

FNIHB-OR Nursing Policy and Procedure

Section: **Professional Nursing Practice**

Policy Number: **II - 41**

Subject: **Sexual Assault and Intimate
Partner Abuse**

Issued: **2018-01-22**
Revised:

1. POLICY

- 1.1 Community Health Nurses (CHNs) offer and provide unconditional and non-judgmental support, medical care, and forensic evidence collection to consenting individuals who have experienced sexual assault (SA) or intimate partner violence (IPV).
- 1.2 All possible options around SA or IPV care will be discussed with the client.
- 1.3 Client choice will be respected and facilitated in as timely a manner as possible.
- 1.4 Mental health care is of paramount importance and must be emphasized as a key component of quality SA and IPV care.
- 1.5 CHNs will complete and submit occurrence report following all events of SA or IPV.
- 1.6 Documentation of SA and IPV will be regularly reviewed by Nursing Practice Consultants (NPC) for the purpose of education, identifying gaps, and ensuring appropriate patient care was received.

2. PRINCIPLES

- 2.1 Victims and survivors of sexual assault and intimate partner violence deserve the highest quality of care and support possible, delivered in a manner that is acceptable to them.
- 2.2 SA and IPV can be complex events that involve both physical and emotional trauma. The CHN must be aware that multiple visits with both the medical team, and mental health services, will likely be necessary after an SA or IPV event has occurred.
- 2.3 While SA and IPV are generally perpetrated against women, men may also be victims of these acts. Men may be more reluctant to seek care. CHNs will demonstrate empathy and give high quality care to male victims, and ensure that men have access to resources that assist male victims.
- 2.4 Generally, the age of consent for sexual activity is 16. Additionally, a young person 14 or 15 years of age can legally consent to sexual activity with someone less than 5 years older,

and a young person 12 or 13 years of age can legally consent to sexual activity with someone less than 2 years older.

A person under 18 years of age cannot consent to sexual activity if the other person has a relationship of trust or authority over them, or they are dependent on that person. People in positions of trust or authority include, for example, a teacher, coach, babysitter, family member, minister or doctor. Persons under 18 also cannot consent if it involves exploitative activity, such as prostitution or pornography or if they are paid, or offered payment, for sex (Department of Justice, 2017a).

3. DEFINITIONS

Consent: The voluntary agreement of the complainant to engage in the sexual activity in question. Conduct short of a voluntary agreement to engage in sexual activity does not constitute consent as a matter of law (Department of Justice, 2017b). A person is unable to consent to sexual activity if they are intoxicated or otherwise impaired.

Intimate Partner Violence (Domestic Violence or Abuse): Domestic abuse does not always involve physical violence. Abuse can include other forms of mistreatment and cruelty such as constant threatening, psychological/emotional, financial/material, spiritual and verbal abuse. It can also include sexual assault, in which case the victim has the same options as any other person who has been sexually assaulted (SADVTC, 2017).

Sexual Assault: Sexual assault is any form of unwanted sexual activity that is forced upon a person without that person's consent. Sexual assault can range from unwanted sexual touching, to forced intercourse. While most sexual assaults are perpetrated against women, both women and men can be, and are, sexually assaulted (Ontario Network of Sexual Assault/Domestic Violence Treatment Centers, SADVTC, 2017).

Sexual Assault Treatment Centre: A service that specializes in the care of patients that have been sexually assaulted, sexually abused or the victims of intimate partner violence. These facilities are located within most hospitals and provide both direct patient care and telephone advice for nurses working in remote areas. Services include medical care, sexual assault evidence kit collection, safety planning and mental health counselling.

4. PROCEDURE

4.1 Mandatory Education

The CHN will attend all mandatory education sessions around Sexual Assault and Domestic Violence and Sexual Health and will inform their Nursing Practice Consultant (NPC) when they have completed these sessions.

In Nursing Stations or Health Centres with Treatment

4.2 Sexual Assault of an Adult

- 4.2.1 Patient choice is paramount in determining the plan of care. The Sexual Assault Evidence Kit (SAEK) is an optional part of treatment but is not a requisite for receiving care. The purpose of the SAEK is to collect possible evidence to assist in a legal investigation, and will only be tested if police are involved. If the patient does not want to involve police it is unnecessary to complete the SAEK. If the patient is unsure if they want to involve police, the SAEK can be completed and stored for up to six months. The storage of the kit is only possible if the facility allows for secure storage, including access to a refrigerator and freezer, and chain of evidence can be maintained. If the patient is unsure and wants to complete a kit but storage space is unavailable, the CHN should discuss transfer to an SATC that can accommodate this.
- 4.2.2 The CHN (General Class) will consult with an NP or physician for all cases of sexual assault. As a reminder, the Sexual Transmitted Infection (STI) Medical Directive requires that CHNs consult with a physician/NP prior to administering STI medication if a sexual assault is suspected to have occurred.
- 4.2.3 Generally, anyone who has reached sexual maturity can be assessed and treated as an adult, paying special consideration to developmental age and needs. Consult with the physician/NP or Sexual Assault Treatment Centre (SATC) if you are unsure if the patient should be treated as an adult or child. Medically treating a person that has reached sexual maturity as an adult does not absolve responsibility around mandatory reporting. See Principles 2.4 and 2.5 for more information on age of consent.
- 4.2.4 The CHN will use the Adult Sexual Assault Documentation Tool (*Appendix A*). This tool serves as both a guide to care options and will become part of the client record.
- 4.2.5 The CHN will consider drug facilitated sexual assault (DFSA) and complete the DFSA Documentation Tool (*Appendix B*) when appropriate.
- 4.2.6 The CHN will consider strangulation and complete the Strangulation Documentation Tool (*Appendix C*) when appropriate.
- 4.2.7 The CHN will ensure that mental health follow up is offered to the client, including both community and external options. The nurse will obtain consent and send referral to mental health services at initial visit. In instances where a referral is not required, the nurse will assist the client to set up own appointment at initial visit.
- 4.2.8 A follow-up phone call in 5-7 days is encouraged and will be made to each

client that gives consent to this. The purpose of this call is to identify any new issues that have arisen, ensure patient has attended any follow-up appointments, to offer support, and to answer any questions the patient may have. This call should ideally be made by the CHN that initially cared for the patient, however if the CHN leaves the community prior to the call being made the responsibility will fall to the Nurse in Charge (NIC) or delegate.

4.3 Sexual Assault or Abuse of a Child

- 4.3.1 All cases of sexual assault and sexual abuse against children should be referred to expert practitioners outside of the community.
- 4.3.2 Obtaining a thorough history of an alleged sexual assault of a child is a difficult skill. While the CHN needs to ensure the medical wellbeing of the child, it is easy to influence a child and promote/support misinformation, which could interfere with legal proceedings and the child's wellbeing. For this reason, the CHN should not question the child any further than to determine if any urgent medical care is required. For example, ascertaining if the child has any pain is important, but asking why the child has this pain is beyond the scope of expertise of the CHN. Consult with SATC services prior to questioning a child.
- 4.3.3 The CHN will report all instances of assault, abuse, or violence witnessed by a child to the appropriate Child and Family Services Organization.
- 4.3.4 The CHN will consult with the closest sexual assault treatment centre (SATC) to determine a plan of care. Depending on the time of last contact with the alleged perpetrator, the SATC may recommend the child is medevaced immediately, or they may suggest a scheduled appointment within the next few days. The SATC may also suggest interventions for the CHN to complete with the patient.
- 4.3.5 If the child is to be sent out the next day, Child and Family Services must be notified that the child will be staying in the community to ensure the child's safety.
- 4.3.6 If there is no safe place for the child to stay in the community, the child will need to be sent out by medevac.
- 4.3.7 In instances where a medevac is delayed, the CHN may be required to provide some care or collect some evidence. Determining which care to provide and which evidence to collect will be done in conjunction with the accepting physician/NP and the SATC.
- 4.3.8 The CHN will communicate this plan of care with the Community Physician or Nurse Practitioner.
- 4.3.9 The CHN will clearly document in the nurse's notes the complete history

obtained; any examination provided; any care provided, any samples collected, persons consulted/notified; and the plan of care.

