Violence
- Child Sexual Abuse
- Child Physical Abuse
- Elder Abuse
- Felonious Assault
- Suspect Evaluation

Special Services:

- FNE On-Call 24 hours a day
- Scheduled appointments available
- Colposcopy evaluation

Sentara Norfolk General Hospital Forensic Nurse Examiners Program

Sentara Norfolk General Hospital, Emergency Department
600 Gresham Drive
Norfolk, VA 23507

Contact: Debra Blankenship, RN
Phone: 757.388.2443

Services Available:

- Adult Sexual Assault
- Adolescent Sexual Assault
- Domestic Violence
- Suspect Kit Collection

Special Services:

- FNE On-Call 7 days a week from 7a-7p
- Follow up examinations
- Colposcopy evaluation

WESTERN REGION

Carilion Clinical Forensic Nurse Examiners (Bedford)

Carilion Bedford Memorial Hospital
1613 Oadwood Street
Bedford, VA 24523

Contact: Caroline Butt
Phone: 540.587.3250
Fax: 540.586.7314

Services Available:

- Adult Sexual Assault
- Domestic Violence
- Child Sexual Abuse - Acute and Chronic
- Child Physical Abuse
- Elder Abuse
- Felonious Assault

Special Services:

- FNE On-Call 24 hours a day
- Scheduled appointments available
- Colposcopy evaluation

Carilion Clinical Forensic Nurse Examiners (New River Valley)

Carilion New River Valley Medical Center
2900 Lamb Circle
Christiansburg, VA 24073

Contact: Cris Whitaker, April Bennett
Phone: 540.731.2866
Fax: 540.731.2867

Services Available:

- Adult Sexual Assault
- Domestic Violence
- Child Sexual Abuse - Acute
- Child Physical Abuse
- Elder Abuse
- Felonious Assault

Special Services:

- FNE On-Call 24 hours a day
- Colposcopy evaluation

Carilion Health System Clinical Forensic Nurse Examiners (Roanoke)

Carilion Roanoke Memorial Hospital
1906 Belleview Avenue
Roanoke, VA 24014

Contact: Melissa Ratcliff Harper, MSN, APRN, SANE-A, SANE-P
Phone: 540.981.7337
Fax: 540.266.5849
Voicemail: 540.266.6025

mratcliffharper@carilion.com

Services Available:

- Adult Sexual Assault
- Domestic Violence
- Child Sexual Abuse
- Child Physical Abuse
- Elder Abuse
- Felonious Assault

Special Services:

- FNE On-Call 24 hours a day
- Scheduled appointments available
- Colposcopy evaluation

Lewis-Gale Medical Center Forensic Nurse Examiners

Lewis-Gale Medical Center
1900 Electric Road
Salem, VA 24153

Also serving Montgomery Regional Hospital and Pulaski Community Hospital

Contact: Ann Adkins, RN, SANE-A
Phone: 540.776.4013
Fax: 540.776.4849
Ann.Adkins@HCAhealthcare.com

Services Available:

- Adult Sexual Assault
- Domestic Violence
- Child Sexual Abuse - Acute and Chronic
- Child Physical Abuse
- Elder Abuse
- Malicious Wounding
- Suspect Evaluations

Special Services:

- FNE On-Call 24 hours a day
- Scheduled appointments available
- Colposcopy evaluation

Forensic Nurse Examiners of Centra Health

Lynchburg General Hospital
1901 Tate Springs Road
Lynchburg, VA 24501

Contact: Sharon Bondurant, RN, SANE-A
Donna Callum, RN, SANE-A
April Rasmussen, RN, SANE-A
Phone: 434.200.3642
Fax: 434.200.5531

Services Available:

- Adult Sexual Assault
- Domestic Violence

- Child Sexual Abuse - Acute and Chronic
- Child Physical Abuse
- Elder Abuse/Incapacitated Adult
- Felonious Assault
- Suspect Evaluations
- Pediatric Deaths

Special Services:

- FNE On-Call 24 hours a day
- Scheduled appointments available
- Colposcopy evaluation

Rockingham Memorial Hospital Sexual Assault Nurse Examiners

Rockingham Memorial Hospital
235 Cantrell Ave
Harrisonburg, VA 22801

Contact: Bobbie Forkovitch Glover
Phone: 540.433.4100 or 540.564.7378
Fax: 540.433.4693

Services Available:

- Adult Sexual Assault
- Child Sexual Abuse - Acute

Special Services:

- FNE On-Call 24 hours a day
- Scheduled appointments available
- Medscope evaluation

CENTRAL REGION

Henrico Doctors Hospital Forensic Nurse Examiners

Henrico Doctors Hospital Forrest Campus
1602 Skipwith Road
Richmond, VA 23229

Contact: Mary Mule, RN
Phone: 804.289.4605
Fax: 804.287.4313

Services Available:

- Adult Sexual Assault
- Domestic Violence
- Child Sexual Abuse - Acute
- Child Physical Abuse
- Elder Abuse
- Felonious Assault

Special Services:

- Colposcopy evaluation

Mary Washington Hospital Forensic Nurse Examiners

Mary Washington Hospital
1001 Sam Perry Blvd
Fredericksburg, VA 22401

Contact: Gail Perkins, RN, SANE-A
Manager, Forensic Services
Phone: 540-741-2741
Fax: 540.741.1555

Services Available:

- Adult Sexual Assault
- Pediatric Sexual Assault

Special Services:

- FNE On-Call 24 hours a day
- Medscope Evaluation

Forensic Nurse Examiners of St. Mary's Hospital

St. Mary's Hospital
5801 Bremo Road
Richmond, VA 23226

Contact: Bonnie Price, MSN, RN, SANE-A, SANE-P
Phone: 804.281.8574
Fax: 804.287.7634
bonnie_price@bshsi.org

Services Available:

- Adult Sexual Assault
- Domestic Violence
- Child Sexual Abuse - Acute and Chronic
- Child Physical Abuse
- Elder Abuse
- Felonious Assault
- Suspect Evaluations

Special Services:

- FNE On-Call 24 hours a day
- Scheduled Appointments Available
- Colposcopy evaluation

VCUHS Forensic Nurse Examiners

VCUHS
401 North 12th Street
PO Box 980401, Emergency Services
Richmond, VA 23298

Contact: Jean Cheek, RN, SANE-A
Antigone Jones, BSN, RN
Phone: 804.628.0623
Pager: 804.373.1016
Fax: 804.828.2203

Services Available:

- Adult Sexual Assault
- Arson/Burn Accidents
- Blood Alcohol Testing
- Domestic Violence
- Elder Abuse
- Felonious Assault
- MVC Accidents
- Pedestrian Accidents
- Suicide Attempts
- Work Related Injuries

Special Services:

- In House FNE Coverage
- Scheduled appointments available
- Colposcopy evaluation

University of Virginia Forensic Nurse Examiners

University of Virginia
PO Box 10014
Charlottesville, VA 22906-0014

Contact: Sarah Anderson, PhD, RN, SANE-A
Phone: 434.924.1100 or 434.531.5760
Fax: 434.924.2877
Slm9r@virginia.edu

Services Available:

- Adult Sexual Assault
- Domestic Violence
- Child Sexual Abuse
- Elder Abuse
- Felonious Assault

Special Services:

- FNE On-Call 24 hours a day
- Schedules appointments available
- Colposcopy evaluation

Appendix 12: Sample Forensic Examination Consent Forms

Appendices are provided as reference resources only; they do not represent guidelines written and approved by the Working Group and Advisory Board.

