

Crime Victims Compensation Program

Sexual assault exam report / Domestic Violence strangulation report form

Exam performed in: <input type="checkbox"/> Office (Independent Clinic) <input type="checkbox"/> Hospital (ED or Floor)	Exam Level/Billing Code: <input type="checkbox"/> No Exam/0130C <input type="checkbox"/> Level 2/0132C (46–119 minutes) <input type="checkbox"/> Level 1/0131C (5–45 minutes) <input type="checkbox"/> Level 3/0133C (120+ minutes)
Time elapsed since assault: _____ Hours _____ Days _____ Months _____ Unknown	
Patient's age at exam (in years): _____	
Circumstances of visit:	
Address or approximate location of assault:	City and state where assault occurred:
At the time of the assault, was the victim confined or living in any county or city jail, federal jail or prison or in any other federal institution, or any state correctional institution maintained and operated by the Department of Social and Health Services or the Department of Corrections? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, where?	<input type="checkbox"/> Sexual assault without strangulation <input type="checkbox"/> Sexual assault with strangulation Is this Domestic Violence? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Domestic Violence strangulation <hr/> Forensic Evidence kit completed? <input type="checkbox"/> No <input type="checkbox"/> Yes Anoscopy performed? <input type="checkbox"/> No <input type="checkbox"/> Yes Physical exam completed? <input type="checkbox"/> No <input type="checkbox"/> Yes Colposcopy performed? <input type="checkbox"/> No <input type="checkbox"/> Yes
Diagnostic Testing: (Bill Separately) Lab Work <input type="checkbox"/> No <input type="checkbox"/> Yes Imaging: CTA, CT, MR <input type="checkbox"/> No <input type="checkbox"/> Yes Other Imaging Study <input type="checkbox"/> No <input type="checkbox"/> Yes	Medication Given: (Bill Separately) Prophylaxis for STDs <input type="checkbox"/> No <input type="checkbox"/> Yes Prophylaxis for HIV <input type="checkbox"/> No <input type="checkbox"/> Yes Emergency Contraception <input type="checkbox"/> No <input type="checkbox"/> Yes Hepatitis B Vaccine <input type="checkbox"/> No <input type="checkbox"/> Yes Tetanus Vaccine <input type="checkbox"/> No <input type="checkbox"/> Yes
Exam performed by (name – please print):	Form completed by (name – please print):
<input type="checkbox"/> RN <input type="checkbox"/> MD <input type="checkbox"/> PA-C <input type="checkbox"/> ARNP <input type="checkbox"/> DO <input type="checkbox"/> Other: _____	_____ (Signature)
Additional comments:	Police report made? <i>For data collection purposes only</i> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown
Claimant (patient) Name – may use patient ID label:	Medical facility where exam performed:
Medical Record #: _____ Gender: <input type="checkbox"/> F <input type="checkbox"/> M Date of Birth: _____	Date of exam (use the month/day/year format):

A health services provider who requests from the department payment for providing services shall maintain all records necessary for the director's authorized auditors to audit the provision of services. A provider shall keep all records necessary to disclose the extent of services the provider furnishes to a victim of crime. At a minimum, these records must provide and include prompt and specific documentation of the type of service for which payment is sought. Records must be maintained for audit purposes for a minimum of five years.