4.4 Statutory Sexual Assault

- 4.4.1 Nurses must report all cases of statutory sexual assault. See Principles 2.4 for guidance in determining if statutory sexual assault has occurred. This includes reporting for sexual assault that is disclosed incidentally, such as during sexually transmitted infection screening or contact tracing.
- 4.4.2 Treat all cases of statutory sexual assault as sexual assault. See Principle 2.4.

4.5 Intimate Partner Violence

- 4.5.1 The CHN will include intimate partner violence screening with all Well Woman and prenatal care encounters. To facilitate a safe environment for disclosure, the CHN will complete this screening away from the client's partner or other family members.
- 4.5.2 If a disclosure of historical intimate partner violence is made, the CHN will discuss safety planning with the client using the Safety Planning Tool (*Appendix D*). The CHN can also give a copy of this plan to the patient to complete on their own, or with the assistance of a trusted community worker or friend.
- 4.5.3 If a client presents to the health facility who has been victimized by an intimate partner, the CHN will utilize the Intimate Partner Violence Documentation Tool (*Appendix E*).
- 4.5.4 Reporting intimate partner violence to law enforcement is the solely the decision of the client. The exception to this is in the case of a gunshot wound or if the client or others disclose that they are going to commit harm to themselves or others. If the client does choose to report to law enforcement, the CHN will offer the client a telephone and private space to do this.
- 4.5.5 The CHN will ensure that mental health follow-up is offered to the client, including both community and external options. The nurse will obtain consent, and send referral to mental health services, at the initial visit. In instances where a referral is not required, the nurse will assist the client to set up own appointment at initial visit.
- 4.5.6 A follow-up phone call in 5-7 days is encouraged, and will be made to each client that gives consent to this. The purpose of this call is to identify any new issues that have arisen, to ensure the patient has attended any follow-up appointments, to offer support, and to answer any questions the patient may have. This call should ideally be made by the CHN that initially cared for the patient, however if the CHN leaves the community prior to the call being made

the responsibility will fall to the Nurse in Charge (NIC), or delegate. As the person inflicting abuse may live in the home, it may be safer for the patient to call the CHN or to come to the clinic in person. This option will be discussed with the patient.

4.5.7 The CHN will be aware that violence often escalates during times of stress, including pregnancy, loss of a job, addiction, or when the abused partner tries to leave the relationship. The CHN will keep this in mind when completing assessment and safety planning.

4.5.8 If a child witnesses intimate partner violence, the CHN must report this to Child and Family Services. It is advisable to make the presenting client aware of this and to offer the client an opportunity to make this report themselves.

In Public Health Facilities

4.6 Public Health Facilities should include screening for IPV in well-person care.

4.7 The CHN should create and maintain a list of available community resources for persons that disclose SA or IPV.

4.8 If a disclosure or IPV is made, the CHN should assist the patient in completing safety planning.

4.9 The CHN is responsible for mandatory reporting as outlined in Principles 4.3.2, 4.4.1 and 4.5.5

5. RELATED POLICIES:

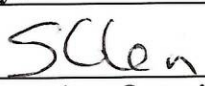
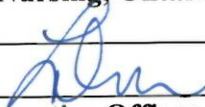
FNIHB-OR Policy: Mandatory Reporting of Child Welfare Concerns

6. REFERENCES AND FURTHER READING

Department of Justice: *A Definition of Consent to Sexual Activity*. (2017).

Department of Justice: *Age of Consent to Sexual Activity*. (2017).

Ontario Network of Sexual Assault and Domestic Violence Treatment Centers (2017).

| | |
|---|------------------------|
| Approved by: | Effective Date: |
|  Jan 22/18 | January 22 2018 |
| Director of Nursing, Ontario Region FNIHB | |
|  Date: JAN 26 2018 | |
| Regional Executive Officer, Ontario Region, FNIHB | |

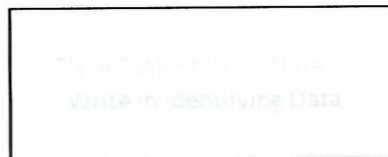
HEALTH CANADA
First Nations & Inuit Health Branch - Ontario Region
APPENDIX A – Adult Sexual Assault Assessment and Documentation Tool

First Nations Inuit Health Branch – Ontario Region

Adult Sexual Assault Assessment and Documentation Tool

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Guidelines: To be completed by Community Health Nurse for patients that have been sexually assaulted. Retain all forms in numbered order in the patient's health file..



| | | | |
|---|--|--|--|
| Confidentiality Agreement | | | |
| The information you provide to us is private. Your information is discussed only in relation to your medical and psychological needs with those persons involved in your medical care which could include the community health nurse, the nurse practitioner, and the physician. The nurses will ask for your written consent before releasing information to persons not directly involved in your care such as the police, or community resources such as a counselling centre. | | | |
| There are exceptions to confidentiality where information may be given without your consent. These include: | | | |
| 1. Cases of suspected child abuse or neglect which must be reported to the appropriate child welfare agency. This includes a domestic violence situation where there is a child residing in the same home. | | | |
| 2. Reasonable belief that informing is necessary to prevent a risk of death or serious injury. | | | |
| 3. A subpoena, summons or warrant is served by the court. If a police investigation is initiated, any documentation and evidence collection related to the visit can be subject to a warrant. | | | |
| 4. When you disclose suicidal ideation or a suicide attempt. | | | |
| Confidentiality Clause Reviewed <input type="checkbox"/> No <input type="checkbox"/> Yes | | | |
| As Sexual Assault requires 1:1 nursing attention, please ensure that you do not see or speak with any other patients until you have finished caring for this client. If required, have second nurse take all calls during this time. | | | |
| If your patient has significant injuries or requires immediate medevac, please initiate transfer prior to beginning this documentation tool. | | | |
| Administrative Information | | | |
| Date: | | Time: | |
| Name of Attending CHN: | | | |
| Name of Any Supporting CHNs: | | | |
| Patient Referred by: | <input type="checkbox"/> self | <input type="checkbox"/> family/friend | <input type="checkbox"/> police <input type="checkbox"/> other _____ |
| Accompanied by: | <input type="checkbox"/> alone | <input type="checkbox"/> family/friend | <input type="checkbox"/> other _____ |
| Police Involved: | <input type="checkbox"/> No <input type="checkbox"/> Yes | Occurrence number _____ | Officer's Name _____ |
| Police Service : _____ | | | |
| Reminder: If the patient chooses police involvement and police are present, they should be outside the room during the CHN's history and examination. They may do their own interview of the patient before or after the CHN's assessment. | | | |
| Support Services/Person offered? | <input type="checkbox"/> Declined <input type="checkbox"/> Accepted | Name of Agency/Individual: _____ | |
| Interpreter called: | <input type="checkbox"/> NA <input type="checkbox"/> Yes | Name/Agency _____ | |
| Child Protection Involved: <input type="checkbox"/> No <input type="checkbox"/> Yes | | | |
| Service/ Worker name: _____ | | | |
| Sexual Assault Treatment Center Consulted? <input type="checkbox"/> Yes <input type="checkbox"/> No Time: _____ | | | |
| Which SATC? _____ | | | |
| Name of Consultant: _____ | | | |
| Reason for consult and advice: _____ | | | |
| _____ | | | |
| _____ | | | |
| _____ | | | |
| _____ | | | |
| _____ | | | |
| _____ | | | |