SAMPLE 1:

CONSENT FOR A FORENSIC EVALUATION

- I. I understand that a forensic evaluation can, with my consent, be conducted by a forensic nurse examiner to identify and preserve potential evidence of the assault. I understand that I may withdraw my consent at any time for any portion of the evaluation.
- II. I understand that this evaluation is for evidentiary and forensic purposes only and that any medical conditions will need to be addressed by the Emergency Department Physician or my primary care physician.
- III. I understand that the forensic evaluation may include history gathering, an assessment and evidence collection.
- IV. I understand that all licensed healthcare professionals are required under state law to report suspected child abuse and neglect, as well as adult abuse and neglect (Va. Code Sec. 63.2-1509; 63.1-55.3) and that this will be done by hospital staff, if the evaluation warrants a report.

I give permission for [Name of Forensic Nurse Examiner Program or Healthcare Facility/Provider] to perform a forensic evaluation of me. I certify that I have read, understand and agree to the conditions described above.

Signature of Patient or Legal Representative _____
DATE

If signed by legal representative, relationship to patient: _____

Signature of Witness: _____
DATE

CONSENT FOR PHOTOGRAPHY

- I. I understand that photographs, videotapes, digital or other images may be recorded to document my care for forensic purposes, and I consent to this. Like all evidence collected in this evaluation, these items may be used in criminal and civil legal proceedings. I understand that the above mentioned photographic images may include the genital and anal area.
- II. I understand that [Name of Healthcare Facility] will retain ownership rights to these photographs, videotapes, digital, or other images but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or outlined in the [Name of Healthcare Facility] policy. Images that identify me will be released only upon written authorization from me or my legal representative or unless disclosure is required by law, a court, or a legal process.

Signature of Patient or Legal Representative _____
DATE

If signed by legal representative, relationship to patient: _____

Signature of Witness: _____
DATE

SAMPLE 2:

Authorization To Evaluate For Possible Abuse

A. Conditions

1. I understand that the examination for evidence of physical/sexual assault can, with my consent, be conducted by an examiner to discover and preserve evidence of the assault. I understand that I may withdraw my consent at any time for any portion of the evidential examination.
2. Information concerning the interview, examination and family history may be released to the state agency in charge of investigating suspected abuse, law enforcement agencies, or your physician, clinician or therapist.
3. Photographs, videotapes and video prints may be taken as evidence. Like all evidence collected in this evaluation, these records are to be used for medical treatment and legal purposes.

B. Authorization

I, the custodial, give permission for [Name of Healthcare Provider/Facility] to evaluate me. I certify that I have read, understand and agree to the conditions described in section A.

_____	_____	_____
Signature	Witness	Date

I understand the collection of evidence may include photographing injuries and in cases of sexual assault, may include the genital area. Knowing this, I consent to having photographs taken.

_____	_____	_____
Signature	Witness	Date

I understand that any photographs taken may be used for educational purposes and, if used for such purposes my identity will be kept confidential.

☐ I consent to the use of photography for educational purposes.

☐ I refuse to consent to the use of photography for educational purposes.

_____	_____	_____
Signature	Witness	Date

Appendix 13: Considerations for Documentation of the Forensic Exam

Appendices are provided as reference resources only; they do not represent guidelines written and approved by the Working Group and Advisory Board.

Documenting the Forensic Medical Exam

©Forensic Nurse Examiners of St. Mary's Hospital 2008

Documentation is one of the essential components of the forensic evaluation. A comprehensive document serves several purposes, including:

- Enabling the investigative agencies to make informed, accurate case depositions
- Providing evidence in the event of judicial proceedings
- Preserving evidence of findings
- Refreshing the healthcare provider's memory of the evaluation

Essential Components:

The following components should be included in the documentation of a forensic evaluation:

1. Consent for the evaluation
2. Past medical history
3. History of the event
4. Physical exam findings
5. Evidence collection and chain of custody
6. Medical treatment received
7. Follow-up referrals and discharge instructions

Consent:

Healthcare providers must receive a separate written consent to perform a forensic medical exam on a patient reporting a sexual assault. In instances where consent can not be obtained from the patient or a parent/guardian/next of kin/power of attorney, consent may be obtained legally through a court order or search warrant.

The process of obtaining consent should address:

1. Patient's name, date of birth, and medical record number
2. Authorization to evaluate and collect evidence
3. Authorization to release evidence to a specific member of law enforcement
4. Authorization to release the medical records to a specific member of law enforcement (may require additional consent or release of record forms in order to be HIPPA compliant)
5. Authorization to photograph injuries and to release those photographs to a specific member of law enforcement (may require additional consent for release of record forms in order to be HIPPA compliant)
6. Signature of the individual consenting to the evaluation and their relationship to the patient
7. Signature of the healthcare provider witnessing the consent

Past Medical History:

Obtaining a thorough past medical history assists in differentiating between findings that are the result of trauma and those that can be attributed to pathophysiologic conditions. It also establishes pattern of findings and determines medical treatment modalities.

A thorough past medical history should include:

1. Allergies

2. Previous hospitalizations
3. Previous surgeries
4. Diagnosed illnesses
5. Current medications
6. Vaccination/tetanus status

Best Practice: A thorough past medical history should contain information regarding procedures or events that may affect the anogenital exam findings. Examples should include: previous speculum examinations, pregnancy with vaginal delivery, tampon use, recent urinary catheterization, previous sexual activity, etc. The occurrence and timing of these events may impact the interpretation of anogenital exam findings.

History of Event:

A history of the reporting event assists the healthcare provider in determining the location of potential evidence. Documentation of the event should be done using quotations as much as possible. Document only what the patient tells you. Assumptions should not be made and clarifying questions should be asked to make clear any ambiguous statements.

Documentation of the history of the event should include:

1. Location of the assault
2. Date and time of the assault
3. Name or description of alleged assailant
4. Detailed description of acts committed
5. Statements made by alleged assailant in quotations
6. Weapons, restraints, threats used
7. Presence of injuries to the assailant
8. Name and agency of investigating law enforcement officer
9. Has the patient bathed, douched, urinated, defecated, brushed teeth, changed cloths, smoked, or chewed gun since the assault?
10. Last consensual intercourse, type and with whom

Physical Exam Findings:

A thorough head-to-toe assessment should be performed and documented on all patients reporting a history of sexual assault. Findings should be documented using written descriptions, diagrams, and whenever possible obtaining photographs.

The following items should be documented regarding the exam:

1. The location of any findings (i.e. trauma, medical conditions and pre-existing injuries)
2. The size (including actual measurements), shape and color of all visible findings, in addition to the presence or absence of bleeding or fluids noted. It is always preferable to describe the finding, as opposed to "naming it." For example, documenting that the patient has a "bite mark" to her left arm would be incorrect. The proper method for documentation would include: The patient has a 2 cm oval red area, with central sparing noted to her left upper arm. Patient stated, "Joe bit me on my arm."
3. The condition of the patient's clothing
4. Using objective statements, the patient's appearance, demeanor, emotional state, and affect during the exam
5. Any complaints of pain or bleeding
6. On the body diagram, document a quote from the patient as to the cause of a finding, if it is known. For example, patient stated, "John hit me in the face and busted my lip" or "The bruise on my shin is just a bruise from me tripping over the dog; that was there before I was attacked." Be sure to document any pre-existing findings.

7. Type and location of cultures obtained during the anogenital exam
8. Evidence collected (A detailed inventory of items collected should be documented either on the forms provided with the evidence kit or in the forensic report. For example, “3 items of clothing collected” would not be detailed or specific enough. The nurse should note, “bag 1- contains blue t-shirt; bag 2 – contains yellow underpants; bag 3 – contains green sweatshirt.”)
9. Chain of custody, including the date and time the PERK is released and the name and title of the releasing and accepting individuals
10. Safety assessment/plan

Key Note: Documenting the findings of a genital exam as “Normal” or “WNL” (within normal limits) is inadequate and provides no useful information. Notations such as these should not be used in the forensic medical record. Instead, a clear description of what was found, and what was not found, at the time of the exam should be documented (Giardino et al., 1992, p. 130-131).

