Cindy Jennings BSN, RN, CEN, SANE-A
SANE Program Coordinator
Miami Valley Hospital

- SANE – Sexual Assault Nurse Examiner
- FNE – Forensic Nurse Examiner
- SAFE – Sexual Assault Forensic Examiner
- IAFN – International Association of Forensic Nurses
- SART – Sexual Assault Response Team

- Original SANE Programs
  - Memphis, Tennessee 1976
  - Minneapolis, Minnesota 1977
  - Amarillo, Texas 1979
- Slow growth of programs although not widely recognized until late 1980's.
- In 1991, list of 20 SANE programs published in *Journal of Emergency Nursing.*

- Thirty-one independent programs came together to found the

- First national meeting in 1992.
- Responsible for developing standards for practice and education.
- Credentialing body.

- Forensic nursing recognized as a new specialty of nursing in 1995 by the American Nurses Association.
- SANE is the largest subspecialty of forensic nursing.
- SANE programs are predicted to become the standard of care for sexual assault victims required by JCAHO by 2010

- To meet the needs of the sexual assault patient by providing immediate, compassionate, culturally sensitive, and comprehensive medical - forensic evaluation and treatment by trained, professional nurse experts within the parameters of the individual's State Nurse Practice Act, the SANE standards of the IAFN, and the individual's agency/community policies.

- To protect the patient from further harm.
- To provided crisis intervention.
- To provide timely, thorough, and professional forensic evidence collection, documentation, and preservation of evidence.
- To evaluate and treat prophylactically for sexually transmitted diseases.
- To evaluate pregnancy risk and offer prevention.
- To assess, document, and seek care for injuries.
- To appropriately refer victims for immediate and follow-up medical care and follow-up counseling.
- To enhance the ability of law enforcement agencies to obtain evidence and successfully prosecute sexual assault cases.

PROCEDURE FOR SEXUAL ASSAULT/ABUSE EVIDENCE COLLECTION

⇨All Steps Required by the Ohio Protocol for Sexual Assault Forensic and Medical Examination⇦

Please proceed in numerical order and complete all steps. If the patient declines a step, write "patient declined" on the collection envelope. These items may be used in court to prosecute a sexual assault/abuse case. Therefore, it is important to follow instructions and write legibly. Remove strip to seal envelopes (do not lick). The **Assault/Abuse History** and **After Care Information and Resources** forms are for your convenience and may be replaced by institutional forms. **Steps 8, 13 and 15 apply only to children.**

⇨⇨If this is a SUSPECT collection, please see separate instructions on RED paper⇦⇦

☐Step 1 "Information You Should Know…" and Consent for Exam and Release of Evidence. **(Release Not Necessary for Child Abuse Cases)**

☐Step 2 Assault/Abuse History Form ***KIT COPY MUST BE READABLE***

☐Step 3 If indicated – urine and blood samples for drug testing

☐Step 4 Clothing Collection—***underwear required***

☐Step 5 Dried stains--perform at time of external physical examination

☐Step 6 **Cut** Head Hair Standards

☐Step 7 Oral Swabs and Smear. **Collect regardless of type of assault/abuse.**

☐Step 8 **Children Only**--Oral Culture (if indicated) **DO NOT PUT CULTURE IN EVIDENCE BOX. Send to hospital/facility lab.**

☐Step 9 Fingernail scrapings/swabbings/cuttings

☐Step 10 Pubic hair **combings**

☐Step 11 **Cut** Pubic hair **standards**

☐Step 12 Anal/perianal Swabs and Smears. **Collect regardless of type of assault/abuse.**

☐Step 13 **Children Only**--Anal/perianal Culture if indicated) **DO NOT PUT CULTURE IN EVIDENCE BOX.** Send to hospital lab.

☐Step 14 Vaginal (or penile) Swabs and Smear. **Collect regardless of type of assault/abuse.**

☐Step 15 **Children Only**--Vaginal Culture (if indicated) **DO NOT PUT CULTURE IN EVIDENCE BOX. Send to hospital/facility lab.**.