Nurse's Signature and Designation _____ Initials _____

SATC: Sexual Assault Treatment Centre including Thunder Bay SADV, ACT, James Bay area SADV, Kenora SADV etc

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| | |
|---|---|
| Physician or NP Consult (mandatory) <input type="checkbox"/> Yes Provide physician/NP with a copy of this documentation tool. You may wish to complete the health history and assault history sections and consult SATC prior to consulting the physician/NP. Name of consultant: _____ Time of Consult: _____ Reason for consult and orders: _____ _____ _____ _____ | |
| Relevant Health History – inform the patient that this information is necessary for performing a thorough assessment | |
| Allergies | <input type="checkbox"/> No <input type="checkbox"/> Yes Describe: _____ |
| Immunizations | <input type="checkbox"/> None <input type="checkbox"/> Current/up to date (including Hep B series) If immunizations not up to date offer all missing immunizations. If Hep B not up to date patient should be offered Hep B Immune Globulin – discuss with Sexual Assault Treatment Centre or Consulting MD/NP. |
| Medical history | <input type="checkbox"/> diabetes <input type="checkbox"/> kidney disease <input type="checkbox"/> lung disease <input type="checkbox"/> asthma <input type="checkbox"/> epilepsy <input type="checkbox"/> hepatitis <input type="checkbox"/> liver disease <input type="checkbox"/> Other _____ Comments: _____ |
| Medications | _____ _____ _____ <small>Include prescription, non prescription, over the counter, recreational, herbal</small> |
| Physical disability | <input type="checkbox"/> No <input type="checkbox"/> Yes Describe: _____ |
| Developmental Disability | <input type="checkbox"/> No <input type="checkbox"/> Yes Describe: _____ |
| Relevant Hospitalizations: <small>(with dates if known)</small> | _____ _____ _____ |
| Surgery: | <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Tubal ligation <input type="checkbox"/> Other: _____ |
| Last menstrual period: _____ Cycle: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular Cycle length: _____ | |
| Is the patient | Pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes Due Date: _____ Breast feeding? <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Sexually active: <input type="checkbox"/> No <input type="checkbox"/> Yes Previous pelvic exam: <input type="checkbox"/> No <input type="checkbox"/> Yes | |
| Contraception: <input type="checkbox"/> No <input type="checkbox"/> Yes Method: _____ | |
| Date of last consensual intercourse: _____ Condom used: <input type="checkbox"/> No <input type="checkbox"/> Yes | |
| Inform the patient that this information is required to determine risk of pregnancy, STIs and to guide evidence collection if SAEK being performed. | |

Nurse's Signature and Designation _____ **Initials** _____
 SATC Sexual Assault Treatment Centre including Thunder Bay SADV, ACT, James Bay area SADV, Kenora SADV etc

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Guidelines: To be completed by Community Health Nurse for patients that have been sexually assaulted. Retain all forms in numbered order in the patient's health file.

File with Patient Record
Write in Identifying Data

| | | | |
|---|-----------------------------------|---|------------------------------|
| Sexual Assault History | | | |
| Date of assault: _____ | | Time of assault: _____ | |
| Location: (check all that apply) <input type="checkbox"/> Patient's home <input type="checkbox"/> Assailant's home <input type="checkbox"/> Friend's home <input type="checkbox"/> Relative's home <input type="checkbox"/> Vehicle <input type="checkbox"/> Outside <input type="checkbox"/> Other _____ Address: _____ (if known) | | | |
| Number of assailants: _____ | | Known to Client: <input type="checkbox"/> No <input type="checkbox"/> Yes | |
| Length of association: _____ | | Relationship: _____ | |
| Where does(do) the assailant(s) live? _____ | | | |
| Physical contact with: <input type="checkbox"/> weapon <input type="checkbox"/> Object Describe: _____ | | | |
| Did assailant: <input type="checkbox"/> Hit <input type="checkbox"/> Kick <input type="checkbox"/> Grab <input type="checkbox"/> Hold <input type="checkbox"/> Burn <input type="checkbox"/> Strangle | | | |
| If strangulation, Strangulation Checklist completed? <input type="checkbox"/> No <input type="checkbox"/> Yes | | | |
| Verbal threats <input type="checkbox"/> No <input type="checkbox"/> Yes Quotes: _____ | | | |
| Drug facilitation suspected <input type="checkbox"/> No <input type="checkbox"/> Yes Why? _____ | | | |
| If yes completed DFSA checklist <input type="checkbox"/> No <input type="checkbox"/> Yes | | | |
| Describe any physical or mental impairment prior to, during or after the assault and the timing: _____ | | | |
| Suspicion or knowledge that assault was recorded (webcam, phone, camera) <input type="checkbox"/> No <input type="checkbox"/> Yes | | | |
| If yes, describe: _____ | | | |
| Care Options Discussed | | | |
| Sexual Assault Evidence Kit | <input type="checkbox"/> Accepted | <input type="checkbox"/> Declined | <input type="checkbox"/> N/A |
| Diagnostic testing | <input type="checkbox"/> Accepted | <input type="checkbox"/> Declined | <input type="checkbox"/> N/A |
| Medication | <input type="checkbox"/> Accepted | <input type="checkbox"/> Declined | <input type="checkbox"/> N/A |
| Injury documentation | <input type="checkbox"/> Accepted | <input type="checkbox"/> Declined | <input type="checkbox"/> N/A |
| Police involvement | <input type="checkbox"/> Accepted | <input type="checkbox"/> Declined | <input type="checkbox"/> N/A |
| Third party report (nurse reports to police anonymously without giving patient name/information) | <input type="checkbox"/> Accepted | <input type="checkbox"/> Declined | <input type="checkbox"/> N/A |
| Community Referrals (Mental Health etc) | <input type="checkbox"/> Accepted | <input type="checkbox"/> Declined | <input type="checkbox"/> N/A |
| Which Agency? _____ | | | |
| Transfer outside the community? | <input type="checkbox"/> Accepted | <input type="checkbox"/> Declined | <input type="checkbox"/> N/A |
| Which Facility? _____ <small>If transferring, consult the sexual assault treatment centre or accepting physician to determine which care is appropriate while awaiting transfer. Clearly document orders on Page 1 of this form and ensure that documentation is sent to accepting facility.</small> | | | |

