



REPLY TO  
ATTENTION OF

**DEPARTMENT OF THE ARMY**  
HEADQUARTERS, U. S. ARMY MEDICAL COMMAND  
2050 WORTH ROAD  
FORT SAM HOUSTON, TEXAS 78234-6000

MCCG

OTSG/MEDCOM Policy Memo 04-009

Expires 27 JUL 06

**27 JUL 2004**

MEMORANDUM FOR

COMMANDERS, MEDCOM REGIONAL MEDICAL COMMANDS  
COMMANDERS, MEDCOM REGIONAL DENTAL COMMANDS  
COMMANDER, 18TH MEDICAL COMMAND

SUBJECT: Medical Treatment Facility Management of Reported Alleged Sexual Assault Cases

1. References:

- a. Army Regulation (AR) 40-3, Medical, Dental, and Veterinary Care, 12 Nov 02.
- b. AR 25-50, Preparing and Managing Correspondence, 3 Jun 02.
- c. AR 40-66, Medical Records Administration and Health Care Documentation, 10 Mar 03.
- d. AR 40-68, Clinical Quality Management, 26 Feb 04.
- e. AR 40-400, Patient Administration, 12 Mar 01.
- f. AR 190-22, Searches, Seizures, and Disposition of Property, 1 Jan 83.
- g. AR 195-5, Evidence Procedures, 28 Aug 92.
- h. AR 608-18, The Army Family Advocacy Program, 20 Oct 03.
- i. Articles 120 and 134, Manual for Courts Martial, 84.
- j. Bamberger, J.D., et al. Post-Exposure Prophylaxis for HIV Infection Following Sexual Assault, American Journal of Medicine, 106:323-6, Mar 99.
- k. Centers for Disease Control, Morbidity and Mortality Weekly Report, 51(RR06); 1-80, 10 May 02.  
<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5106a1.htm#AssaultSTDs>

MCCG

SUBJECT: Medical Treatment Facility Management of Reported Alleged Sexual Assault Cases

- l. Department of Defense Directive (DODD) 6025.18, Privacy of Individually Identifiable Health Information in DOD Health Care Programs, 19 Dec 02.
- m. DOD Instruction 4000.19, Interservice and Intragovernmental Support, 9 Aug 95.
- n. Field Manual 19-20, Law Enforcement Investigations, 15 Nov 85.
- o. Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Accreditation Manuals, current edition.
- p. MEDCOM Regulation 40-36, Medical Facility Management of Sexual Assault, 2 Feb 95.
- q. National Center for Human Immunodeficiency Virus (HIV), Sexually Transmitted Diseases (STD) and TB Prevention, Division of STD Treatment Guidelines, 02.
- r. Sexual Battery: Management of the Rape Gynecology and Obstetrics, John J. Sciarra, ed., J.G. Lippincott Company, 95.
- s. Stenchever, Morton A.; Droegmuller, William; Herbst, Arthur L.; Mishell, Daniel R.; Comprehensive Gynecology, 4th Edition. Mosby, 6 Sep 02.
- t. Technical Bulletin, Med 293, Procedures for Medicolegal Examinations in Alleged Sex Crime, 30 May 75.

2. Purpose: This memorandum augments MEDCOM Regulation 40-36 and applies to all personnel delineated in paragraph 3 of that regulation. Together, these two documents prescribe the minimal policies, procedures, and responsibilities for managing alleged sexual assault cases and provide a template for medical treatment facilities (MTFs) to use in designing their own sexual assault management programs.

3. Proponent: The proponent for this policy is the USAMEDCOM, Directorate of Health Policy and Services (MCHO-CL-H), 2050 Worth Road, Suite 10, Fort Sam Houston, TX 78234-6010.

4. Responsibilities: (Also see MEDCOM Regulation 40-36.)

a. Each MTF commander will have overall responsibility for implementation of a sexual assault management program. This program will—

- (1) Adhere to the provisions of this memorandum.

MCCG

SUBJECT: Medical Treatment Facility Management of Reported Alleged Sexual Assault Cases

(2) Receive widest dissemination to MTF personnel.

(3) Be reviewed and updated annually.

b. MTF personnel having contact or potential contact with sexual assault patients will participate in annual sexual assault awareness training (see MEDCOM Regulation 40-36).

c. The Emergency Medical Department/Service (EMD/S)/Urgent Care Clinic charge nurse or triage coordinator will—(Also see Appendix A.)

(1) Notify the health care provider on-call for examination of sexual assault patients.

(a) The obstetrics/gynecology (OB/GYN) physician on-call will be the examining physician if the patient is female. If the OB/GYN physician on-call is unable to respond in a timely manner, the family practitioner (FP) on-call will be notified. The Deputy Commander for Clinical Services will be notified immediately of any difficulty in obtaining a provider to care for the patient.

(b) The pediatrician/FP on-call will be the examining physician if the patient is under 18 years of age. All female examinations should be performed in consultation with OB/GYN.

(c) The FP/internal medicine physician on-call will be the examining physician if the male patient is 18 years or older.

(2) Coordinate the involvement of supplemental personnel to report or stand by, as needed, by contacting—

(a) The Provost Marshall's Office, who coordinates with the Criminal Investigation Division (CID), if the patient presents without prior military police (MP) or CID notification. If a memorandum of understanding has been established for non-federal property jurisdiction, notify the appropriate city or county law enforcement agency. Notification of non-federal property jurisdiction agencies is an official act of the commander or the commander's representative appointed for this purpose.

(b) The on-call behavioral health crisis counselor and/or patient advocate assigned to respond to sexual assault cases who will establish immediate contact with the patient and ensure crisis counseling and support is provided (see Appendix B).

(c) The laboratory technician who will receive some of the evidence collected during the examination (i.e., stat lab work).

MCCG

SUBJECT: Medical Treatment Facility Management of Reported Alleged Sexual Assault Cases

(d) The Patient Administration Division (PAD) (administrative officer of the day after duty hours) for records management and release of information to law enforcement agencies (see Appendix C of this memorandum, AR 40-66, and DODD 6025.18). PAD will ensure that the SF 558 (Medical Record - Emergency Care and Treatment) original is filed in the health record (HREC), outpatient treatment record (OTR), or civilian employee medical record (CEMR) and that the entire record is secured in a locked file in PAD. Accountability of the HREC, OTR, or CEMR should be maintained using the OF 23 (Charge-Out Record) or another charge-out system (e.g., the automated record charge-out using bar codes in the Composite Health Care System).