Medical Treatment:

Documentation of medical treatment received should include:

1. Any medical treatment required to stabilize injuries
2. Laboratory tests performed
3. Radiology tests performed
4. Medications administered including prophylactic antibiotics, HIV post-exposure prophylaxis and pregnancy prevention medications

Follow-Up Referrals & Discharge Instructions:

Discharge instructions and follow-up referrals should include information regarding follow-up sexually transmitted disease and pregnancy testing, safety planning, counseling services, and victim-witness or court contacts. Depending on the results of the safety assessment, it may be necessary to provide the patient with information regarding shelters or safe-houses in the area. Detailed written medication instructions should be provided regarding emergency contraception and STD post-exposure prophylaxis.

References:

Giardino AP, Finkel MS, Giardino ER, Seidl T, Ludwig S. Documentation and Conclusions. In Foster DS, ed. *A Practical Guide to the Evaluation of Sexual Abuse in the Prepubertal Child*. Newbury Park, CA: Sage Publications, Inc.; 1992:128-135.

Girardin BW, Faugno DK, Seneski PC, Slaughter L, Whelan M. Care of the sexually assaulted patient. In Arndt S, Ferrell J, Rosof J, eds. *Color Atlas of Sexual Assault*. St. Louis, MO: Mosby-Year Book, Inc.; 1997:83-128.

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Appendix 14: Evidence Preservation Procedures and Practices

Appendices are provided as reference resources only; they do not represent guidelines written and approved by the Working Group and Advisory Board.

In order to preserve potential evidence prior to the performance of a forensic evaluation:

- Standard precautions will be maintained at all times.
- All personnel will be sensitive to maintaining the integrity and preservation of potential evidence pending the performance of a forensic evaluation.
- Gloves must be changed in between handling individual pieces of evidence or touching non-evidentiary animate or inanimate objects.
- Evidence may include body fluids (saliva, vaginal fluid, semen, urine, blood, etc.), hair, clothing, bullets, and foreign materials (debris, leaves, dirt, etc.).
- Every effort will be made to avoid disrupting any potential evidence. Activities that should be avoided prior to a forensic examination include bathing or showering, changing clothing, brushing teeth, smoking, eating or drinking.
- Any evidence collected must be placed individually in paper bags or separate, sterile, sealed containers labeled with the patient's name, medical record number, the name of the person collecting the evidence, and the date and time of collection.
- The person collecting the piece of evidence is responsible for maintaining chain of custody. Chain of custody refers to "a record of individuals who have had physical possession of the evidence and the process used to maintain and document the chronological history of the evidence" (Truman, 2001, p.9). Any collected evidence must be maintained in the custody of the collecting individual at all times until released to a member of law enforcement. It is the responsibility of the collecting individual to document when and where the potential evidence was collected. It is the responsibility of the releasing individual to document the date and time and to whom any potential evidence is released.

The following evidentiary procedures apply to all Medical Examiner cases:

- All clothing and personal articles must be sent with the body to the Medical Examiner's Office.
- Do not release any personal effects to family members.
- Do not throw away any personal effects or items worn at the time of death.
- Do not release any contraband (guns, knives, drugs, money, or other personal effects) to family members. These items may only be released to the investigating police officer directly.
- Send the body wrapped in the receiving linen to the Medical Examiner's Office.
- Any debris, powder, glass, or other foreign materials found in or around the body should be left in place. Do not attempt to clean the body in any way. Leave all items used to resuscitate the patient in place including IV lines, sutures, intubation equipment, drains, etc.
- All collected specimens including gastric contents, urine, and blood should be sent with the body to the Medical Examiner's Office or sent to the hospital laboratory with notification to hold all samples for the Medical Examiner's Office.
- The patient should not be left unattended with family members.
- The patient should not be held or moved by family members without the approval of the Medical Examiner's Office.
- All unsuccessful treatment attempts should be documented in the patient's medical record.

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Appendix 15: Recommended Equipment and Supplies for Forensic Exams

Appendices are provided as reference resources only; they do not represent guidelines written and approved by the Working Group and Advisory Board.

Laboratory supplies

- Vacutainers
- Tourniquet
- Needles
- Blood tubes (various types)
- Urine collection cups
- Specimen bags

Evidence collection supplies

- Physical Evidence Recovery Kits issued by the Virginia Department of Forensic Science (victim and suspect)
- Various sizes of additional evidence bags, containers and envelopes
- Evidence tape and labels
- Chain of custody drug screen kits
- UV light source
- Scales and rulers to include in photographs (various colors, lengths and shapes)
- ABFO ruler for photographing bite marks

Miscellaneous supplies

- Toluidine blue dye
- Spray bottle with vinegar/water mixture
- 16g Foley catheters
- Syringes
- Speculums (preferably clear, plastic speculums so that the view of the vaginal walls is not obstructed)
- DNA/Gen Probes and/or cultures for STD testing
- Q-tips
- Chuxs
- 4X4 sponges
- Gloves and more gloves!
- Biohazard supplies
- Charting and documentation supplies

Hygiene items for the patient

- A change of clothing (various sizes)
- Underpants
- Tooth paste, tooth brush, mouthwash, soap, shampoo, lotion, comb
- Sanitary pad
- A packet of gum or breath fresheners

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Appendix 16: CICF Policies and Guidelines for Payment of Sexual Assault Forensic Examinations

The following document is provided by the Virginia Criminal Injuries Compensation Fund and is available online at http://www.cicf.state.va.us/forensic_exams.shtml.

PROCEDURES AND GUIDELINES
For
PAYMENT OF SEXUAL ASSAULT FORENSIC EXAMINATIONS
By
THE CRIMINAL INJURIES COMPENSATION FUND
A division of
THE VIRGINIA WORKERS' COMPENSATION COMMISSION

Criminal Injuries Compensation Fund
Post Office Box 26927
Richmond, Virginia 23261
(800) 552-4007

Workers' Compensation Commission
1000 DMV Drive
Richmond, Virginia 23220
(877) 664-2566

Revised May 23, 2008



**Criminal Injuries
Compensation Fund**
Easing the Burden for Crime Victims

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CICF FORENSIC SEXUAL ASSAULT PAYMENT POLICIES AND PROCEDURES:

Per §19.2-165.1(B) of the Code of Virginia, an adult victim of an alleged sexual assault is no longer required to report this offense to law enforcement in order to request a forensic examination, or for the Commonwealth to pay for the examination

In accordance with §19.2-368.3 and §19.2-368.11:1(F) of the Code of Virginia, the following policies and procedures outline the requirements that must be met in order for the Criminal Injuries Compensation Fund (CICF) to consider payment of the Physical Evidence Recovery Kit (PERK) examination in sexual assault cases.

DEFINITIONS:

As used throughout these guidelines, the following words and phrases shall have the following meanings:

“PERK” and “examination” shall mean Physical Evidence Recovery Kit, or the process by which forensic evidence is gathered, per §19.2-165.1 of the Code of Virginia. More specifically, a “PERK” or “examination” shall mean all services directly related to the gathering of forensic evidence and initial testing and treatment for pregnancy and sexually transmitted diseases.

“CICF” shall mean the Criminal Injuries Compensation Fund

“Criminal Fund” shall mean the fund administered by the Supreme Court of Virginia to pay for costs associated with evidence collection, with the exception of sexual assault PERK examinations.

“Facility with capacity” shall mean the health care provider has a Physical Evidence Recovery kit available and staff trained to gather evidence and complete the kit

“FNE” shall mean Forensic Nurse Examiner

“SANE” shall mean Sexual Assault Nurse Examiner

NOTE: FNE and SANE may be used interchangeably.