Nurse's Signature and Designation _____ **Initials** _____
 SATC Sexual Assault Treatment Centre including Thunder Bay SADV, ACT, James Bay area SADV, Kenora SADV etc

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Guidelines: To be completed by Community Health Nurse for patients that have been sexually assaulted. Retain all forms in numbered order in the patient's health file.

| |
|---|
| Sexual Assault Evidence Collection Kit (SAEK) |
| If SAEK done: Kit # _____ Time kit opened: _____ Time kit closed: _____ |
| SAEK should be completed within 12 days of the assault. If greater than 12 days is passed this care option is not as useful. Discuss with SATC if unsure. If using SAEK, complete all SAEK documentation. Use the body diagrams in the SAEK to record injuries instead of using this documentation tool to avoid double documentation. |

Complete this highlighted section only if no SAEK completed. Inform patient that the purpose of collecting this information is to guide care options. If not completing SAEK, record patient injuries on body diagrams included in this documentation tool

| | | | | | | |
|---|-----------|-----|------------|-----------|-----|------------|
| Did the assailant kiss/lick/bite etc <input type="checkbox"/> No <input type="checkbox"/> Yes Body location(s) | | | | | | |
| | Attempted | | | Completed | | |
| During the assault was there penile penetration of the victim's: | No | Yes | Don't know | No | Yes | Don't know |
| Vagina | | | | | | |
| Mouth | | | | | | |
| Anus | | | | | | |
| Condom used <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know | | | | | | |
| Penetration with <input type="checkbox"/> Finger <input type="checkbox"/> Foreign object Describe object: _____ | | | | | | |
| | Attempted | | | Completed | | |
| | No | Yes | Don't know | No | Yes | Don't know |
| Vagina | | | | | | |
| Mouth | | | | | | |
| Anus | | | | | | |

| Diagnostic Tests (as ordered by NP/MD) Ordering Provider Name | | | | | |
|--|---|-----------------------------------|---------------------------------|--------------------------------|---------------------------------|
| Pregnancy | <input type="checkbox"/> urine Result: | | <input type="checkbox"/> blood | | |
| Gonorrhea/Chlamydia (note that this test will not indicate an infection that is the result of an acute sexual assault, only a previous infection. For this reason it is advisable to treat for these today and have patient return for a test of cure in 4 weeks) | <input type="checkbox"/> cervix | <input type="checkbox"/> urethral | <input type="checkbox"/> rectal | <input type="checkbox"/> urine | <input type="checkbox"/> throat |
| Trichomonas/ Bacterial Vaginosis | <input type="checkbox"/> vaginal culture | | | | |
| Hepatitis B | <input type="checkbox"/> HbsAg | <input type="checkbox"/> AbsAb | | | |
| Syphilis | <input type="checkbox"/> VDRL | | | | |
| Toxicology (for suspected DFSA) | <input type="checkbox"/> blood | <input type="checkbox"/> urine | | | |
| HIV | <input type="checkbox"/> blood (ensure that informed consent is obtained) | | | | |
| HIV PEP baseline | <input type="checkbox"/> blood including CBC, creatinine and eGFR, liver function tests | | | | |
| Other | | | | | |

Nurse's Signature and Designation _____ Initials _____

SATC Sexual Assault Treatment Centre including Thunder Bay SADV, ACT, James Bay area SADV, Kenora SADV etc

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Guidelines: To be completed by Community Health Nurse for patients that have been sexually assaulted. Retain all forms in numbered order in the patient's health file.

Patient Information
Write in Identifying Data

| Medications (obtain physician or NP order) | | |
|--|---|--------------------------|
| Ordering Provider Name _____ | | |
| | Onsite | Take home |
| Emergency contraception | <input type="checkbox"/> | <input type="checkbox"/> |
| Gonorrhea (Will also cover for chlamydia) | <input type="checkbox"/> | <input type="checkbox"/> |
| Chlamydia | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis B (see Appendix A of this document for a detailed explanation on how to determine which product should be used) | <input type="checkbox"/> | <input type="checkbox"/> |
| Tetanus if due (Also complete HIS paperwork for any immunizations given) | <input type="checkbox"/> | <input type="checkbox"/> |
| HIV Post Exposure Prophylaxis (PEP) Kit | PEP Given? <input type="checkbox"/> Yes <input type="checkbox"/> No <small>How PEP is obtained and the drug regime chosen may be determined by the services the patient has chosen. If collaborating with an SATC (such as ACT or Thunder Bay SADV), that program may cover the cost of the medication. NIHB also covers. Consult with nearby SATC if you or the ordering provider are unsure of how to get this medication for a patient)</small> Where is PEP coming from? _____ PEP Medications Used _____ | |
| Other medications | Consider medications for pain relief and management of nausea. Record medication, amount, dosing frequency and amount dispensed below. _____ _____ _____ | |

Nurse's Signature and Designation _____ Initials _____
 SATC Sexual Assault Treatment Centre including Thunder Bay SADV, ACT, James Bay area SADV, Kenora SADV etc
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Guidelines: To be completed by Community Health Nurse for patients that have been sexually assaulted. Retain all forms in numbered order in the patient's health file.

Aviation Identifying Data

[illegible]

SATC Sexual Assault Treatment Centre including Thunder Bay SADV, ACT, James Bay area SADV, Kenora SADV etc

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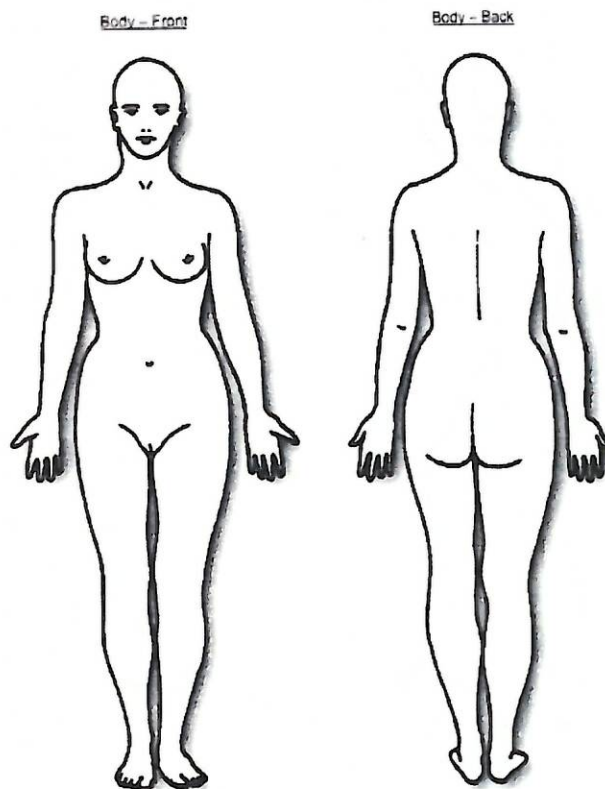
Page 17

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Place Photographs in this Area &
Write Identifying Data

Mark all injuries relevant to the assault as well as areas of tenderness and alternate light source findings on the diagram. Describe colour, appearance and size of injuries. Provide a brief history of injuries. **USE QUOTATION MARKS IF YOU ARE USING THE EXACT WORDS OF THE VICTIM.** Examples of terminology: Contusion/Bruiise; Laceration/Tear; Abrasion/Scratch; Incision/Cut; Penetrating injury; Symmetry; Tenderness; Instability; Redness; Swelling.

