

STEP 14

PATIENT INFORMATION FORM

Kit Number: _____

Hospital Name: _____

Hospital Telephone Number: _____

Date of Examination: _____

(Month/Day/Year)

Patient label: (top copy only)

With your consent, the following tests were conducted (check all that apply):

- Pregnancy Test Gonorrhea Chlamydia
- Trichomonas Hepatitis B HIV nPEP baseline labs
- Syphilis Hepatitis C Other _____

The following is a list of medications you were given. We recommend that you follow-up with your provider as directed to ensure that this treatment was effective.

<u>Medication</u>	<u>Dose and Instructions</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

- You chose not to be given medication that could prevent sexually transmitted infections.
- You chose not to be given medication that could prevent pregnancy, the time frame had passed when Emergency Pregnancy Prevention would have been considered effective, or is not applicable.
- You were given medicine called post-exposure prophylaxis (PEP) to reduce the risk of you becoming infected with HIV. You were given a copy of the **HIV PROPHYLAXIS (HIV N PEP) PATIENT INFORMATION FORM (STEP 15A)**. For more information on HIV PEP medications and side effects call the **National HIV N PEP Hotline at 1-888-448-4911** and/or log onto the Centers for Disease Control website at www.cdc.gov.
- Samples were obtained to look for suspected drug facilitated sexual assault. The samples are not evaluated by the hospital laboratory. Information regarding the results should be obtained through the investigating law enforcement agency. If you are reporting ANONYMOUSLY, the samples will NOT be analyzed until you report the crime to law enforcement.
- You have chosen to have the evidence collection obtained ANONYMOUSLY. If you choose to report the crime to law enforcement, **please call the _____ police department at this phone number _____**. The SERIAL NUMBER identifying your kit is _____. **You can report your sexual assault to law enforcement at any time.** If you choose not to report the crime, the evidence will not be analyzed.
- Under the law, NH health care professionals are obligated to report all cases of suspected child abuse or elder/vulnerable adult abuse. Because of the circumstances that brought you in today, a report has been/will be made with the following agencies:
 - NH Division of Children Youth and Families (1-800-894-5533)
 - NH Bureau of Elderly & Adult Services (1-800-949-0470)
 - Other _____

You have been given the following documentation:

- FOLLOW UP EXAMINATION VOUCHER FORM.**
- SEXUAL ASSAULT CRISIS CENTER LIST** for follow up support and confidential free services.
- NH CRIME VICTIM'S BILL OF RIGHTS.**
- FINANCIAL ASSISTANCE FOR VICTIMS CARD.**

If you do not have medical insurance, the State of NH will pay for the cost of this evaluation. If you have insurance, please be sure all necessary information is forwarded to the hospital for billing purposes.

Patient Signature _____

Date: _____

Examiner Signature _____

Time: _____