REQUIREMENTS:

The alleged sexual assault must have occurred after July 1, 2008.

The location of the alleged sexual assault must be within the Commonwealth of Virginia.

Reporting to law enforcement is NOT a pre-condition for evidence collection or for payment by CICF.

The PERK must be conducted in accordance with the guidelines set forth by the Virginia Department of Forensic Science, utilizing an approved PERK.

Reimbursement will only be made for sexual assault-related PERK examinations. [PERKs or forensic examinations for any other purpose must be approved by the local Commonwealth's Attorney or their designee in advance of the examination per rules of the Virginia Supreme Court's Criminal Fund. The Criminal Fund will reimburse non-sexual assault evidence collection in accordance with their rules.]

Facilities should retain records pertaining to the examination for three years for audit purposes if necessary.

CICF will not pay for adult PERKs collected more than seventy-two (72) hours past the date and time of the alleged incident, unless good cause can be shown by the FNE. The seventy-two (72) hour window may not apply for child victims of sexual assault, and state lab protocols with respect to PERK collection on child victims apply.

NOTE: If in a specific case a Forensic Nurse Examiner (FNE/SANE) believes that viable evidence may exist beyond seventy-two hours, the FNE must submit an explanation to the CICF along with the standard required documentation so that the bill may be considered.

Bill must be forwarded to CICF by the health care facility or provider within one year of the date of treatment.

Should a patient inadvertently receive a bill from a facility, or pay any amount out-of-pocket for a sexual assault forensic examination, he/she may seek reimbursement by CICF within one (1) year of the date of the alleged assault.

PATIENT PAYMENT OPTIONS

The patient may select from the following two (2) options:

- 1) For **CICF** to pay for the examination in full.
- 2) For the treatment facility to bill her/his health insurance provider and have CICF pay any remaining balance, **or** the patient is covered by a federally-funded health care program (Medicaid, Medicare, Champus, Tricare, FAMIS or the Veterans Administration) **AND** wants CICF to cover any unpaid eligible balances.

BILLING INSTRUCTIONS FOR HEALTH CARE FACILITY/PROVIDER

Only patients who opt to take responsibility for PERK payment should receive any billing notices from healthcare providers related to the exam.

Once the bill has been sent to CICF for consideration, the patient shall not be placed in collections by a health care provider per §19.2-368.5:2 and §19.2-368.11:1(F) of the Code of Virginia.

The **CICF REQUEST FOR PAYMENT FORM** must be submitted with a detailed, itemized billing statement. **Health Insurance Claim Forms (HICF) will not be accepted.**

ITEMS TO BE INCLUDED FOR PAYMENT:

To be eligible for payment, the gross sexual assault forensic examination must include at least all services directly related to the gathering of forensic evidence and related testing and treatment for pregnancy and sexually transmitted diseases. The tests and treatments performed shall be based on each patient's individual need and preference. Licensed hospital and licensed health care practitioners must have available and offer to provide at least the following tests and treatments:

1. Professional/practitioner's services
 - History
 - Physical
 - Collection of specimens
 - Completion of the Commonwealth of Virginia's Department of Forensic Sciences' Physical Evidence Recovery Kit (PERK) based on each patient's individual need
 - Treatment for the prevention of sexually transmitted infection
2. Emergency department
 - Emergency room, clinic room or office room fee
 - Pelvic tray
3. Laboratory
 - Blood testing for syphilis and Hepatitis B

- HIV test
- Cultures for gonorrhea, chlamydia, trichomonas and other sexually transmitted infections (STI)
- 4. Pregnancy testing (blood test or urinalysis)
- 5. Other laboratory tests that are required for the purpose of evidentiary examination that are not traditionally related to a PERK. **NOTE:** an explanation must accompany the Request for Payment Form and itemized bill.
- 6. Medications
 - Pregnancy prophylaxis
 - Sexually transmitted disease prophylaxis
 - One dose sedative, antidepressant or tranquilizer
 - Anti-emetic
- 7. Ambulance fee to transport the patient to facility with the capacity to complete the PERK.

What is NOT Covered:

- Cost of treating injuries
- Follow-up or second appointments
- Duplicative services
- Medications filled off-site
- Air transport
- Follow-up medications
- Counseling
- Lost wages due to physical or emotional injury

IMPORTANT NOTES FOR COMPLETING THE REQUEST FOR PAYMENT FORM:

The Request for Payment Form must be completed in its entirety even if the patient is not reporting the crime to law enforcement.

If the patient does not wish to receive correspondence from CICF about payment of additional costs, then patient's mailing address may be omitted.

NOTE: If the patient does not wish for CICF to pay for her/his exam, it is not necessary to complete the Patient Information section.

PAYMENT FOR OTHER SERVICES RENDERED AT THE TIME OF PERK EXAMINATION:

If a patient incurs costs for uncovered items, including additional treatment or medications, she/he may wish to file a crime victim compensation application with the Virginia Criminal Injuries Compensation Fund (CICF). In order to be eligible for CICF, the patient must report the crime to law enforcement and cooperate with prosecution efforts. Claim forms can be found at www.cicf.state.va.us, or at local victim-serving programs.

If a patient does not wish to file a crime victim compensation claim through CICF or if the patient is ineligible for crime victim compensation (not reporting the crime to law enforcement, for instance), the patient and/or the patient's health insurance will be responsible for all expenses beyond the PERK exam.



MARY VAIL WARE
DIRECTOR



Post Office Box 26927 • Richmond, VA 23261 • 800.552.4007 • 877.377.5164 (Fax)

SAFE (Sexual Assault Forensic Exam) Payment Program Request for Payment Form

Please review these instructions thoroughly before submitting a request for payment:

- Both pages of this form must be completed by the individual performing the examination.** A claim is not set up within our system and a bill is not considered eligible for reimbursement without this completed form.
- An itemized, detailed bill must accompany this form. Health Insurance Claim Forms (HICF) may not be considered.
- If the patient has a federally-funded health insurance, or elects to bill their private insurance, **and** wants the SAFE Payment Program to pay any patient out-of-pocket responsibility, an explanation of benefits must accompany this form and the bill.
- The request for payment must be submitted within **one (1) year** of the date of service. Any claim not submitted or perfected by the deadline will be denied and patient shall not be held liable for the balance due.
- The alleged sexual assault for which the exam was performed must have occurred within the Commonwealth of Virginia or the claim will be denied.
- Requests for payment are only considered for a forensic examination completed on a victim of sexual assault. **NOTE:** Forensic examinations conducted for any other crime, including suspect PERKs, should be submitted to the Supreme Court of Virginia in accordance with their payment policy.
- Please inform patients that not all expenses are eligible for reimbursement through the SAFE Payment Program and that the patient or his/her insurance may be responsible. If patient declines evidence collection, the claim will be denied.
- Per §19.2-368.5:2 and §19.2-368.11:1(F) of the Code of Virginia, the patient may not be placed in collections once this form is filed with the SAFE Payment Program of the Criminal Injuries Compensation Fund.**
- Please send both pages of this form, itemized billing statement and any additional necessary documentation to:

MAIL: SAFE Payment Program, P.O. Box 26927, Richmond, VA 23261; FAX: 877.377.5164.

For questions, please contact the Forensic Payment Coordinator at 804.367.1018.

PATIENT/INCIDENT INFORMATION

Patient information is for financial and reporting purposes only. If the patient's address is provided, he/she will receive confirmation of payment of the exam as well as information about benefits available through the Criminal Injuries Compensation Fund.