DESCRIPTION OF INJURIES: FEMALE: FRONT AND BACK



- ☐ No visible physical injuries noted ☐ Photographs Taken by police ☐ SAEK diagrams used
☐ Area not examined
☐ Not applicable, male body diagram used.

Nurse's Signature and Designation _____ **Initials** _____
SATC Sexual Assault Treatment Centre including Thunder Bay SADV, ACT, James Bay area SADV, Kenora SADV etc

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HEALTH CANADA
First Nations & Inuit Health Branch - Ontario Region
APPENDIX A – Adult Sexual Assault Assessment and Documentation Tool

First Nations Inuit Health Branch – Ontario Region

Adult Sexual Assault Assessment and Documentation Tool

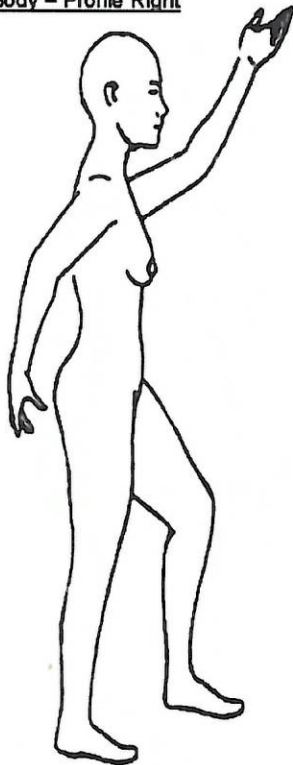
Page | 8

Guidelines: To be completed by Community Health Nurse for patients that have been sexually assaulted. Retain all forms in numbered order in the patient's health file.

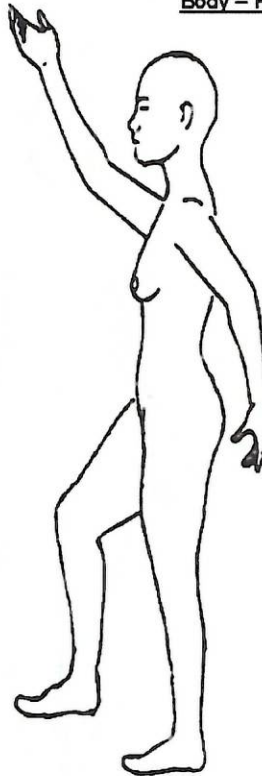
Mark all injuries relevant to the assault as well as areas of tenderness and alternate light source findings on the diagram. Describe colour, appearance and size of injuries. Provide a brief history of injuries. USE QUOTATION MARKS IF YOU ARE USING THE EXACT WORDS OF THE VICTIM. Examples of terminology: Contusion/Bruise; Laceration/Tear; Abrasion/Scratch; Incision/Cut; Penetrating injury; Symmetry; Tenderness; Instability; Redness; Swelling.

DESCRIPTION OF INJURIES: FEMALE BODY PROFILE

Body – Profile Right



Body – Profile Left



- ☐ No visible physical injuries noted ☐ Photographs Taken by police ☐ SAEK diagrams used
☐ Area not examined

Nurse's Signature and Designation _____ Initials _____
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Guidelines: To be completed by Community Health Nurse for patients that have been sexually assaulted. Retain all forms in numbered order in the patient's health file.

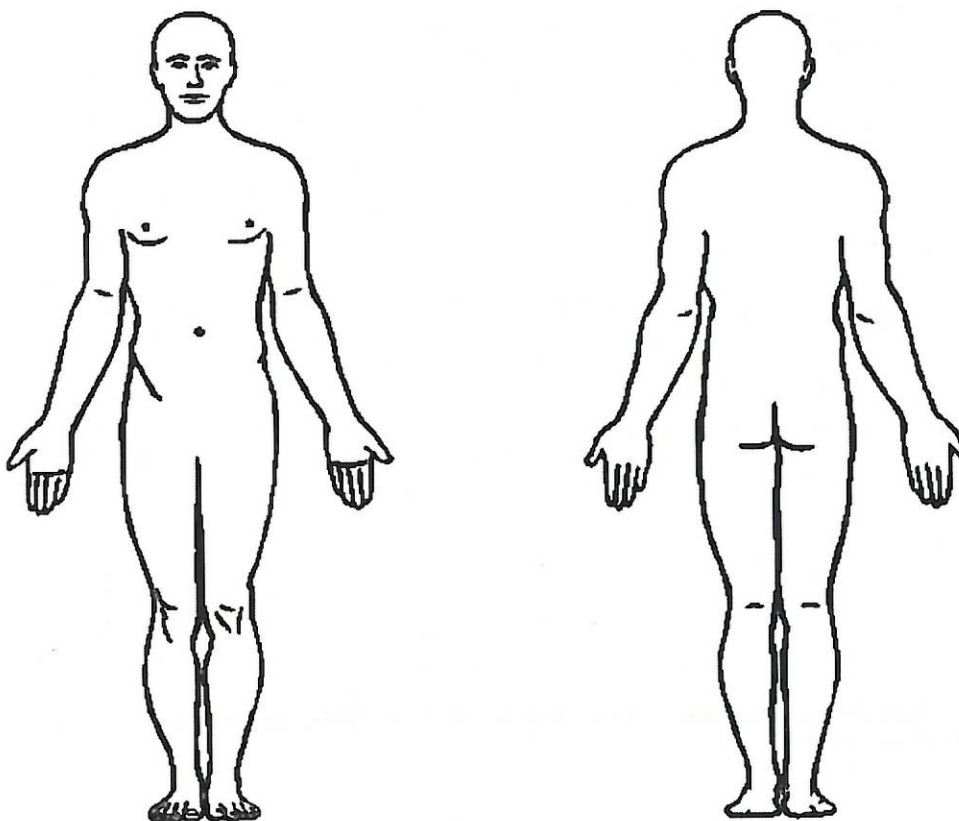
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Adult Sexual Assault Assessment and Documentation Tool

Write Identifying Data

Mark all injuries relevant to the assault as well as areas of tenderness. Describe colour, appearance and size of injuries. Provide a brief history of injuries. **USE QUOTATION MARKS IF YOU ARE USING THE EXACT WORDS OF THE VICTIM.**
Examples of terminology: Contusion/Bruise; Laceration/Tear; Abrasion/Scratch; Incision/Cut; Penetrating injury; Symmetry; Tenderness; Instability; Redness; Swelling.