(e) The service member patient's chain of command. Only name, age, unit, and rank may be provided; patient health information will not be provided.

(f) The on-call chaplain who will immediately contact the patient to establish pastoral support (see Appendix D).

(3) Treat the patient with compassion and sensitivity and ensure the maintenance of patient privacy to the maximum extent possible including minimizing the number of persons required to be involved with the patient at one time.

(4) Ensure staff members who will be involved in the medicolegal examination are familiar with the contents of the Sexual Assault Determination (SAD) Kit and the procedure for performing the examination before entering the patient room. Have at least one SAD Kit on hand at all times to avoid delay in providing care.

(5) Receive the patient and assess the need for emergency care.

(6) Move the patient to the trauma room, if indicated. If stable, move to a location where privacy can be maintained and continue to triage the patient.

(7) Triage the patient as "emergency" to be seen after higher priority emergencies.

(8) Explain the evidence collection procedure (see Appendix E) to the patient.

(9) Prepare consent documentation relevant to the age of the patient.

(10) Appoint one individual (preferably the same sex as the patient) to remain with the patient at all times. This may be a medic, nurse, a behavioral health crisis counselor, patient advocate, or a representative from the chaplain's office.

MCCG

SUBJECT: Medical Treatment Facility Management of Reported Alleged Sexual Assault Cases

(11) Ensure that one person familiar with the SAD Kit is identified to assist the health care provider in collecting evidence. Personnel available to support the health care provider and patient may come from the MTF and/or military and civilian community as previously arranged through memorandums of agreement (MOA). An assistant of the same sex as the patient is preferred. If the MTF or community advocate who is there to support the patient is not the same sex as the patient and/or cannot be present when the medical examination is performed or forensic evidence is collected, the same-sex assistant will be utilized.

(12) Provide written discharge instructions to the patient, making every effort to ensure his/her understanding. If possible, include another responsible adult in the discussion of discharge instructions. Discharge instructions will include as a minimum—

(a) How to take medications given.

(b) Confirmation of follow-up appointments for examination within 48-72 hours. Explain that this examination is a general physical examination because bruising may take a few days to develop. Pelvic/rectal examinations do not need to be repeated unless specific complaints develop.

d. The health care provider will:

(1) Treat the patient with compassion and sensitivity.

(2) Determine which facility would be most appropriate for the care of minors (i.e., civilians below the age of 18 who are not emancipated by reason of marriage) who have been sexually assaulted.

(3) For males, determine appropriate health care provider based on the patient's injuries.

(4) Support the senior medical officer's decision (para 5.d.) to provide care locally or refer for emergency medical treatment as indicated. Determine if there is a medical contraindication to an interview by MP and/or CID investigators.

(5) If contraindications exist to an interview by investigators, brief the investigators as to details of the event and the assailant, as described by the patient.

(6) Direct movement of the patient to a trauma room if the patient is not stable. The medicolegal examination can be performed in the operating room while the patient is under anesthesia if conditions warrant.

(7) Assess the current emotional status of the patient.

**MCCG**

**SUBJECT: Medical Treatment Facility Management of Reported Alleged Sexual Assault Cases**

(8) Obtain the patient's written consent for the medicolegal examination and its release to the appropriate investigative agency. This is done according to instructions in MEDCOM Reg 40-36 using DA Form 4700/MEDCOM OP 29-2-R (Sexual Assault Patient Release Statement).

(9) Ensure that the patient is not disrobed if the medical examination is not immediately required for reported injuries. If immediate treatment is needed for a patient who is stable, clothing is removed and collected according to the protocol in the SAD Kit. Allowing the patient to remain clothed for as long as possible adds to the patient's comfort and sense of control over the situation.

(10) Conduct a complete sexual assault examination on female patients 14 years old and older according to instructions enclosed with the SAD Kit.

(11) Conduct a complete sexual assault examination on adult male patients according to the SAD Kit.

(12) Ensure that the proper chain of custody for any collected evidence is established and maintained using DA Form 4137 (Evidence/Property Custody Document).

(13) Arrange for further STD blood testing because of the risk of STD infection (e.g., gonorrhea, chlamydia, bacterial vaginosis, *Trichomonas vaginalis*, syphilis, hepatitis, and/or HIV). Further blood testing for STDs should include:

(a) Rapid plasma reagin (RPR) test (for syphilis).

(b) Hepatitis B surface antigen (hepatitis panel).

(c) HIV.

(14) Offer the patient antibiotic prophylaxis for the prevention of gonorrhea, chlamydia, bacterial vaginosis, *T. vaginalis*, and syphilis. Before providing treatment, the patient should be questioned as to their hypersensitivity to various drugs, in particular penicillin. See Appendix F\* for CDC recommendations; see Appendix G\* for American Academy of Pediatrics recommendations.

(15) Offer the patient prophylaxis against pregnancy according to procedures in appendix H\*.

\*NOTE: Reference: Centers for Disease Control, Morbidity and Mortality Weekly Report, 51(RR06); 1-80, 10 May 02.

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5106a1.htm>

MCCG

SUBJECT: Medical Treatment Facility Management of Reported Alleged Sexual Assault Cases

This Appendix provides recommended procedures as of the date of this memorandum. Refer to above CDC website and/or other nationally recognized standards for current guidance.

(16) Bruising and contusions may not be visible for 48-72 hours post assault. Arrange for a follow-up examination in 48-72 hours to observe for bruises and contusions and document appropriately on SF 600 (Medical Record - Chronological Record of Medical Care). A repeat examination (a general medical examination with no pelvic examination needed unless specific complaints develop) should be scheduled with the same provider. The patient should have input on the location of the follow-up examination. A consult (SF 513 (Medical Record - Consultation Sheet) or DD Form 2161 (Referral for Civilian Medical Care)) should be completed if the patient will not be receiving follow-up care from the same location. Arrange an additional appointment 2-4 weeks later to give blood and culture results; test for pregnancy, if necessary; and assess the need for psychological counseling, as appropriate.

