# STEP 1

# PATIENT CONSENT FOR EXAM

## FORENSIC MEDICAL REPORT: ADULT/ADOLESCENT SEX CRIME EXAMINATION

**Confidential Document** | **Patient Identification Label**

## A. GENERAL INFORMATION (PRINT CLEARLY – PRESS FIRMLY OR TYPE)

**1. Name of Patient**

| **2. Address** | **City** | **State** | **Zip Code** | **Telephone (W) (H)** |
|---|---|---|---|---|
| | | | | |

| **3. Age** | **DOB** | **Gender** | **Ethnicity** | **Date/Time of Arrival** |
|---|---|---|---|---|
| | | | | |

## B. REPORTING

**Jurisdiction** ☐ **City** ☐ **County** ☐ **Federal** ☐ **Tribal** ☐ **Other:**

| **Name of Responding Officer** | **Agency** | **ID Number** | **Telephone** | **Case#** |
|---|---|---|---|---|
| | | | | |

## C. PATIENT INFORMATION

Health care professionals are required by law to report to the proper authorities cases in which medical care is sought for gunshot or stab wound injuries (MCA 37-2-302). Medical personnel are also required to report cases involving child abuse (under age 18), elder abuse (over age 60) and abuse of the developmentally disabled (MCA 41-3-201, 52-3-811).

Medical information contained in this report is confidential and protected under state law. However, patient information, without patient authorization, may be released upon court order; may be released to a law enforcement officer about the general physical condition of a patient being treated in a health care facility if the patient was injured by the possible criminal act of another (50-16-503(4); and (MCA 50-16-525), e.g., for statistical purposes, and as required when necessary to implement or enforce state statutes or local health rules concerning the prevention or control of reportable diseases (MCA 50-1-202).

Victims of crime are eligible to submit crime victim compensation claims to the Office of Crime Victim Services for out-of-pocket medical expenses and psychological counseling. In order to be eligible for compensation, a crime must be reported to law enforcement within 120 hours of occurrence or show good cause why it was not reported in that time frame.

## D. PATIENT CONSENT

A forensic medical examination can, with your consent, be conducted to collect evidence of a sex crime. The forensic examination consists of the following procedures: Obtain pertinent patient/assault history; Perform physical examination; Administer appropriate medical treatment; Screen for pregnancy and/or administer medications for pregnancy prophylaxis, if appropriate; Screen for sexually transmitted diseases and/or administer medications for STD prophylaxis, if appropriate; Collect evidence including, but not limited to, clothing, swabs of stains/debris, fingernail swabs, vaginal swabs, rectal swabs, and reference DNA sample; Collect blood and urine specimens for drug/alcohol testing (toxicology), if indicated; Photograph physical injuries - which may include genital area - to be used as evidence; Release evidence collected and information obtained to law enforcement.

Please check a box below:

☐ I request to report this sexual assault to the law enforcement agency that has jurisdiction of where the assault occurred and have forensic evidence collected. I understand that the law enforcement agency shall send my Sexual Assault Evidence Kit to the Montana State Crime Lab within 30 days

☐ I do not want to report this sexual assault at this time to any law enforcement agency, but I request to have forensic evidence collected. I understand that my Sexual Assault Evidence Kit will be sent to the FREPP program within the Montana Department of Justice Office of Victim Services. My Sexual Assault Evidence Kit will remain in the FREPP program until I file a report with a law enforcement agency or contact the Office of Victim Services. I acknowledge if I do not file a report within one (1) year then the Office of Victim Services may destroy my Sexual Assault Evidence Kit.

☐ I do not want to report this sexual assault at this time. I decline any forensic evidence collection. I only request to be evaluated by a medical provider.

☐ I do not want to report this sexual assault at this time. I decline any forensic evidence collection. And I decline to be seen by a medical provider at this time.

Patient Request:

☐ I request that a victim-witness advocate be contacted on my behalf

☐ Other request (specify): _____

If I choose to report to law enforcement, I authorize the agents of the above named medical facility to release the medical report and evidence collected to the appropriate law enforcement agency.

I understand that this is not a routine medical checkup, and that the clinician doing the exam will not be held responsible for identifying, diagnosing, or treating any existing medical problems. I hereby waive all medical privilege in connection with the examination, treatment, and evidence found. I expressly authorize the use of such information/evidence in any subsequent criminal proceedings against the assailant(s). I also consent to the review of the medical/forensic evaluation by a multidisciplinary team for the purpose of coordinating the investigation and interventions. The multidisciplinary team may include professionals from many disciplines including law enforcement, prosecution, child protection, mental health/advocacy and health care.

Signature of Patient (or Guardian-Relationship) Date

Clinician Signature Date

**DISTRIBUTE ALL PAGES OF THIS DOCUMENT AS LISTED BELOW**