Step 1

Ohio Department of Health Consent For Exam, Photographs, and Release of Evidence

***** Place Copy of Consent in Kit. Keep original with Medical Record*****

PAYMENT/ADVOCACY (Initial both)

______ I understand that I will **not** be charged for the antibiotics and evidence collection exam. Any other medications and medical treatment including but not limited to x-rays and blood work will be billed to me, my insurance or another named party for payment.

______ I understand that I may have a support person or advocate of my choosing with me during all or part of the exam, including the assault history and genital exam.

MEDICAL FORENSIC EXAM/PHOTO DOCUMENTATION

______ I consent to the medical forensic exam and evidence collection. I understand that I can decline any portion of the exam or any portion of the evidence collection process. (A minor patient does not have to have consent of a parent or legal guardian before proceeding with the exam.)

_____ I consent to photo documentation which may include my genitals. I understand that I can decline any portion of photo documentation including photo documentation of my genitals.

REPORTING

_____I understand the hospital is legally required to report sexual assaults to law enforcement. My name and contact information will be given to law enforcement. I understand that the hospital is legally required to report all abuse or suspected abuse of patients 17 years of age or younger to the Department of Children Services. For patients 17 years or younger, the hospital is required to send a letter to the parent or legal guardian notifying them of the exam. The sexual assault evidence collection kit and toxicology samples for drug-facilitated sexual assault will be given to law enforcement and may be tested at a crime lab.

Patients 18 years or older (Initial one)

_____ I agree to speak to law enforcement. I understand that my name and contact information will be provided.

_____ I **DO NOT** agree to speak with law enforcement at this time. My name and contact information will be given to law enforcement. I understand that law enforcement may attempt to contact me. I understand that I am not obligated to participate in the investigation of this crime, but that law enforcement may investigate it.

_____________________________________ ____________ _______________
Signature of patient or guardian Date Time

____
Print name

____
Relationship if other than patient