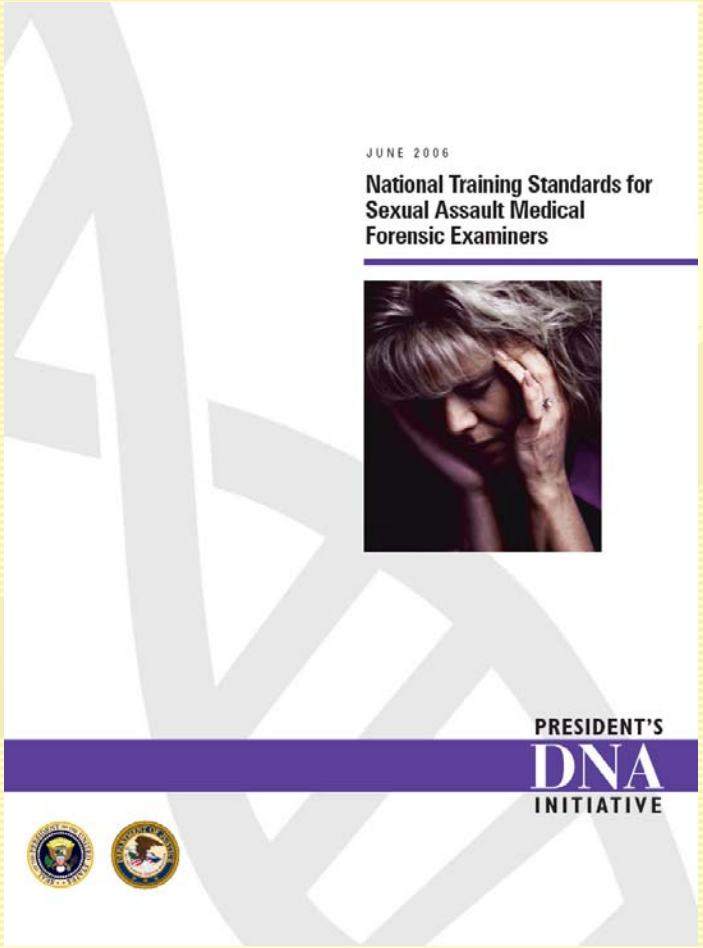
☐Step 16 Blood standard

☐Step 17 Complete documentation of all injuries.

☐Step 18 Give **After Care Information and Resources** form to patient.

☐Step 19 Seal Kit. Complete information on box lid. Complete **Chain of Custody** and release kit and clothing bags to law enforcement.

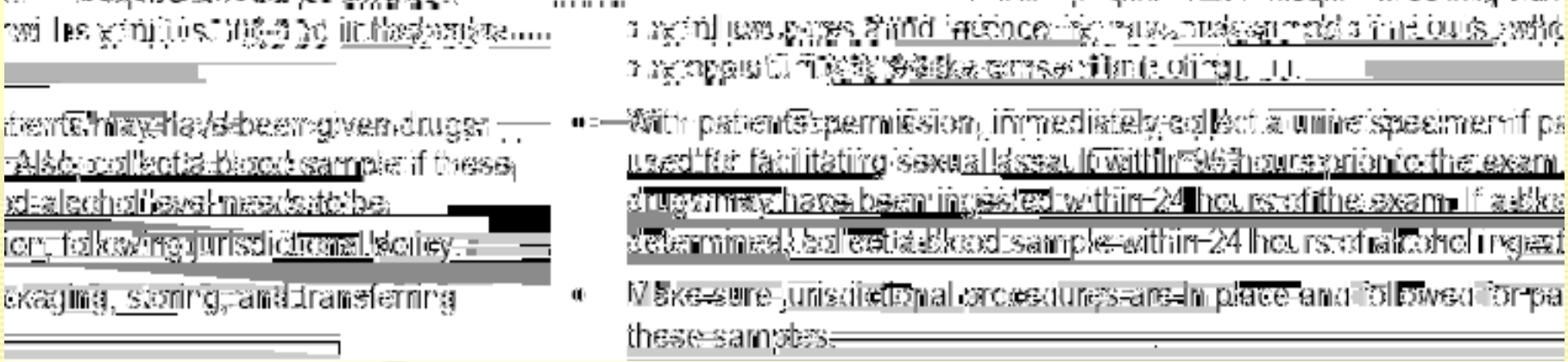
- Literature review
- Traditional relationship
  - DFSA
- Standards and protocols
  - Federal
  - State



7. Drug-Facilitated Sexual Assault

Recommendations at a glance for jurisdictions and responders to facilitate response in suspected drug-facilitated sexual assault:

- Educate examiners, 911 dispatchers, law enforcement representatives, prosecutors, judges, and advocates on issues related to drug-facilitated sexual assault. Develop policies to clarify first responders' roles in cases involving suspected drug-facilitated assault.
- Be clear about the circumstances in which toxicology testing may be indicated. Routine testing is not recommended.
- Informed consent of patients to collect toxicology samples should be sought. Prior to giving consent, patients should be aware of the purposes and scope of testing, potential benefits and consequences,



