

Surname	UMRN / MRN		
Given Name	DOB	Gender	
Address		Post Code	
	Telephone		
	Given Name	Given Name DOB Address	

This form is for use in Emergency for patients aged 13+ years who allege sexual assault

ALWAYS CONTACT SARC: Phone (08) 6458 1828 (24 hours / 7 days) or After Hours SARC Doctor available direct via KEMH switchboard (08) 6458 2222

Support person present: VES NO	"Can we contact	anyone for you	? "				
Support person present: YES NO "Can we contact anyone for you?"							
"I need to ask some questions about what happened so we can help and support you"							
BRIEF DETAILS OF ASSAULT	Date of assault:		Time of assaul	lt:			
TYPE OF ASSAULT	☐ Vaginal ☐ Oral ☐ Anal ☐ Penis			nis			
Penetrated with (e.g. penis, finger, object)							
Condom used: Yes No		Ejaculation:	☐ Yes ☐ No				
QUESTIONS To determine medical review				YES	NO		
Have you sustained any injuries or are you in	n pain? (exclude m	inor genital disc	omfort / soreness)				
Did you experience a blow to the head or los	ss of consciousness	?					
Was any pressure applied to your neck by any means?							
Do you have any vaginal or anal bleeding?							
For female patients: Could you be pregnant?							
Date of last period: Are you on any contraception?							
Do you have safe accommodation?							
Do you have any children under 18 years of age? (If YES , ask if they are safe?)							
Do you have current or recent past mental health issues? (assess suicidality / self-harm)							
If YES to any questions above the patient ma	ay need to be revie	wed by a doctor					
FORENSIC QUESTIONS			YES	NO			
Did you know the person who did this prior to	this incident?						
Are the police involved?							
(If no current police involvement) Do you wish to report to the police? Have you passed urine since it happened?							
If anal assault, have you opened your bowels since it happened?							
Have you had a shower or bath since it happened?							
Have you changed clothes since the incident?							
"It will be helpful for us to know as part of your physical and forensic assessment whether you have used alcohol or drugs in the past 24 hours"							
☐ Alcohol consumed (number of units):							
☐ Drugs consumed (type and amount):							

WACHS SARC Emergency Care: History & Checklist Doctor: Date: Doctor: Date: Doctor: Date: CLINICAL MANAGEMENT – after discussion with SARC Doctor, some of the following medications may be required: Emergency Contraception Azithromycin 1g (PO) Ceftriaxone 500mg IM/IV Hepatitis B trimunoglobulin Hepatitis B vaccination HIV NPEP required (call SARC for advice) Has a mandatory report been made? YES NO N/A (If <18yrs, mandatory reporting obligations apply). Please see: www.health.wa.gov.au/mandatoryreport. FORENSIC MANAGEMENT IF CLIENT CONSENTS TO FORENSIC SAMPLING (Call SARC ASAP for advice on sample collection and storage) Early Evidence kit collected (please indicate below which specimens taken) YES NO Oral rinse Vulval / penile wipe Anal wipe First void urine Toxicology: Urine Toxicology: Blood Clothing collected (use paper bags, one item per bag) YES NO Full Forensic Examination Kit collected YES NO Full Forensic Examination Kit collected YES NO Samples collected by: Samples provided to (name of police officer): SUPPORT Referred to support service SARC Metro Social Work SARC Regional SARC Metro Social Work Counselling Services Relationships Australia Other: Contact made with: Nurse Name (please print): Doctor Name (please print): Nurse Signature: Doctor Signature: Date & Time: Date & Time: Date & Time: Doctor Signature: Date & Time: Doctor Signature: Date & Time: Doctor Signature: Doctor Signature: Doctor Signature: Date & Time: Doctor Signature: Date & Ti		Surname		UMRN / MRN	
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Comments:	Comments:				

Any questions? Ph: (08) 6458 1828 or via KEMH Switchboard 08 6458 2222