Name:	DOB:	Last 4 SSN:	Sex: M/F
Address:			
Date/Time of Assault (if unknown, please provide possible date range):			
Crime Location (City/County):			
Did patient report crime to law enforcement? (please circle) Y/N		PERK No.:	
Individual Requesting Exam: Patient/Other (name and title)			
Offender name (if known and if patient reported crime to law enforcement):			

FACILITY/BILLING INFORMATION

Facility Name:	
Billing/Payment Address:	
Billing Contact Person:	Phone No.:
Name/Title of Individual Conducting Exam:	Phone No.:
Medical Record/Patient Account No.:	Initial/Follow-up (please circle one)
Please select patient's billing preference from the two options below:	
<input type="checkbox"/>	Patient wishes for the SAFE Payment Program to pay for eligible examination related expenses in full.
<input type="checkbox"/>	Patient wishes for the provider to bill his/her private health insurance or is covered by a federally-funded health insurance (Medicaid, Medicare, Tricare, Veterans' Administration, etc.) and would like the SAFE Payment Program to pay any unpaid eligible out of pocket expenses. Please list insurance provider:

SAFE (Sexual Assault Forensic Exam) Payment Program

Request for Payment Form, page 2

BILLING INFORMATION cont.

Please select the following items that should appear on the itemized billing statement for this patient. (NOTE: any services appearing on the itemized bill that are not indicated here will **not** be eligible for reimbursement. This section may be omitted as long as equivalent documentation is provided.)

- ☐ Physician Fee for medical screening exam ☐ Physician bills separately
- ☐ Examiner Fee (explain level billed)
- ☐ Facility/ Equipment and Supplies/Colposcopy (circle all that apply and that are not included in examiner fee)

Labs (check all that apply and specify type and quantity)

- ☐ Gonorrhea
- ☐ Chlamydia
- ☐ Syphilis
- ☐ Hepatitis B
- ☐ Trichomonas
- ☐ HIV
- ☐ Pregnancy

Additional labs ordered not listed above (must include explanation, including but not limited to: drug and alcohol screens; lab work to administer HIV PEP, etc.):

Medications (specify type and dose administered)

- ☐ STI Prophylaxis
- ☐ Emergency Contraception
- ☐ HIV PEP
- ☐ One dose sedative, tranquilizer, antidepressant
- ☐ Anti-emetic

Additional Documentation: Please provide additional information necessary in the consideration of payment of this exam, including, but not limited to: justification for PERK completed >72 hours after the crime; justification for follow-up exam; etc.

Storage location of PERK:

- ☐ Law Enforcement Agency (agency name) _____
- ☐ Division of Consolidated Laboratory Services because _____ (law enforcement agency name) refused to accept and store PERK with/without (circle one) patient's name.

IMPORTANT NOTE: Division of Consolidated Laboratory Services (DCLS) is intended to only be used for temporary storage when local law enforcement is unwilling to accept and store evidence from non-reported assaults without the patient's name.

- ☐ Other (please specify location and reason)
- ☐ Receipt for actual cost of shipping to DCLS included for reimbursement

Appendix 17: CICF Notice to Patients About Payment of Sexual Assault Examinations

The following document is provided by the Virginia Criminal Injuries Compensation Fund and is available online at http://www.cicf.state.va.us/forensic_exams.shtml.



Criminal Injuries Compensation Fund

Easing the Burden for Crime Victims

Date of Exam:

Facility Name:

PERK Number:

NOTICE REGARDING PAYMENT OF YOUR SEXUAL ASSAULT EXAMINATION

What is a sexual assault forensic examination?

It is an examination used to gather medical evidence to aid in the prosecution of a sexual assault and is conducted in accordance with the guidelines set forth by the Virginia Department of Forensic Science.

When should an examination be done?

An examination should be done within seventy-two (72) hours after the assault. If you are requesting an examination beyond this time frame, the Forensic Nurse Examiner (FNE) may offer other options.

Do I have to file a report with the police to have an examination?

Adult victims are not required to participate in the criminal justice system or cooperate with law enforcement in order to request or receive a sexual assault examination. It is important to know that if you choose not to report the assault, evidence that would normally be collected by law enforcement from you, the suspect(s) and the crime scene(s) may be permanently lost. Delayed reporting may also decrease the chance for a successful prosecution of the offender for the assault against you. **NOTE:** Health care providers will be required to report to law enforcement on behalf of child and elderly victims of sexual assault.

Who will pay for the examination?

The Commonwealth of Virginia, under the auspices of the Virginia Criminal Injuries Compensation Fund (CICF) will pay for your exam and related costs **regardless** of your choice with respect to reporting to law enforcement.

What is required for CICF to pay?

In order for CICF to pay for the exam, your name, date of birth, last four digits of your Social Security number and medical record number will be provided to CICF. This information will be used for payment purposes only and is not given out by CICF.

What if I receive a bill?

If you receive a bill to pay any amount out-of-pocket, including health insurance co-pays or deductibles, you will have up to one year from the date of the alleged assault to request payment by CICF.

What if I have other expenses, such as treatment for injuries and follow up care?

Costs for treatment of additional injuries, any follow-up care and/or counseling may be covered by CICF if you choose to report the crime to law enforcement and cooperate with prosecution efforts. A CICF application must be submitted to apply for additional benefits.

What if the assault happened in another state, but I had an examination in Virginia?

The state in which the assault occurred will be responsible for payment of the bill. Since each state may vary in regards to their payment procedures, you may contact CICF for assistance.

If you have questions about exam payment or to apply for other CICF benefits, call 1-800-552-4007 or visit our website at www.cicf.state.va.us.

To speak with a victim advocate or for referral to your local rape crisis center you may call the Virginia Family Violence and Sexual Assault Hotline 24 hours a day, 7 days a week at 1-800-838-8238 or the Virginia Crime Victim Assistance INFO-LINE at 1-888-887-3418 from 9am-5pm Monday-Friday.

Appendix 18: Virginia Legislation About Payment of Forensic Examination

VIRGINIA ACTS OF ASSEMBLY -- 2008 SESSION

CHAPTER 251

An Act to amend and reenact §§ 19.2-165.1, 19.2-368.3, and 19.2-368.11:1 of the Code of Virginia, relating to Criminal Injuries Compensation Fund.

[H 956]

Approved March 4, 2008

Be it enacted by the General Assembly of Virginia:

1. That §§ 19.2-165.1, 19.2-368.3, and 19.2-368.11:1 of the Code of Virginia are amended and reenacted as follows:

§ 19.2-165.1. Payment of medical fees in certain criminal cases; reimbursement.

~~All~~ A. *Except as provided in subsection B, all medical fees ~~involved~~ expended in the gathering of evidence for all criminal cases where medical evidence is necessary to establish a crime has occurred and for cases involving abuse of children under the age of 18 shall be paid by the Commonwealth out of the appropriation for criminal charges, provided that any medical evaluation, examination, or service rendered be performed by a physician or facility specifically designated by the attorney for the Commonwealth in the city or county having jurisdiction of such case for such a purpose. If no such physician or facility is reasonably available in such city or county, then the attorney for the Commonwealth may designate a physician or facility located outside and adjacent to such city or county.*

Where there has been no prior designation of such a physician or facility, such medical fees shall be paid out of the appropriation for criminal charges upon authorization by the attorney for the Commonwealth of the city or county having jurisdiction over the case. Such authorization may be granted prior to or within 48 hours after the medical evaluation, examination, or service rendered.

~~Upon conviction of the defendant in any such case, the court shall order that the defendant reimburse the Commonwealth for payment of such medical fees.~~

B. *All medical fees expended in the gathering of evidence through physical evidence recovery kit examinations conducted on victims complaining of sexual assault under Article 7 (§ 18.2-61 et seq.) of Chapter 4 of Title 18.2 shall be paid by the Commonwealth pursuant to subsection F of § 19.2-368.11:1. Victims complaining of sexual assault shall not be required to participate in the criminal justice system or cooperate with law-enforcement authorities in order to be provided with such forensic medical exams.*

C. *Upon conviction of the defendant in any case requiring the payment of medical fees authorized by this section, the court shall order that the defendant reimburse the Commonwealth for payment of such fees.*

§ 19.2-368.3. Powers and duties of Commission.