5. Policy:

a. Each MTF will develop procedures for the management of alleged sexual assault patients that ensure—

- (1) MTF personnel treat each patient with dignity and respect.
- (2) The psychological needs of the patient are met, acknowledging the patient has experienced a violent crime.
- (3) Patient privacy throughout the examination and interrogation.
- (4) Patient is informed of treatment expectations and procedures.
- (5) The presence of a consistent advocate during the initial examination and interrogation process.
- (6) By-name designation of a sexual assault crisis counselor 24/7.
- (7) Emergency care and stabilization of patients sustaining life-threatening physical trauma (physical battery, knife wounds, gunshot wounds, severe bleeding from trauma to the genitals, etc.) resulting from alleged acts of sexual abuse.
- (8) The medical management of patients in need of pregnancy prevention and prophylaxis for prevention of STD.

MCCG

SUBJECT: Medical Treatment Facility Management of Reported Alleged Sexual Assault Cases

(9) The collection and safekeeping of identified articles and a chain-of-custody protocol for evidence subject to future legal proceedings. Appendices E and I provide examples.

(10) Follow-up services for medical or psychological needs.

b. Collected evidence must be retained in the physical custody of the examining health care provider until turned over to law enforcement authorities.

c. Sexual assault on MTF grounds and in MTF facilities is a JCAHO reviewable sentinel event. Such events will be handled according to the provisions of AR 40-68 and will be included in the organization's written sentinel event policy.

d. Patients alleging sexual assault or attempted sexual assault will be referred to the EMD/S supporting the MTF. The determination to treat and examine the patient locally or refer to another facility will be made by the senior medical officer present depending on the extent and seriousness of injuries. In overseas facilities, transfer to a host nation medical facility may be made, after coordination, in the case of a local national patient.

e. MTF commanders will ensure development of MOAs (see Appendix J) when planning determines that patient care and/or evidence collection will take place in off-post facilities. Some communities have intervention consortiums established identifying a single EMD/S where all cases are referred. These MOAs will be in place prior to a need for them. The MOA will address all aspects including patient forensic evidence processing, evaluation, treatment, post-event counseling, and medical follow-up. The expectation is that a process is developed and maintained between law enforcement and MTFs by which patients' cases are forensically and medically managed, regardless of where the assault event took place or where care is provided. This requirement includes maintaining visibility on the status and capabilities of investigation, patient advocacy, and medical support processes in the military and civilian community. The MOAs will include visibility of civilian care providers' credentials.

f. MOAs will be coordinated through the MTF's support agreement manager (SAM) who usually resides in the MTF's Resource Management Division (RMD). The SAM can assist functional managers in developing the MOA and ensuring coordination with the RMD and Staff Judge Advocate (SJA) as a minimum.

g. All patients must consent to medical treatment by signing Optional Form 522 (Medical Record - Request for Administration of Anesthesia and for Performance of Operations and Other Procedures).

(1) When a non-active duty adult refuses consent, the forensic or medicolegal examination will not be performed.

MCCG

SUBJECT: Medical Treatment Facility Management of Reported Alleged Sexual Assault Cases

(2) When an active duty adult refuses consent, notify the physician. If consent is still not obtained, the physician will contact the SJA for guidance.

(3) For examination of a minor (see para 4.b.(2) for definition of minor), consent must be obtained from the parent or guardian. If consent is refused, notify the SJA (see AR 608-18). The EMD/S staff should be mindful of the following: "Unless otherwise required by applicable law, parental consent is not required for medical examination, treatment, or hospitalization of a child abuse patient in the MTF when both of the parents are suspected of inflicting abuse or concealing information about the abuse." (para 3-16. b., AR 608-18).

h. All 24-hour EMDs/Ss and other areas that perform/could perform examinations on alleged sexual assault patients will have at least one SAD Kit immediately available.

i. The presence of a same-sex chaperone is preferred during a medical examination or when forensic evidence is collected. This chaperone can be a community advocate or a same-sex assistant. If the community advocate is present and is not the same sex as the patient and cannot be present during the medical examination or when forensic evidence is collected, utilize a same-sex assistant.

j. Release of information to law enforcement personnel is subject to the procedures outlined in Appendix C.

k. For a non-military medical beneficiary, refer to the local SJA and PAD due to variations in local national population, status of forces agreements. Any local national who was allegedly sexually assaulted by an active duty service member of the U.S. Forces (on or off the installation) can aid in the collection of samples/tests required by a U.S. Government investigation office in order to aid in the prosecution or investigation of such incidents.

(1) Coordination with the business office manager must be accomplished in determining which, if any, of these samples/tests are to be billed. This is determined based on patient category, the services provided, and whether or not the services are covered in the patient's insurance plan.

(2) Before such tests or samples can be gathered, a written consent must be obtained after full disclosure in the patient's own language, if not fully conversant in English.

6. Procedures: Procedures relevant to the policies prescribed by this memorandum are contained in Appendixes as follows:

a. Guidelines for The Charge Nurse.

MCCG

SUBJECT: Medical Treatment Facility Management of Reported Alleged Sexual Assault Cases

- b. Counseling Guidelines for Sexual Assault Crisis Counselors.
- c. Release of Information to Law Enforcement Authorities.
- d. Counseling Guidelines for the Clinical Pastoral Care Provider (Chaplain).
- e. Evidence Disposition.
- f. Antibiotic Prophylaxis for the Prevention of Gonorrhea, Chlamydia, Bacterial Vaginosis, Trichomoniasis Vaginosis, Syphilis and the Probability of HIV Infection.
- g. American Academy of Pediatrics Recommended Medical Treatments.
- h. Prophylaxis Against Pregnancy.
- i. Pathology: Receipt of Clinical Evidence.
- j. Sample Memorandum of Agreement.
- k. Recommended Contents of Sexual Assault Investigation Kit.

