

**Kentucky Claims Commission - Crime Victims Compensation
Sexual Assault Exam Program
500 Mero St., 2SC1, Frankfort, KY 40601
Office 502-782-8255 Fax 502-573-4817**

SAFE EVIDENTIARY REPORT

GENERAL INFORMATION

Patient Name: _____ Date of Birth: _____

Facility: _____

LAB ORDERS

____ CBC w/o Diff, Hepatic Function Panel, Creatinine (Serum) (if giving HIV n PEP)

____ Urine Pregnancy Test ____ Lab HcG ____ HIV 1-2 ____ Toxicology Testing ____ RPR

MEDICATION

____ Rocephin ____ Metronidazole ____ Azithromycin ____ Lidocaine

____ Plan B (levonorgestrel) Other : _____

____ Promethazine ____ Odansetron ____ NPEP Starter Kit

SAMPLES COLLECTED

Reference Samples: ____ Blood ____ Buccal ____ Hair

Source Samples: ____ Oral ____ Vaginal ____ Cervical ____ Anal Swabs ____ External Genital Swabs

EXAM / ASSESSMENTS

____ Genital Examination ____ Inspect / Palpate ____ Toluidine Blue Dye

____ Alternate Light Source ____ Photo Documentation ____ Head to Toe Assessment

____ Speculum ____ Colposcope

FORENSIC EXAMINER INFORMATION

Printed Name and Title of Examiner

License Number

Examiner Signature

Date

Physician, SANE, Physician Assistant or Advanced Practice Registered Nurse
whose training and/or scope of practice includes performance of genital examinations
(Examiner Fee \$200.00)