The Commission shall have the following powers and duties in the administration of the provisions of this chapter:

1. To adopt, promulgate, amend and rescind suitable rules and regulations to carry out the provisions and purposes of this chapter *and to include a distinct policy for the payment of physical evidence recovery kit examinations.*

2. Notwithstanding the provisions of § 2.2-3706, to acquire from the attorneys for the Commonwealth, State Police, local police departments, sheriffs' departments, and the Chief Medical Examiner such investigative results, information and data as will enable the Commission to determine if, in fact, a crime was committed or attempted, and the extent, if any, to which the victim or claimant was responsible for his own injury. These data shall include prior adult arrest records and juvenile court disposition records of the offender. For such purposes and in accordance with § 16.1-305, the Commission may also acquire from the juvenile and domestic relations district courts a copy of the order of disposition relating to the crime. The use of any information received by the Commission pursuant to this subdivision shall be limited to carrying out the purposes set forth in this section, and this information shall be confidential and shall not be disseminated further. The agency from which the information is requested may submit original reports, portions thereof, summaries, or such other configurations of information as will comply with the requirements of this section.

3. To hear and determine all claims for awards filed with the Commission pursuant to this chapter, and to reinvestigate or reopen cases as the Commission deems necessary.

4. To require and direct medical examination of victims.

5. To hold hearings, administer oaths or affirmations, examine any person under oath or affirmation and to issue summonses requiring the attendance and giving of testimony of witnesses and require the production of any books, papers, documentary or other evidence. The powers provided in this subsection may be delegated by the Commission to any member or employee thereof.

6. To take or cause to be taken affidavits or depositions within or without the Commonwealth.

7. To render each year to the Governor and to the General Assembly a written report of its activities.

8. To accept from the government of the United States grants of federal moneys for disbursement under the provisions of this chapter.

§ 19.2-368.11:1. Amount of award.

A. Compensation for Total Loss of Earnings: An award made pursuant to this chapter for total loss of earnings which results directly from incapacity incurred by a crime victim shall be payable during total incapacity to the victim or to such other eligible person, at a weekly compensation rate equal to 66 2/3 percent of the victim's average weekly wages. The total amount of weekly compensation shall not exceed \$600. The victim's average weekly wages shall be determined as provided in § 65.2-101.

B. Compensation for Partial Loss of Earnings: An award made pursuant to this chapter for partial loss of earnings which results directly from incapacity incurred by a crime victim shall be payable during incapacity at a weekly rate equal to 66 2/3 percent of the difference between the victim's average weekly wages before the injury and the weekly wages which the victim is able to earn thereafter. The combined total of actual weekly earnings and compensation for partial loss of earnings shall not exceed \$600 per week.

C. Compensation for Loss of Earnings of Parent of Minor Victim: The parent or guardian of a minor crime victim may receive compensation for loss of earnings, calculated as specified in subsections A and B, for time spent obtaining medical treatment for the child and for accompanying the child to, attending or participating in investigative, prosecutorial, judicial, adjudicatory and post-conviction proceedings.

D. Compensation for Dependents of a Victim Who Is Killed: If death results to a victim of crime entitled to benefits, dependents of the victim shall be entitled to compensation in accordance with the provisions of §§ 65.2-512 and 65.2-515 in an amount not to exceed the maximum aggregate payment or the maximum weekly compensation which would have been payable to the deceased victim under this section.

E. Compensation for Unreimbursed Medical Costs, Funeral Expenses, Services, etc.: Awards may also be made on claims or portions of claims based upon the claimant's actual expenses incurred as are determined by the Commission to be appropriate, for (i) unreimbursed medical expenses or indebtedness reasonably incurred for medical expenses; (ii) expenses reasonably incurred in obtaining ordinary and necessary services in lieu of those the victim would have performed, for the benefit of himself and his family, if he had not been a victim of crime; (iii) expenses directly related to funeral or burial, not to exceed \$5,000; (iv) expenses attributable to pregnancy resulting from forcible rape; (v) mental health counseling for survivors as defined under subdivisions A 2 and A 4 of § 19.2-368.4, not to exceed \$2,500 per claim; (vi) reasonable and necessary moving expenses, not to exceed \$1,000, incurred by a victim or survivors as defined under subdivisions A 2 and A 4 of § 19.2-368.4; and (vii) any other reasonable and necessary expenses and indebtedness incurred as a direct result of the injury or death upon which such claim is based, not otherwise specifically provided for. Notwithstanding any other provision of law, a person who is not eligible for an award under subsection A of § 19.2-368.4 who pays expenses directly related to funeral or burial is eligible for reimbursement subject to the limitations of this section.

F. Notwithstanding the provisions of subdivision 3 of § 19.2-368.10, §§ 19.2-368.5, 19.2-368.5:1, 19.2-368.6, 19.2-368.7, 19.2-368.8, subsection G of this section, and § 19.2-368.16, the Criminal Injuries Compensation Fund shall pay for physical evidence recovery kit examinations conducted on victims of sexual assault. Any individual that submits to and completes a physical evidence recovery kit examination shall be considered to have met the reporting and cooperation requirements of this chapter. Funds paid for physical evidence recovery kit collection shall not be offset against the Fund's maximum allowable award as provided in subsection H. Payments may be subject to negotiated agreements with the provider. Healthcare providers that complete physical evidence recovery kit examinations may bill the Fund directly subject to the provisions of § 19.2-368.5:2. The Commission shall develop policies for a distinct payment process for physical evidence recovery kit examination expenses as required under subdivision I of § 19.2-368.3.

In order for the Fund to consider additional crime-related expenses, victims shall file with the Fund following the provisions of this chapter and Criminal Injuries Compensation Fund policy.

¶ G. Any claim made pursuant to this chapter shall be reduced by the amount of any payments received or to be received as a result of the injury from or on behalf of the person who committed the crime or from any other public or private source, including an emergency award by the Commission pursuant to § 19.2-368.9.

¶ H. To qualify for an award under this chapter, a claim must have a minimum value of \$100, and payments for injury or death to a victim of crime, to the victim's dependents or to others entitled to payment for covered expenses, after being reduced as provided in subsection ¶ G, shall not exceed \$25,000 in the aggregate.

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Appendix 19: Submission of Forensic Evidence to Division of Consolidated Laboratory Services

In accordance with Executive Order 92 (2009), the Division of Consolidated Laboratory Services (DCLS) shall accept and store the Physical Evidence Recovery Kit (PERK) in cases of sexual assault “where evidence is collected from an alleged victim but that victim is not yet prepared to release personal identifying information to law enforcement.” DCLS will store the PERK for 120 days.

This Appendix contains the following documents:

- Instructions for submission of PERK evidence to DCLS
- Consent form for the release of evidence to DCLS
- Executive Order Number 92 (2009)

**Division of Consolidated Laboratory Services
600 North 5th Street
Richmond, Virginia 23219**

**Instructions for Submission of
PERK Evidence in Cases
Without Law Enforcement Reporting**

In accordance with Executive Order 92 (2009) the Division of Consolidated Laboratory Services (DCLS) shall accept and store the Physical Evidence Recovery Kit (PERK) in cases of sexual assault where the person elects not to make a report to law enforcement.