FOR THE COMMANDER:



JOSEPH G. WEBB, JR.  
Major General  
Chief of Staff

CF:  
ASGs  
OTSG/MEDCOM Directorates  
COMMANDER, CFLCC (ATTN Surgeon)

## APPENDIX A

### Guidelines for The Charge Nurse

1. The EMD/S/Urgent Care Clinic charge nurse will act as the coordinator among the various sections and agencies, assisting in the management of the patient and the collection of evidence.
2. The charge nurse will help ensure that all staff are cognizant that the sexual assault patient has experienced a significant degree of physical and/or emotional trauma that can result in a wide range of responses. For example, some patients may appear hysterical and tearful, while others may demonstrate feelings of shock and disbelief. It is critical that staff speak to the patient in a non-judgmental, supportive fashion.
3. It is imperative that the patient regains control of his/her own body. He/she should be encouraged to make decisions about treatment and follow-up with positive feedback from those who are assisting. The patient should not be coerced/forced to undergo an examination until he/she is ready, and the patient should not be restrained in any way during the examination. The assistant can explain the examination procedures and emphasize the reason for performing the examination, ultimately allowing the patient to reach independent decisions.
4. Subsequent to the charge nurse calming and comforting the patient, a brief understandable explanation of the following required medicolegal procedures should be made:
  - a. General physical examination.
  - b. Pelvic/rectal/oral examination, as indicated.
  - c. Medicolegal specimen collection.
  - d. Medications to be administered, if any (i.e., STD/pregnancy).
5. In those cases where the patient does not wish to lodge a complaint with police authorities or render a sworn statement, explain the following options:
  - a. The patient may elect to receive medical care without lodging a formal complaint with authorities or rendering a sworn statement.
  - b. The patient may have the evidence collected now and decide later about lodging a formal complaint with authorities or rendering a sworn statement.

**APPENDIX A**  
(continued)

6. Even if the patient does not desire to lodge a formal complaint, notification to the MPs is still required.

7. Advise the patient that a counselor will be available for assistance. Remain with the patient (or arrange for another attendant) until the counselor arrives or until the patient is discharged. To provide consistency, the same person will remain with the patient throughout the patient's stay.

## **APPENDIX B**

### **Counseling Guidelines for Sexual Assault Crisis Counselors**

1. Behavioral Health Service staff members typically perform the functions of sexual assault crisis counselors. It is the responsibility of the counselor to attend to the emotional and practical needs of the patient while the patient is at the clinic or in the EMD/S.
2. Trained counselors are aware that sexual assault is forced sexual aggression that can have devastating effects on the patient's physical, emotional, social, spiritual, and sexual stability. Counselors understand that sexual assault is a very real crisis and that patients demonstrate a wide range of behaviors and emotions (e.g., anger, fear, hostility, guilt, confusion, apathy, shock, disbelief, etc.). To interpret these responses as being appropriate or inappropriate and thereby making a judgment if sexual assault did or did not occur is not the function of the counselor. It is critical to establish a therapeutic relationship with the patient, and the essential ingredient is an empathic, non-judgmental, supportive atmosphere.
3. It is imperative that the patient regains control of his/her own body. He/she should be encouraged to make decisions about treatment and follow-up, with positive feedback from the counselor. The patient should not be coerced/forced to undergo an examination until he/she is ready, and the patient should not be restrained in any way during the examination. The counselor can explain the examination procedures and emphasize the reason for performing the examination, ultimately allowing the patient to reach independent decisions.
4. Responsibilities of the sexual assault crisis counselor, in addition to crisis intervention counseling, include—
  - a. Being present during any examination and/or questioning of the patient taking place regardless of the location, if appropriate and indicated.
  - b. Advising the attending physician about the patient's medical/emotional condition.
  - c. Arranging for follow-up care by appointment with Behavioral Health Services the next duty day.
  - d. Assisting the patient with practical matters such as notification of family, if indicated, transportation, clothing, admission procedures, etc.

**APPENDIX B**  
(Continued)

5. The Behavioral Health Service will provide the EMD/S with a current on-call crisis counselor roster and telephone numbers for notification purposes.
6. For after-duty hours, contact the on-call counselor who will notify the respective Chief, Behavioral Health Service the following duty day.

## APPENDIX C

### Release of Information to Law Enforcement Authorities

1. Military law enforcement authorities pursuing an investigation of an alleged sexual offense must be provided prompt and accurate information. An MTF may release Protected Health Information (PHI) on active duty service members directly to a CID or MP upon receipt of a proper investigatory request (the minimum necessary rule applies to such a release). Personnel will defer to SJA if unsure of request legitimacy. This requires the requesting agent to specify the need for, and scope of, the information requested, and the MTF to ensure that the content of the records released is limited to that specific need and scope. Disclosure of PHI regarding military family members (MFMs) or civilians not affiliated with the military who have been brought to the MTF on an emergency basis require patient authorization, an exception to the Health Insurance Portability and Accountability Act, or a court order. There is an exception for release of PHI on military members and MFMs to the Family Advocacy and Case Review Committees. Much depends on the status of the patient (active duty, family member, civilian), and care must be taken to safeguard a patient's PHI. The SJA will be contacted for additional guidance as needed.
2. DA Form 4700 MEDCOM OP 29-1-R, Sexual Assault Medical Examination Report, (see MEDCOM Regulation 40-36) may be released to law enforcement personnel. This form consists of three copies. The original should be given to the investigating agent with the content of the SAD Kit examination. The yellow copy should be kept with the EMD/S record, SF 558 (Medical Record –Emergency Care and Treatment). The third copy may be kept in a working file in the EMD/S for reference as needed. File other medical documentation (such as laboratory, x-ray, SF 600 (Chronological Record of Medical Care) pertaining to the sexual assault with the SF 558 or in the Inpatient Treatment Record. The original SF 558 will be filed in the Health Record (HREC) or Outpatient Treatment Record (OTR) or Civilian Employee Medical Record (CEMR) and the entire record will be secured in a locked file in the PAD. The original and copy of the SF 558, along with the yellow copy of the Medical Examination Report, should be locked in a secure container until the next duty day at which time they will be hand-carried to the PAD office for proper distribution and safe-keeping. PAD will forward the original SF 558 to the patient's medical record and lock the EMD/S copy of the SF 558, the yellow copy of the DA Form 4700 MEDCOM OP 29-1-R, the report of laboratory examination of specimens, and returned laboratory request slips in a secure file. Documentation will be thorough and legible.
3. If the need for information is urgent, both the request for information and permission to disclose it, may be given verbally by the Deputy Commander for Clinical Services/Command Surgeon or representative (duty officer). Immediately afterwards, the individual releasing such information will prepare a memorandum for record explaining the circumstances. The requesting agent, CID, or MP will follow-up the

## APPENDIX C

(continued)

verbal request with a written one using DA Form 4254 (Request for Private Medical Information), which will also be forwarded to PAD. Copies of the DA Form 4700 MEDCOM OP 29-1-R will be distributed per instructions contained in paragraph 2, above.