DESCRIPTION OF INJURIES: MALE: FRONT AND BACK



- ☐ No visible physical injuries noted ☐ SAEK diagrams used ☐ Area not examined
☐ Not applicable, female body diagram use

Nurse's Signature and Designation _____ **Initials** _____

SATC: Sexual Assault Treatment Centre including Thunder Bay SADV, ACT, James Bay area SADV, Kenora SADV etc

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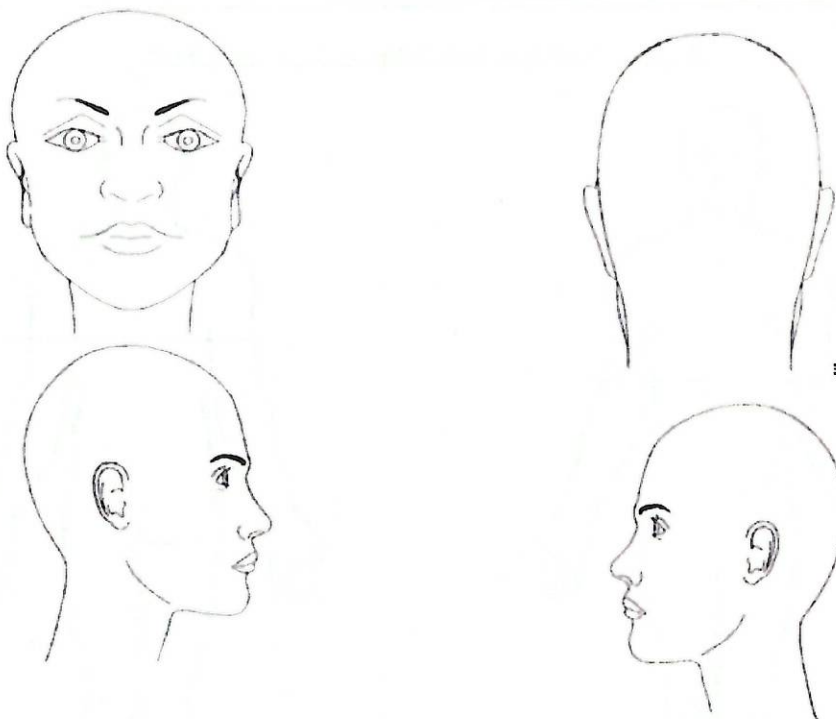
Adult Sexual Assault Assessment and Documentation Tool

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Guidelines: To be completed by Community Health Nurse for patients that have been sexually assaulted. Retain all forms in numbered order in the patient's health file..

Mark all injuries relevant to the assault as well as areas of tenderness.
Describe colour, appearance and size of injuries. Provide a brief history of injuries.
USE QUOTATION MARKS IF YOU ARE USING THE EXACT WORDS OF THE VICTIM.
Examples of terminology: Contusion/Bruise; Laceration/Tear; Abrasion/Scratch; Incision/Cut; Penetrating injury; Symmetry; Tenderness; Instability; Redness; Swelling.

DESCRIPTION OF FACIAL INJURIES: FOR BOTH MALE AND FEMALE



- ☐ No visible physical injuries noted ☐ Photographs Taken by police ☐ SAEK diagrams used
☐ Areas not examined

Nurse's Signature and Designation _____ Initials _____
SATC Sexual Assault Treatment Centre including Thunder Bay SADV, ACT, James Bay area SADV, Kenora SADV etc

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HEALTH CANADA
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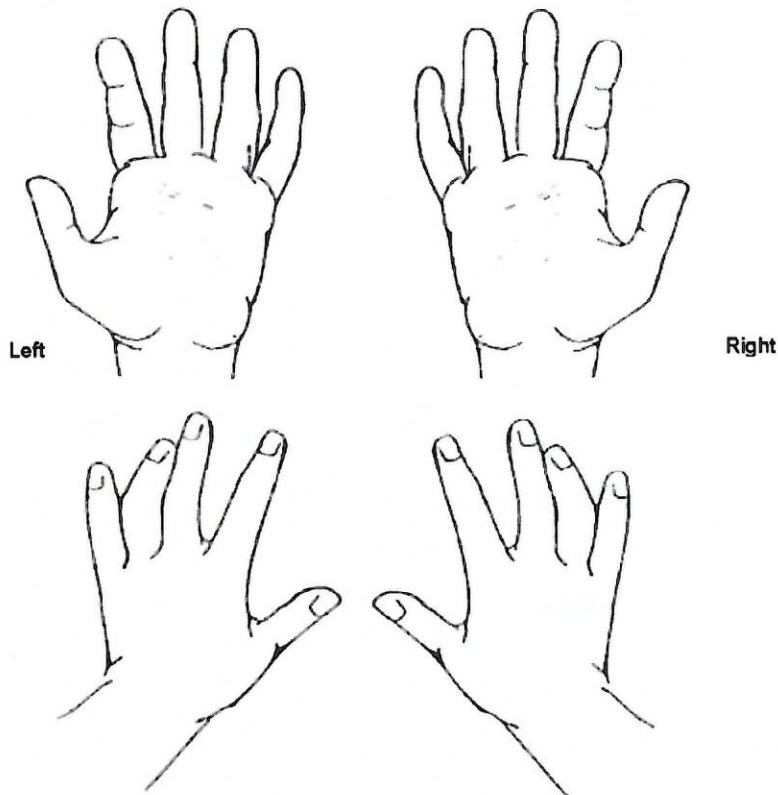
Adult Sexual Assault Assessment and Documentation Tool

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Guidelines: To be completed by Community Health Nurse for patients that have been sexually assaulted. Retain all forms in numbered order in the patient's health file.

Mark all injuries relevant to the assault as well as areas of tenderness .
Describe colour, appearance and size of injuries. Provide a brief history of injuries.
USE QUOTATION MARKS IF YOU ARE USING THE EXACT WORDS OF THE VICTIM.
Examples of terminology: Contusion/Bruise; Laceration/Tear; Abrasion/Scratch; Incision/Cut; Penetrating injury; Symmetry; Tenderness; Instability; Redness; Swelling.

DESCRIPTION OF HAND INJURIES: FOR BOTH MALE AND FEMALE



- ☐ No visible physical injuries noted ☐ Photographs Taken by police ☐ SAEK diagrams used
☐ Areas not examined

Nurse's Signature and Designation _____ **Initials** _____
SATC Sexual Assault Treatment Centre including Thunder Bay SADV, ACT, James Bay area SADV, Kenora SADV etc

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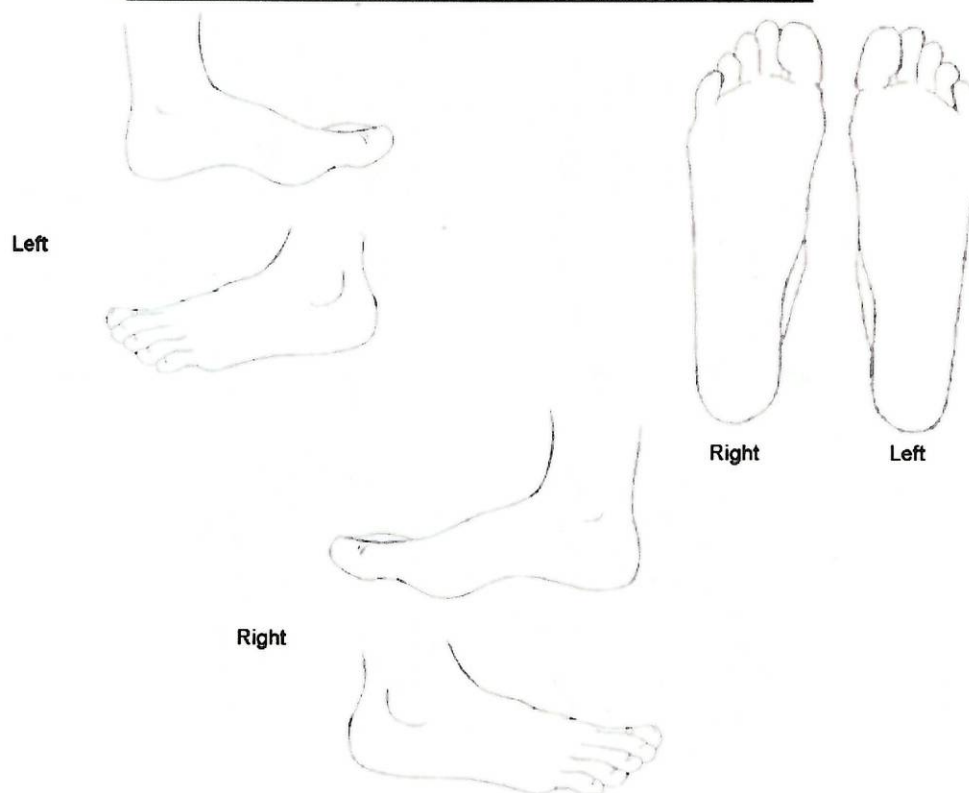
Adult Sexual Assault Assessment and Documentation Tool