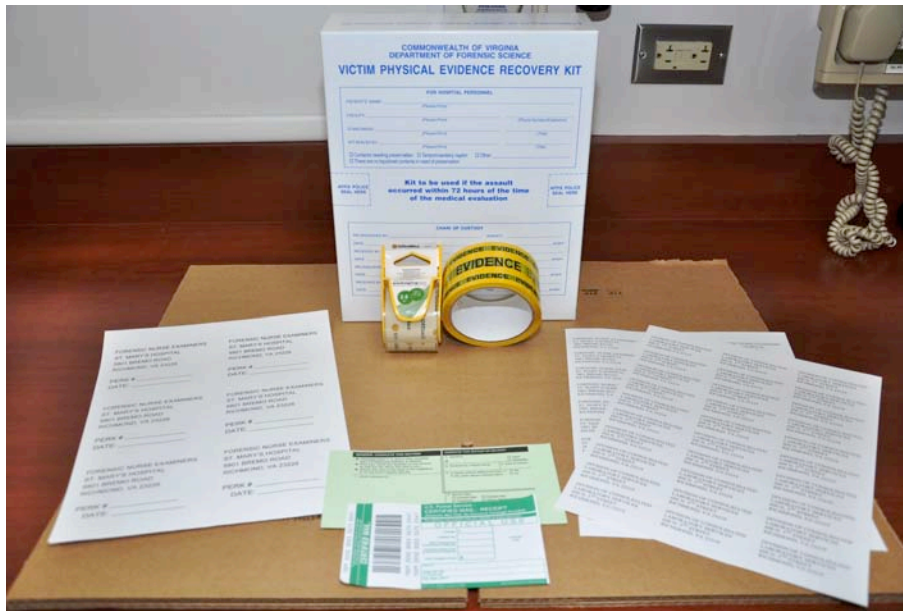
Below are instructions for packaging and submitting the PERK to the DCLS.

1. Evidence collected must be packaged within the PERK box only. Items not included in the PERK box will not be accepted, including drug screen specimens, bags of clothing or other items.
2. The PERK shall be sealed on all four sides with evidence tape or in the absence of evidence tape, a packing tape of sufficient strength to maintain a seal. All four sides of the seal shall be initialed by the healthcare provider such that part of the initials is on the surface of the box and part on the surface of the tape. The integrity of the seal must be able to withstand the rigors of shipping.
3. Clothing and/or other evidence will not be accepted unless sealed in the PERK box.
4. **No liquid biological specimens such as blood or urine will be accepted. Refrigerated storage is not available**
5. **The healthcare provider will ensure that the victim receives a written copy of the Consent for the Release of Evidence Form with the unique PERK identifier number attached. This unique PERK identifier number can be found within the box on a sheet of peel off, self-adhesive stickers. The victim will be advised that this unique number needs to be provided to law enforcement should the victim choose to make a report.**
6. The healthcare provider should affix the PERK number onto the outside of the PERK box in the designated space, so that is clearly visible.
7. After the procedures stated above are completed, the PERK shall be placed into a sturdy shipping box. The shipping box should be approximately 12" x 10" x 4". Place one of the unique numbered PERK labels to the outside of the shipping box directly beneath the return address. Legibly write the date of collection below the numbered label. (see attached photographs)
8. Upon the completion of Step Number 7, send the box via **U.S. Postal Service Certified Mail** to DCLS at the following address:

**Division of Consolidated Laboratory Services
600 North 5th Street
Richmond, Virginia 23219**

The DCLS will only store the evidence in these non-reported sexual assault cases. PERKs will not be opened. The evidence will remain in storage for a period of 120 days from receipt of the PERK. In the event the victim decides to report the assault, the investigating law enforcement agency shall request the evidence from the DCLS using the Request for Evidence Form.

If you have any questions about evidence submission, please contact Dr. Tom York (804-648-4480 X 151) or Grier Mills (804-648-4480 X 154) at the DCLS.



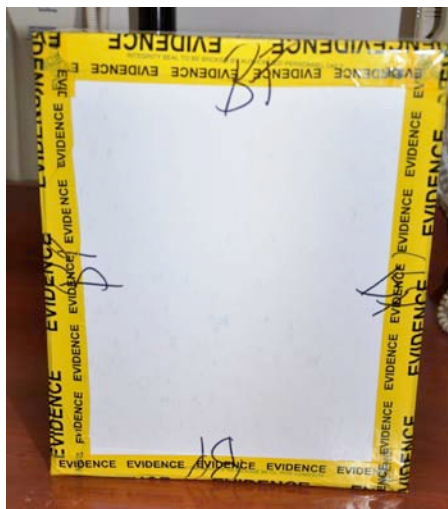
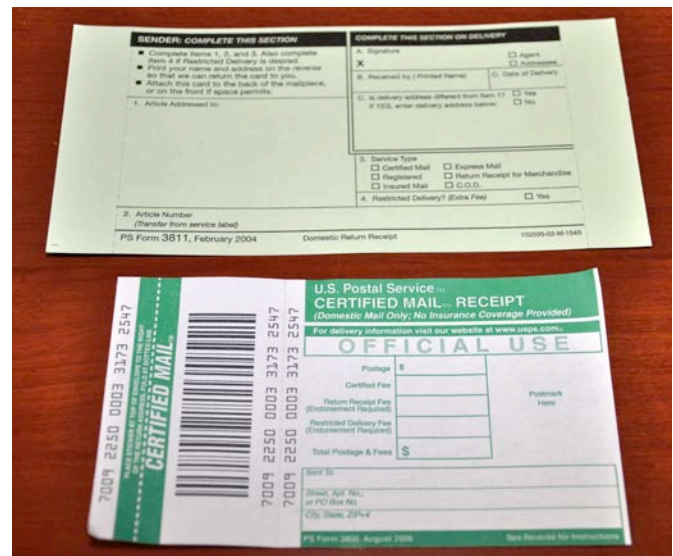
Prepare a packaging and shipping kit, to mail the PERK to DCLS.

Items needed:

1. Sturdy shipping box (apprx. 12x10x4)
2. Packing tape and evidence tape
3. Labels
4. Certified Mail Receipts

The box should be mailed via U.S. Postal Service Certified Mail to:

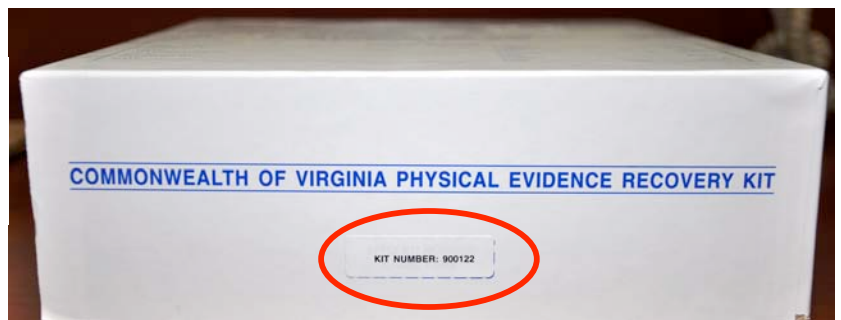
Division of Consolidated Laboratory Services
600 North 5th Street
Richmond, VA 23219



The PERK must be sealed on all four sides with tape and initialed on each side with initials on the surface of the box and on the tape.



The unique PERK number must be attached and clearly visible on the end of the PERK in the designated place.