4. All medical personnel, to include crisis counselors/patient advocates, have an obligation to immediately pass on to the CID (or the appropriate law enforcement agency) any information given by the patient that would help in apprehension of the alleged perpetrator (i.e., physical description, location of incident, time, etc.). The CID agent will be given immediate access to the patient upon completion of the sexual assault examination. The CID agent has the same obligation to respect the patient and act with sensitivity and compassion.

5. Upon request of appropriate law enforcement officials to perform an examination of a suspected assailant or child molester, the health care provider will comply in the following:

a. A suspected assailant or child molester will not be examined in the same room that was or will be used to examine the alleged sexual assault patient to prevent cross-contamination of evidence. Personnel will inspect for remote or recent injuries, disturbance of clothing, bloodstains, semen stains, foreign hair, or other foreign substances on the body (especially under fingernails).

b. Record the results of the examination according to MEDCOM Regulation 40-36 and instructions in the SAD Kit. Use the SAD Kit to collect evidence. If local jurisdiction does not insist upon a particular SAD Kit, MEDCOM recommends PN 1790074, Sexual Assault Investigation Kit, or one that consists of the items listed at Appendix K.

c. Upon collection of specimens and evidence, allow the CID to initiate DA Form 4137. Specimens/evidence should not be placed near a recent sexual assault patient's evidence to prevent cross-contamination. Ensure proper chain of custody is established for any collected evidence.

d. Expedite release and transfer of the physical evidence to the CID special agent or appropriate law enforcement agency investigating the alleged crime.

e. Patients and civilians not normally authorized care in the MTF will be charged for medical examinations related to alleged sexual assaults according to AR 40-400. However, paragraph 3-60, Civilians Injured In Alleged Felonious Assaults On Army Installations states: "When required to complete a criminal investigation, the Secretary

of the Army has given commanders of Army MTFs discretionary authority to provide examination and initial treatment without charge to a civilian injured in an alleged felonious assault (for example, alleged rape) occurring on an Army installation. There is no authority to provide care for civilians in the private sector." The reimbursement source code 93C is used to account for medical care for civilians described in the above. DFAS 37-100 provides the following description of 93C: "Victims of crime and similar programs in the several States. For medical reimbursement of care provided to beneficiaries of the program. (Unpaid balance of billings is not required to follow due process notifications and will not be balance-billed except in cases of fraud or misrepresentation.)"

f. If the on-call physician is delayed, the CID agent may question the patient if the EMD/S physician, in consultation with behavioral health, determines the interview will not be detrimental to the patient.

## **APPENDIX D**

### **Counseling Guidelines for the Clinical Pastoral Care Provider (Chaplain)**

1. Pastoral care providers focus on the spiritual, emotional, and practical needs of the patient and supporting the medical staff.
2. Pastoral care providers are aware that sexual assault is forced sexual aggression that can have devastating effects on the patient's physical, emotional, social, and sexual stability. It is essential to be aware that following sexual assault, a very real crisis, the patient demonstrates a wide range of behaviors and emotions (e.g., anger, fear, hostility, guilt, confusion, apathy, shock, disbelief, etc.). To interpret these responses as being appropriate or inappropriate and thereby making a judgment if sexual assault did or did not occur is not the function of the pastoral care provider. It is critical to establish a pastoral relationship with the patient, and the essential ingredient is an empathic, non-judgmental, supportive atmosphere.
3. It is imperative that the patient regains control of his/her own body. He/she should be encouraged to make decisions in consultation with his/her medical provider about treatment and follow-up, with positive supportive feedback from the pastoral care provider. The patient should not be coerced/forced to undergo an examination until he/she is ready, and the patient should not be restrained in any way during the examination. The pastoral care provider can provide spiritual/emotional support before, during, and after the examination procedures that ultimately support and/or assist the patient to reach independent decisions.
4. Responsibilities of the pastoral care provider, in addition to pastoral crisis intervention counseling, include—
  - a. Being present and/or available during any examination and/or questioning of the patient. It is advisable to have same-sex pastoral support.
  - b. Advising the attending physician about the patient's spiritual/emotional condition.
  - c. Provide follow-up pastoral care.
  - d. Assist the patient with practical matters such as notification of family, if indicated, transportation, clothing, housing, etc.
5. The chaplain will provide the EMD/S a current 24-hour on-call roster of pastoral care providers and telephone numbers for notification purposes.

## APPENDIX E

### Example: Evidence Collection and Disposition

1. Do not touch the items.
2. All specimens must air dry as indicated before being sealed in the evidence collection box.
3. Use only paper bags and envelopes, not plastic. Items will grow mold inside plastic which destroys the evidence.
4. The MTF can establish the example below as a checklist to collect and secure evidence. Supplies and their descriptions may vary by locale.

Test specimen LAB CID

Spermatozoa and vaginal washing

Acid Phosphatase\* (other sites as necessary)

Spermatozoa\* PAP smear (Stained preparation)

Serologic test for syphilis 7ml red top tube

Culture for gonorrhea TM/chocolate plate culture or probtec culturette

HIV test 7ml red top tube

Hepatitis panel 7ml red top tube

Blood alcohol test 7ml gray top tube \*chain of custody

Seminal fluid group\* seminal deposits on filter paper

Saliva specimen\* 2 x 2 gauze (place specimen in [at discretion of physician] sealed urine specimen container)

Fingernail scrapings or clippings from each hand are placed in separate envelopes

Pubic hair\* comb, cut, and plucked (10 - 15 ea) all to be packaged separately

**APPENDIX E**  
(continued)

Clothing\* all clothing worn at time of alleged assault

Blood\* (CID) 15ml red top tube

One purple top tube (DNA purposes)

Other physical evidence as directed by CID\*

\*These so indicated specimens will go to the clinical laboratory locked in an evidence box (following chain of custody). Key to the box will be sealed in an envelope and signed across the seal.