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Guidelines: To be completed by Community Health Nurse for patients that have been sexually assaulted. Retain all forms in numbered order in the patient's health file.

Mark all injuries relevant to the assault as well as areas of tenderness. Describe colour, appearance and size of injuries. Provide a brief history of injuries.
USE QUOTATION MARKS IF YOU ARE USING THE EXACT WORDS OF THE VICTIM.
Examples of terminology: Contusion/Bruise; Laceration/Tear; Abrasion/Scratch; Incision/Cut; Penetrating Injury; Symmetry; Tenderness; Instability; Redness; Swelling.

DESCRIPTION OF FOOT INJURIES: FOR BOTH MALE AND FEMALE



- ☐ No visible physical injuries noted ☐ Photographs Taken by police ☐ SAEK diagrams used
☐ Area not examined

Nurse's Signature and Designation _____ Initials _____
SATC Sexual Assault Treatment Centre including Thunder Bay SADV, ACT, James Bay area SADV, Kenora SADV etc

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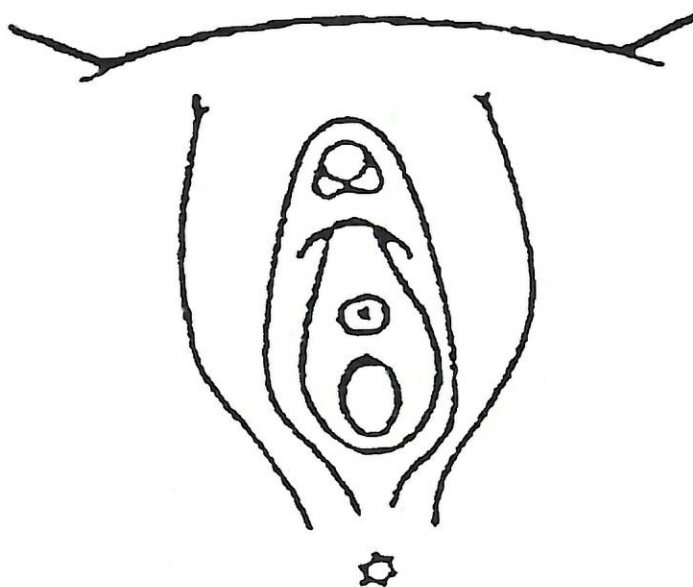
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Guidelines: To be completed by Community Health Nurse for patients that have been sexually assaulted. Retain all forms in numbered order in the patient's health file.

Mark all injuries relevant to the assault as well as areas of tenderness .
Describe colour, appearance and size of injuries. Provide a brief history of injuries.
USE QUOTATION MARKS IF YOU ARE USING THE EXACT WORDS OF THE VICTIM.
Examples of terminology: Contusion/Bruise; Laceration/Tear; Abrasion/Scratch; Incision/Cut; Penetrating injury; Symmetry; Tenderness; Instability; Redness; Swelling.

DESCRIPTION OF GENITALIA INJURIES: FEMALE



- ☐ No visible physical injuries noted ☐ SAEK diagrams used ☐ Area not examined
☐ Not applicable, male body diagram used.

Nurse's Signature and Designation _____ **Initials** _____
SATC: Sexual Assault Treatment Centre including Thunder Bay SADV, ACT, James Bay area SADV, Kenora SADV etc

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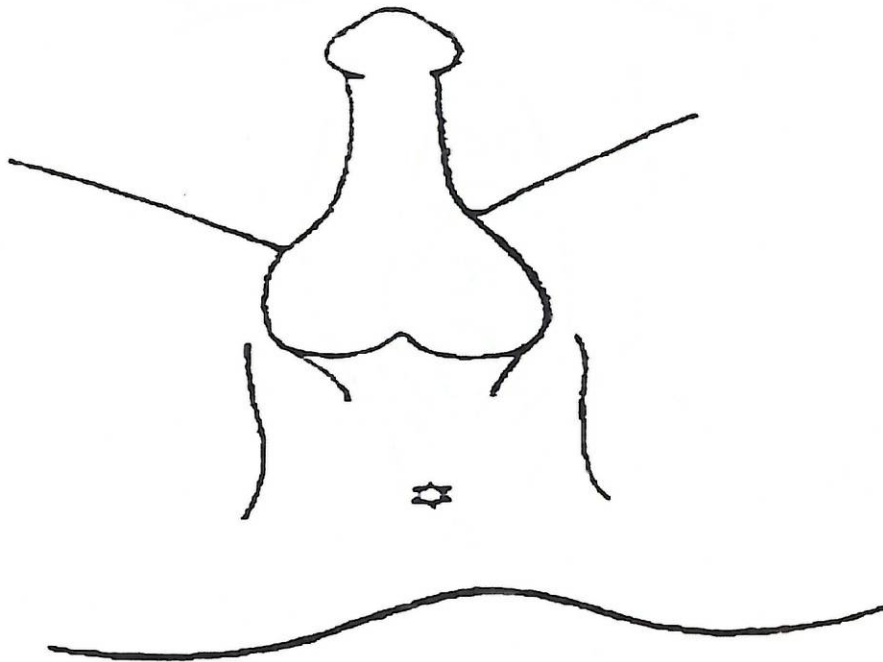
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Guidelines: To be completed by Community Health Nurse for patients that have been sexually assaulted. Retain all forms in numbered order in the patient's health file.

Mark all injuries relevant to the assault as well as areas of tenderness.
Describe colour, appearance and size of injuries. Provide a brief history of injuries.
USE QUOTATION MARKS IF YOU ARE USING THE EXACT WORDS OF THE VICTIM.
Examples of terminology: Contusion/Bruise; Laceration/Tear; Abrasion/Scratch; Incision/Cut; Penetrating injury; Symmetry; Tenderness; Instability; Redness; Swelling.

DESCRIPTION OF GENITALIA INJURIES: MALE



- ☐ No visible physical injuries noted ☐ SAEK diagrams used ☐ Area not examined
☐ Not applicable, female body diagram used.

Nurse's Signature and Designation _____ Initials _____
SATC Sexual Assault Treatment Centre including Thunder Bay SADV, ACT, James Bay area SADV, Kenora SADV etc

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First Nations & Inuit Health Branch - Ontario Region
APPENDIX A – Adult Sexual Assault Assessment and Documentation Tool

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Guidelines: To be completed by Community Health Nurse for patients that have been sexually assaulted. Retain all forms in numbered order in the patient's health file.