**COMMONWEALTH OF VIRGINIA
DEPARTMENT OF FORENSIC SCIENCE
VICTIM PHYSICAL EVIDENCE RECOVERY KIT**

FOR HOSPITAL PERSONNEL

PATIENT'S NAME: _____ KIT NUMBER: 900122 (Print)

FACILITY: St. Mary's Hospital 804-281-8574
(Please Print) (Phone Number/Extension)

CLINICIAN(S): Bonnie Price, MSN, RN Forensic Nurse
(Please Print) (Title)

KIT SEALED BY: Bonnie Price, MSN, RN Forensic Nurse
(Please Print) (Title)

☐ Contents needing preservation: ☐ Tampon/sanitary napkin ☐ Other: _____
☒ There are no liquid/wet contents in need of preservation

Kit to be used if the assault occurred within 72 hours of the time of the medical evaluation

CHAIN OF CUSTODY

RELINQUISHED BY: Bonnie Price AGENCY: St. Mary's Hospital
DATE: 10/10/09 TIME: 0230
RECEIVED BY: Placed in locked mail box AGENCY: _____
DATE: _____ TIME: _____ am/pm
RELINQUISHED BY: _____ AGENCY: _____
DATE: _____ TIME: _____ am/pm
RECEIVED BY: _____ AGENCY: _____
DATE: _____ TIME: _____ am/pm

AFFIX POLICE SEAL HERE

Affix the unique PERK number onto the outside of the box, in the area designated PATIENT'S NAME.

Complete the sections for FACILITY, PHONE NUMBER, CLINICIAN and KIT SEALED BY.

Mark an X designating that the PERK has no liquid or wet contents. Wet and liquid items will not be accepted by DCLS.

Under CHAIN OF CUSTODY fill in the name, agency, date, time and where the box will be placed for shipment.



Place the sealed PERK into a sturdy box for mailing.



Seal the shipping box with packing tape. In the upper left-hand corner, place a return label with the facility's address, next place a unique numbered PERK label and below that write the date.

In the upper right-hand corner, affix the Certified Mail Receipt. The U.S. Postal Service will postmark the receipt and give it to the sender. This receipt must be placed in the patient's medical/forensic record for proof of shipment.

In the center of the box, affix a label printed with the address for DCLS. Below that label affix the completed green U.S. Postal Service Certified Mail address card. Upon receipt of the package by DCLS, this card will be mailed back to the sender and should also be placed in the patient's medical/forensic record for proof of shipment.

**CONSENT FOR THE
STORAGE OF PHYSICAL EVIDENCE
RECOVERY KIT (PERK) FOR
NON-REPORTED SEXUAL ASSAULTS**

Date of Exam:
Health Care Facility:
PERK Number:

I _____ am requesting that the evidence collected from the Physical Evidence Recovery Kit (PERK) examination be stored by the Division of Consolidated Laboratory Services. At this time, I do not want to file a report with the police, and I am not prepared to release my name to law enforcement nor provide them with the evidence collected in the PERK examination.

I have read and understand the following:

A. The benefits of filing a report with law enforcement at this time include:

- a. Law enforcement will have the opportunity to interview me about the assault and collect evidence from the crime scene(s) and from the suspect.
- b. Witnesses may be interviewed in a timely fashion.
- c. Law Enforcement will take immediate custody of the evidence collected from the PERK examination.
- d. My evidence may be analyzed by the Virginia Department of Forensic Science and may aid in the identification of the assailant and subsequent investigations and prosecution.
- e. Law enforcement can assist in addressing immediate safety concerns, and offer immediate protection to victims.
- f. I may be eligible for Crime Injuries Compensation Funds to pay for out-of-pocket expenses relating to this crime.

B. The risks of delaying a report to law enforcement and choosing not to be interviewed at this time may include:

- a. Evidence that would normally be collected by law enforcement may be permanently lost. This includes chain of custody blood and urine specimens collected in instances of suspected drug-facilitated sexual assault.
- b. Suspects and witnesses will not be interviewed, and they may not be available at a later time.
- c. It may be more difficult to successfully file charges and prosecute my case if I delay filing a police report.

C. The evidence collected from the PERK examination will be stored by the Division of Consolidated Laboratory Services.

- a. The evidence is labeled with a unique PERK number (listed on the top of this form), and my name is sealed within the evidence kit when submitted to the Division of Consolidated Laboratory Services for storage.
- b. The Division of Consolidated Laboratory Services shall not release my name or the PERK to law enforcement without my written consent.
- c. The Division of Consolidated Laboratory Services will hold the PERK for 120 days from receipt of the PERK.
- d. My PERK will not be analyzed during this time unless I choose to file a police report.
- e. After 120 days, the Division of Consolidated Labs will dispose of the PERK without any further notification to me.

D. If I decide to file a police report, it is my responsibility to call the following law enforcement agency within 120 days from receipt of the evidence:

Law enforcement agency: _____

Phone number: _____

My signature below indicates my understanding of the information above and my authorization for the Division of Consolidated Laboratory Services to dispose of the PERK 120 days from receipt PERK.

Patient Signature

Date

Health Care Providers Signature

COMMONWEALTH OF VIRGINIA



OFFICE OF THE GOVERNOR

NUMBER NINETY-TWO (2009)

DIRECTING THE DIVISION OF CONSOLIDATED LABORATORY SERVICES OF THE DEPARTMENT OF GENERAL SERVICES TO ACCEPT AND STORE PHYSICAL EVIDENCE RECOVERY KITS RECEIVED FROM HEALTH CARE PROVIDERS

Importance of the Issue

Under Section B of § 19.2-165.1 of the Code of Virginia, “*victims complaining of sexual assault shall not be required to participate in the criminal justice system or cooperate with law-enforcement authorities in order to be provided with such forensic medical exams.*”

Currently, there is a lack of clarity regarding the steps to be taken following a forensic medical examination in an instance where evidence is collected from an alleged victim but that victim is not yet prepared to release personal identifying information to law enforcement.

Law enforcement is not required by the Code of Virginia to accept responsibility for the receipt, transport, and/or storage of evidence without a report from the complainant. Health care providers are not equipped to accept the responsibility to store the evidence in a manner that preserves chain of custody and assures that it can be used in any future prosecution.

The Commonwealth is in a position to help resolve this situation and better facilitate the protection of the privacy rights of sexual assault victims and the preservation of vital evidence in the prosecution of a serious crime by providing a secure process for the acceptance and storage of physical evidence recovery kits (PERK) of alleged sexual assault victims.

Direction to the Division of Consolidated Laboratory Services

Accordingly, by virtue of the authority vested in me as Governor under Article V of the Constitution and the laws of the Commonwealth, including but not limited to Chapter 1 of Title

2.2 of the Code of Virginia, and subject always to my continuing and ultimate authority and responsibility to act in such matters, I hereby direct the Division of Consolidated Laboratory Services of the Department of General Services to accept and store evidence from Physical Evidence Recovery Kits (PERK) received from health care providers provided that:

- 1) the PERK examinations have been conducted by a health care provider on victims complaining of sexual assault under Article 7 (§ [18.2-61](#) et seq.) of Chapter 4 of Title 18.2;
- 2) the health care provider has sent the PERK to the Division of Consolidated Laboratory Services by certified mail or other method of delivery approved by the Division that meets chain of custody requirements;
- 3) the unique PERK number found within the kit is placed on the outside of the PERK and the name of the alleged victim appears on the inside of the PERK. The name of the alleged victim is not disclosed by the Consolidated Lab without the alleged victim's express written consent in advance and the Consolidated Lab meets all federal HIPAA requirements in regard to patient confidentiality;
- 4) the health care provider may include the actual costs of delivery to the Division as a medical fee incurred in gathering evidence as authorized by Section 19.2-165.1 of the Code of Virginia;
- 5) if law enforcement and/or an Attorney for the Commonwealth does not inform the Division of Consolidated Laboratory Services in writing within 120 days of the receipt of the PERK kit by the Division that the alleged victim has proceeded with a report to law enforcement, the Division shall dispose of the PERK.

This Executive Order shall be effective September 30, 2009 and shall remain in full force and effect unless amended or rescinded by further executive order.

Given under my hand and under the Seal of the Commonwealth of Virginia this 28th day of September 2009.

Timothy M. Kaine, Governor

Attest:

Appendix 20: References

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