MIAMI VALLEY HOSPITAL
DAYTON OHIO 45409

CONSENT FOR DRUG TESTING
POST SEXUAL ASSAULT

Part of your forensic examination and collection of evidence, post sexual assault, may include blood, urine, and vomit ... for drugs given during or before a sexual ... vomitus will be tested for drugs including, but not limited to the following:

(Benadryl)
asy GHB Ketamine
) Opiates (Vicodin, Percocet,

Alcohol Antidepressant (Prozac, Celexa, Lexapro) Antihistamines
Benzodiazepines (Valium, Xanax, Ativan, Rohypnol) Cocaine Ecst
Marijuana Methamphetamine Muscle Relaxants (Soma, Flexeril)
Oxycontin, Heroin)

of the drugs may have left your body

A negative test result does not mean that drugs were not used. Evidence o
before the test was done.

r on your drug test. The
s, the prosecutor's office, and
aw. In criminal case
al defense attorney and may
s conflict ... lead to
... conditions.

All drugs, over the counter, prescription, and illegal drugs, will appea
results of your drugs test may be released to law enforcement agencie
defense attorneys, in accordance with your authorization and/or the l
against your assailant, your test results will be available to the crimin
become public knowledge, even if unrelated to the sexual assault. Th
the release of your private health information such as medical condi

torily explained terms and all

The drug testing procedure, in the respective terms have been satisfac
of my questions have been answered to my satisfaction.

I have read and fully understand this document.

I voluntarily consent to the drug testing.

Witness) (Date) (Patient or Guardian Signature) (

☐ HCPOA ☐ Executor ☐ Guardianship forms received

MEDICAL PERSONNEL USE ONLY

me of exam ______

Patient Name ______ DOB ______ Date and ti
Date and time of assault ______ Reason for drug testing ______

e/Time of Vomitus draw ______
s than 24 hours)
e in specimen cup)

Date/Time of blood draw ______
(Less than 24 hours from assault)
(2 10-ml grey topped tubes)

Date/Time of Urine draw ______
(Less than 96 hours from assault)
(20-ml of urine)

Dat
(Less
(Plac

the counter medications over past month:

Current prescription medication taken:

Illegal and over

MVH Miami Valley Hospital

Health Information Management
One Wyoming Street (937) 208-3060
Dayton, Ohio 45409-2793

IMPORTANT MESSAGE - PLEASE READ:
Charges may apply to this request. Allow 7-10 working days after completion of Medical Record.
All medical records will be mailed unless otherwise specified.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, the below identified person, do hereby authorize the release of my medical information, as indicated herein, between the following parties:

From: Miami Valley Hospital
Emergency Department
One Wyoming Street
Dayton, Ohio 45409

To: Miami Valley Regional Crime
Laboratory
361 West Third Street
Dayton, OH 45402

I authorize this release of information to either ☐ verify services rendered to process a claim for benefits, ☐ to provide continuity to my medical care, ☐ at the request of the individual, ☐ other _____

I understand that the information I authorize a person or entity to receive may be redisclosed and no longer protected by Federal privacy regulations. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment. I understand that this authorization shall remain in effect for one (1) year from the date of my signature below unless I specify an earlier expiration date in this space _____. I understand that except to the extent that action has been taken in reliance on my authorization, I may revoke this authorization at any time by writing to the person involved (see Notice of Privacy Practices).

It is my desire that only the information in my ☐ inpatient record, ☐ clinic record, ☐ emergency record, ☐ ambulatory testing (please check the appropriate boxes) indicated below is to be released as a result of this authorization:

☐ Face Sheet	☐ Laboratory Reports	☐ Therapy Reports
☐ History & Physical	☐ Operative Reports	☐ Emergency Treatment
☐ Discharge Summary	☐ Pathology Reports	☐ Other specified here: _____
☐ Consultation Reports	☐ Physician Progress Notes	_____
☐ Radiology Reports	☐ Physician Orders	☐ Sexual Assault Report

I am also making the following additional qualification: **IF** the information specified above contains information related to treatment for drug and/or alcohol abuse or for psychiatric and/or mental conditions, or HIV test results or diagnosis, I **am** including this type of information to be released in association with this authorization.

(Date) _____ (Patient or Guardian Signature) _____ (Witness) _____

☐ HCPOA ☐ Executor ☐ Guardianship forms received

To assist you, I am providing the following additional identifying information:

(Print Name When Treated) _____ (Street) _____

(Date of Birth) _____ (City) _____ (State) _____ (Zip) _____

(Social Security #) _____ (Dates of Treatment) _____

Reason patient is unable to sign: _____