## APPENDIX F

### **Antibiotic Prophylaxis for the Prevention of Gonorrhea, Chlamydia, Bacterial Vaginosis, Trichomoniasis Vaginosis, Syphilis and the Probability of HIV Infection**

The Centers for Disease Control and Prevention (CDC) recommends the following prophylactic regimens be provided for sexual assault patients in which vaginal, oral, or anal penetration took place.

Treatment for non-pregnant female consists of—

1. Ceftriaxone, 125 mg intramuscular, in a single dose and metronidazole, 2 gm orally in a single dose

**plus**

Doxycycline, 100 mg orally, twice a day for 7 days

**or**

Azithromycin, 2 gm orally in a single dose

Treatment for pregnant female consists of—

2. Ceftriaxone, 125 mg intramuscular, in a single dose and metronidazole, 2 gm orally in a single dose

**plus**

Erythromycin, 500 mg orally, four times daily for 7 days

**or**

Azithromycin, 1 gm orally in a single dose

If breast feeding: Amoxicillin 3 gm stat + probenecid 1gm stat orally and erythromycin 500 mg, orally twice daily for 14 days. Manage the probable sexually transmitted infection post-exposure prophylaxis treatment regimen with—

- Test for gonorrhea, chlamydia, syphilis, and hepatitis should be performed again within 6 weeks.

**APPENDIX F**  
(continued)

- Warn patient of interaction of metronidazole and alcohol.
- Delay metronidazole for 24 hours if consumed alcohol in previous 12 hours.
- Best to take tablets after meals.
- Symptoms of STDs and the need for immediate examination if symptoms occur and,
- Abstinence from sexual intercourse until STD prophylactic treatment is completed.

3. Inoculation with the hepatitis B vaccine if patient has not had a completed hepatitis B series.

4. Transmission of HIV is always a concern; the CDC recommends post-exposure prophylaxis for HIV infection following sexual assault, even though its efficacy is unknown. The initial post-exposure treatment plan should include—

- Written informed consent from patient, explaining lack of efficacy data; complexities of treatment regimen, including potential toxicities; availability of medications and follow-up care; importance of medication adherence and follow-up care; availability of risk reduction support, as appropriate.
- Potential antiretroviral regimen choices, using current CDC occupational exposure guidelines and/or infectious disease consultation, with adjustment if HIV treatment history of exposure source is known.
- Baseline laboratory studies:
  - HIV antibody by standard serum assay (i.e., not oral fluid or rapid tests);
  - Complete Blood Count (CBC), renal and liver function tests;
  - Pregnancy test (for women of childbearing potential).

Determine appropriateness of antiretroviral prophylaxis based on the time elapsed following the sexual assault – recommended 48 hours, not to exceed 72 hours and should be continued for 28 days. Appropriate treatment regimens for children should be determined in conjunction with a pediatric HIV specialist.

**APPENDIX F**  
(continued)

**Treatment Protocols for probable post-exposure prophylaxis for HIV after sexual assault**

**Treatment regimen (28 days):**

Zidovudine, 300 mg twice daily or 200 mg three times daily and lamivudine, 150 mg twice daily

**Alternative regimen (28 days):**

Didanosine, 200 mg twice daily and stavudine, 40 mg twice daily. Consider adding\* nelfinavir, 750 mg three times daily or indinavir, 800 mg three times daily.

**Testing of patient:**

HIV antibody test (repeat at 6 weeks, 3 months, and 6 months).

Manage the probable HIV post-exposure prophylaxis treatment regimen with—

- Identify clinical contact persons to monitor adverse reactions or to address adherence.
- Short-term clinical follow-up, including—
  - At least two office visits during 28-day treatment period;
  - Repeat CBC, liver and renal function tests, as indicated to monitor for toxicity;
  - Follow-up as appropriate regarding hepatitis B status, pregnancy, etc.;
  - Evaluation for drug toxicities, adherence to regimen, and psychological support needs;
  - As appropriate, peer support mechanisms and mental health and risk reduction counseling and/or referral;
  - Assessment for symptoms of acute retroviral syndrome.
- Provide post-therapy follow-up:
  - Assess potential HIV seroconversion by retesting at 4-6 weeks and 6 months.

## APPENDIX G

### American Academy of Pediatrics Recommended Medical Treatments

American Academy of Pediatrics: 2003 Red Book, 26th Edition: Report of the Committee on Infectious Diseases recommends the following medical treatments for PreAdolescents and Adolescents sexual assault patients

#### ***Prophylaxis After Sexual Assault of Preadolescent Patient***

**Weight <100 lb (<45 kg)**

**Weight ≥100 lb (≥45 kg)**

#### ***N gonorrhoeae***

**1. Ceftriaxone, 125 mg intramuscular (IM) single dose**

**PLUS**

**1. Ceftriaxone, 125 mg IM single dose**

**PLUS**

#### ***Chlamydis trachomatis***

**2a. Erythromycin 50 mg/kg per day, divided into 4 doses for 10-14 days**

**OR**

**2b. Azithromycin, 20 mg/kg (max 1 gm), Orally, in a single dose**

**PLUS**

**2a. Doxycycline, 100 mg twice for 7 days**

**OR**

**2b. Azithromycin, 1 gm, orally in a single dose**

**PLUS**

#### ***For prevention of hepatitis B virus infection***

**3. Begin or complete hepatitis B virus immunization if not fully immunized**

**PLUS**

**3. Begin or complete hepatitis B virus immunization if not fully immunized**

**PLUS**

#### ***For prevention of trichomoniasis and bacterial vaginosis***

**4. Consideration should be given to adding prophylaxis for trichomoniasis and bacterial vaginosis (Metronidazole, 15 mg/kg per day orally, three times daily for 7 days)**

**4. Consideration should be given to adding prophylaxis for trichomoniasis and bacterial vaginosis (Metronidazole, 2 gm, orally, in a single dose)**

**APPENDIX G**  
(continued)

**Prophylaxis After Sexual Assault of Adolescent Patient**

**Antimicrobial prophylaxis is recommended to include an empiric regimen to prevent *Chlamydia trachomatis* infection, gonorrhea, trichomoniasis, and bacterial vaginosis**

**N gonorrhea**

Ceftriaxone, 125 mg, intramuscular, in a single dose

**OR**

Ciprofloxacin, 500 mg, orally, in a single dose

**OR**

Ofloxacin, 400 mg, orally, in a single dose

**OR**

Levofloxacin, 250 mg, orally, in a single dose

**PLUS**

***Chlamydia trachomatis***

Doxycycline, 100 mg, orally, twice daily for 7 days

**OR**

Azithromycin 1 gm, orally, in a single dose

**PLUS**

**For prevention of trichomoniasis  
and bacterial vaginosis**

Metronidazole, 2 gm, orally, in a single dose

**PLUS**

**For prevention of hepatitis B  
virus infection**

Begin or complete hepatitis B virus immunization if not fully immunized. Follow-up doses of vaccine should be administered 1 to 2 and 4 to 6 months after the first dose.

**PLUS**

**For human immunodeficiency virus infection (HIV)**

Appropriate treatment regimens for children should be determined in conjunction with a pediatric HIV specialist.

**APPENDIX G**  
(continued)

**Emergency Contraception**

Oral contraceptive pills containing 50 µg (micrograms) of ethinyl estradiol: 2 pills orally initially, then 2 pills orally 12 hours later,

**OR**

Oral contraceptive pills containing 30 µg of ethinyl estradiol: 4 pills orally initially, then 4 pills orally 12 hours later

**PLUS**

An antiemetic

**Other consideration:**

**Herpes genitalis**

Acyclovir, 400 mg per day three times daily for 7-10 days (same for adults)

**Condyloma acuminata**

May spontaneously resolve; podophyllum resin is often initial therapy of choice; relapses may occur

## APPENDIX H Prophylaxis Against Pregnancy

Ask the patient if she desires prophylaxis against pregnancy. If emergency contraception is used, repeat pregnancy test in one month. Treat with combination oral contraceptive pills (OCP). Medication regimen:

**Combined emergency contraceptive pills (ECP)** contain the hormones estrogen and progestin. The treatment schedule is one dose within 72 hours after sexual assault, and a second dose 12 hours after the first dose. \*\*Give only after obtaining negative pregnancy test.

\*Prescriptive equivalents for the Yuzpe method of emergency contraception\* (About 50% of women who use combined ECPs experience nausea and 20% vomit. If vomiting occurs within one hour after taking a dose, the dose may need to be repeated. The long-acting non-prescription anti-nausea medicine will reduce the risk of nausea and vomiting when taken an hour before ECPs.) (The hormones that have been studied in clinical trials of emergency contraception are found in the dosages below)

1. Table of prophylaxes and dosages:

<b>Pill Brand</b>	<b>Each Dose Contains</b>	<b>1st Dose Within 72hrs</b>	<b>2nd Dose (12 hrs later)</b>
<b>Combination Hormone Pills</b>			
Alesse®	0.5 mg of levonorgestrel and 100 µg of ethinyl estradiol.	5 pink pills	5 pink pills
Aviane®	0.5 mg of levonorgestrel and 100 µg of ethinyl estradiol.	5 orange pills	5 orange pills
Levlen®	0.6 mg of levonorgestrel and 120 µg of ethinyl estradiol.	4 light orange pills	4 light orange pills
Levlite®	0.5 mg of levonorgestrel and 100 µg of ethinyl estradiol.	5 pink pills	5 pink pills
Levora®	0.6 mg of levonorgestrel and 120 µg of ethinyl estradiol.	4 white pills	4 white pills
Lo/Ovral®	0.6 mg of levonorgestrel and 120 µg of ethinyl estradiol.	4 white pills	4 white pills
Low-Ogestrel®	0.6 mg of levonorgestrel and 120 µg of ethinyl estradiol.	4 white pills	4 white pills
Nordette®	0.6 mg of levonorgestrel and 120 µg of ethinyl estradiol.	4 light orange pills	4 light orange pills
Ogestrel®	0.5 mg of levonorgestrel and 100 µg of ethinyl estradiol.	2 white pills	2 white pills
Ovral®	0.5 mg of levonorgestrel and 100 µg of ethinyl estradiol.	2 white pills	2 white pills

Pill Brand	Each Dose Contains	1st Dose Within 72hrs	2nd Dose (12 hrs later)
Preven <sup>®</sup>	0.5 mg of levonorgestrel and 100 µg of ethinyl estradiol.	2 blue pills	2 blue pills
Tri-Levlen <sup>®</sup>	0.5 mg of levonorgestrel and 120 µg of ethinyl estradiol.	4 yellow pills	4 yellow pills
Triphasil <sup>®</sup>	0.5 mg of levonorgestrel and 120 µg of ethinyl estradiol.	4 yellow pills	4 yellow pills
Trivora <sup>®</sup>	0.5 mg of levonorgestrel and 120 µg of ethinyl estradiol.	4 pink pills	4 pink pills

NOTE: There are several choices for combined ECPs listed above. You need to take only one type of pill, not all of them. For example, if you use Ovral, you do not need Nordette. If you are getting your ECPs from a regular pack of birth control pills containing 28 pills (one for every day), remember that the last seven pills do not contain any hormones. In a 28-pill pack of Ovral, Ogestrel, Alesse, Levlite, Lo/Ovral, Low-Ogestrel, Nordette, Levlen, or Levora, any of the first 21 pills can be used as ECPs. If you are using Triphasil or Tri-Levlen, the first 21 pills have three different colors, but only the yellow pills can be used as ECPs. If you are using Trivora, the first 21 pills have three different colors, but only the pink pills can be used as ECPs.

2. Plan-B<sup>®</sup> is a progestin only ECP. One pill is taken immediately and a second pill is taken 12 hours later. Nausea and vomiting are possible side effects of Plan B<sup>®</sup> but are much less common than with ECPs that contain both estrogen and progesterone.

\*\*\*Most women do not need to take anti-nausea medication. \*\*\* (The hormones that have been studied in clinical trials of emergency contraception are found in the dosages below)

#### Plan-B

Progestin-only Pills		1st Dose	2nd Dose (12 hours later)
Ovrette <sup>®</sup>	1.5 mg of levonorgestrel	20 yellow pills	20 yellow pills
		or 40 yellow pills in one dose	
Plan B <sup>®</sup>	0.75 mg of levonorgestrel	1 white pill	1 white pill
		or 2 white pills in one dose	

3. The use of a copper-T intrauterine device (IUD) used as an emergency contraception can be used after 72 hours and less than 5 days after a sexual assault. Not to be used in women with infections or nulliparous or menstrual problems.

**APPENDIX H**  
(continued)

4. Prophylaxis is warranted for post-pubertal female patients who seek care within 72 hours after a sexual assault. All patients who receive prophylaxis should be screened for STDs before initiating treatment. Post-menarcheal patients should be tested for pregnancy before initiating antimicrobial therapy or emergency contraception is given. Before providing treatment, the patient should be questioned as to their hypersensitivity to various drugs, in particular penicillin.

## APPENDIX I

### Pathology: Receipt of Clinical Evidence

1. The on-duty CID agent (contacted through the MP desk sergeant) or their representative during off-duty hours or appropriate law enforcement agent determined by jurisdiction will take receipt of clinical evidence (see Appendix E) in the case of alleged sexual assault. Specimens will be accepted ONLY when examination shows proper collection procedures (per list on chain-of-custody form, guidance, etc.). DA Form 4137 must accompany the clinical evidence.
2. The CID representative or law enforcement agent will sign for receipt of the specimens on the DA Form 4137 in the "received by" column on the form.
3. The following specimens should be submitted to the laboratory unless cancelled by the attending health care provider:
  - a. Serologic test for syphilis (RPR).
  - b. Specimens for Neisseria gonorrhoea, chlamydia, and herpes simplex virus (cervix, vagina, perineum, pharynx, and rectum).
  - c. Urine pregnancy test.
  - d. HIV test.
  - e. Hepatitis panel.
4. Specimens submitted will be logged in and processed according to chain-of-custody procedures. Only those specimens that meet the normal laboratory acceptance criteria for identification and appropriate collection will be accepted.

## APPENDIX J

### Sample Memorandum of Agreement

#### TEMPLATE (SAMPLE ONLY)

MEMORANDUM OF AGREEMENT  
BETWEEN  
DIRECTOR, MEDCOM ACS for Resource Management  
AND  
(INSERT NAME OF AGENCY HERE)

**SUBJECT:** Insert a brief subject that quickly keys readers to what the MOA covers

**1. References.**

a. Always list the official policies and directives for the subject area, starting with DOD documents, followed by Army and then local agency documents.

b. DOD Directive XX-XX.

c. Army Regulation X-XX.

d. MEDCOM Memorandum of Instruction, date, subject: XXXXXXXXXX.

**2. Purpose.** Provide a brief statement defining the purpose.

**3. Background.** Briefly describe the historical context of the agreement and why it is necessary. Describe what problem it solves or how it adds value to the parties. Include the minimum amount of information that will enable readers to better understand and apply the agreement.

**4. Scope.** Answer: To whom does this MOA apply? Who are the parties and how do they relate? How far-reaching is the MOA? Does it cover the entire subject area or just a small aspect of it?

**5. Responsibilities.** An MOA usually lists specifically what each party will do in relation to the other. If the support provided is recurring (e.g., BASOPS), preparation of a DD Form 1144 (Support Agreement) is also recommended to document standards of support, basis of costs, and other detailed information.

a. ACSR will:

**APPENDIX J**  
(continued)

(1) Provide \_\_\_\_\_ support to (insert name of agency) on a one-time basis.

(2) Notify (insert name of agency) of the amount of the support bill and provide instructions on where to send the Military Interdepartmental Purchase Request.

b. (Insert name agency) will:

(1) Reimburse for the incremental direct costs identified for the \_\_\_\_\_ support received.

(2) Identify its one-time support requirements.

6. Resource Needs. It is generally advisable to have a separate paragraph detailing the resources required to implement the MOA. In the example above, a brief statement such as, "support is provided on a reimbursable basis; no additional resources are required to implement this MOA."

7. Implementation Instructions. Although AR 25-50 requires only the effective date, an expanded paragraph is recommended to include a review schedule, how the MOA is implemented, instructions on how to revise and terminate the MOA, etc.

a. This MOA becomes effective on the date of final signature and will remain in effect until the end of the calendar year after the one-time support arrangement is fulfilled.

b. The MOA is considered fully implemented once the support is provided and MEDCOM receives the reimbursement.

c. The parties agree to review the MOA by 1 November 20## to ensure the transaction was successful. If successful, the MOA automatically terminates on 31 December 20## without further action from the parties.

FOR MEDCOM:

FOR (insert agency here):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
DATE

\_\_\_\_\_  
DATE

## APPENDIX K

### Recommended Contents of Sexual Assault Investigation Kit

- 1 Notes to the investigator service data
- 1 Notes to the physician service data
- 1 Evidence checklist service data
- 1 Evidence handling notes service data
- 1 Medical examination report
- 3 9"x12" Size labeled envelopes
- 4 3"x5 1/2" Size labeled coin envelopes
- 5 3"x5 1/2" Size unlabeled coin envelopes
- 2 Pocket combs
- 1 Nail clipper with file
- 4 25x75mm microscope slide with frosted end
- 2 2-Slotted pre-labeled slide holder
- 2 2"x2" Size sterile gauze
- 2 Cotton-tipped wood applicator
- 5 3"x5" Size zip lock bag
- 1 Plastic pipette with molded bulb
- 6 Plastic tube with two cotton tip swabs affixed to the inside of the screw cap closure
- 1 Tube holder for five (5) vacutainer tubes