DISCHARGE INFORMATION – you may give a copy of this sheet directly to patient if they wish, otherwise ensure all appointment information and phone numbers are provided.

If patient requires further immunizations, when are they due: _____
Give appointment card to patient with next immunization appointment date

If patient requires further communicable disease testing (ie. HIV and Hep C at 3 and 6 months, gonorrhea/chlamydia test of cure in 4 weeks) when are these due: _____
Give patient appointment card with next testing appointment date.

If PEP given, how/when will patient receive subsequent doses? _____

If SAEK has been completed has it been picked up by police? ☐ Yes ☐ No ☐ Not applicable
If SAEK has been completed for later pickup, is it stored appropriately in a secure (locked) area of the clinic and with refrigerated and frozen components properly stored? ☐ Yes ☐ No ☐ Not applicable

Recommended Follow-up:

- ☐ Physician/NP (If a strangulation or head injury event has occurred, the patient is advised to follow up at 1-2 weeks and 1 month)
☐ CHN
☐ SATC (ie Thunder Bay SADV, Meno-Ya Win ACT)
☐ Mental Health Service: _____

Have appointments been made with these services? ☐ Yes ☐ No

If yes when and with who: _____

If no, who is responsible for making follow-up appointments? _____

If patient is to make own appointment, do they have all required contact information? ☐ Yes ☐ No

Patient agrees to Follow-up phone call by CHN in 5-7 days: ☐ Yes ☐ No

If no, does patient prefer to call: ☐ Yes ☐ No

Phone number: _____ Is it ok to leave a message? ☐ Yes ☐ No

Alternate phone number: _____
Other means of contact acceptable to patient? _____

Written Information provided:

- ☐ Strangulation What you Need To Know Sheet
☐ Helpers in Your Community Phone Number Sheet
☐ Head Injury General Information Sheet
☐ Women's Shelter Number/Pamphlet Name/Number: _____
☐ Crisis line - Assaulted Women's Helpline /Talk 4 Healing/Good 2 Talk/ Kids Help Phone Line
Number: _____
☐ Other: _____

Education

- ☐ Safety Issues discussed
☐ Discussed information re: the police and justice system
☐ Reviewed coping strategies and importance of self care
☐ Reviewed Signs & Symptoms of Post Traumatic Stress Disorder (PTSD)
☐ Identified client supports (are they available on discharge?) _____

Discharge Plan : Discharged at: _____ (Time) To: _____ (Place)
Transportation: ☐ Family/friend ☐ own ☐ police ☐ taxi ☐ other

or

Transferred care to Ornge/EMS at: _____ (Time)
Accompanied by: ☐ Family/friend ☐ self ☐ police ☐ agency worker ☐ other

Nurse's Signature and Designation _____ **Initials** _____

SATC: Sexual Assault Treatment Centre including Thunder Bay SADV, ACT, James Bay area SADV, Kenora SADV etc

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Guidelines: To be completed by Community Health Nurse for patients that have been sexually assaulted. Retain all forms in numbered order in the patient's health file..

Appendix A: Determining Risk of Hepatitis B.

This form must be completed for every patient that has been sexually assaulted.

| Hepatitis B Risk and Immunization Protocol | | | |
|--|--|--|---|
| Determine Patient's Vaccine Status and follow Ontario Publicly Funded Immunization Schedule. Obtain MD/NP Order For Bloodwork and to give Hepatitis B Immune Globulin (HBIG) | | | |
| Vaccination and antibody response status of victim. | TREATMENT | | |
| | SOURCE | SOURCE | SOURCE |
| | (+) Hepatitis B (Acute/Chronic) | (-) Hepatitis B | Unknown or not available for testing |
| <input type="checkbox"/> Unvaccinated | Acute -HBIG x 1 and initiate HB vaccine series Chronic - initiate HB vaccine series (CDC guideline) | Initiate HB vaccine series | -Initiate Hep B vaccine series if source is low risk. -If source is known high risk then treat as if source is (+) Hepatitis B |
| <input type="checkbox"/> Previously Vaccinated | | | |
| <input type="checkbox"/> a) Known Responder ¹ | NO TREATMENT | NO TREATMENT | NO TREATMENT |
| <input type="checkbox"/> b) Known Non-Responder ² | HBIG x 1 and initiate revaccination or HBIG x 2 ³ | -No treatment if received two series of vaccination. -Initiate revaccination series if only received one series | If source is known high risk, treat as if source is (+) Hepatitis B |
| <input type="checkbox"/> c) Antibody response unknown | Test exposed person for Anti-HBs (1) If adequate ¹ , no treatment needed. (2) If inadequate ² , administer HBIG and vaccine booster. | NO TREATMENT | Test exposed person for Anti-HBs (1) If adequate ¹ , no treatment. (2) If inadequate ² administer vaccine booster and recheck titer in one to two months. |
| 1. A responder is a person with adequate levels of serum antibody to HBsAg (i.e. anti-HBs ≥ 10miu/ml) 2. A non-responder is a person with inadequate levels of serum antibody t HBsAg (i.e. anti-HBs < 10miu/ml) 3. The option of giving one dose of HBIG and reinitiating the vaccine series is preferred for non-responders who have not completed a second 3-dose vaccine series. For persons who previously completed a second vaccine series but failed to respond, two doses of HBIG are preferred | | | |

Nurse's Signature and Designation _____ **Initials** _____
 SATC Sexual Assault Treatment Centre including Thunder Bay SADV, ACT, James Bay area SADV, Kenora SADV etc
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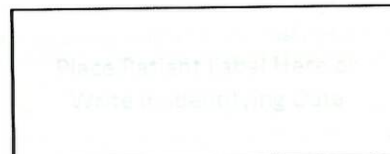
APPENDIX A – Adult Sexual Assault Assessment and Documentation Tool

First Nations Inuit Health Branch – Ontario Region

Adult Sexual Assault Assessment and Documentation Tool

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Guidelines: To be completed by Community Health Nurse for patients that have been sexually assaulted. Retain all forms in numbered order in the patient's health file.



Appendix B: HIV Risk Assessment

This form must be completed for every patient that has been sexually assaulted

| HIV Risk Assessment for PEP – consult with collaborating SATC for further assistance | | |
|---|---------|----------------------|
| <ul style="list-style-type: none"> • NO Penetration • NO contact with assailant's body Fluid | No Risk | Do Not Offer HIV PEP |
| <ul style="list-style-type: none"> • ANAL, VAGINAL or ORAL Penetration (suspected, partial, or completed) • Contact with assailant's body fluid (such as blood or ejaculate via mucous membrane, non-intact skin or bite) • Unknown exposure (such as in DFSA) | At Risk | Offer HIV PEP |

| HIV Risk Assessment Documentation | Yes | No |
|---|-----|----|
| Time lapsed since assault ≤ 72 hours? | | |
| IF > 72 hours since assault - DO NOT OFFER HIV PEP. Recommend baseline HIV test | | |
| Patient at No Risk of HIV | | |
| <ul style="list-style-type: none"> • Counselled on zero/minimal risk/no need for PEP/no need for testing/no need for followup >>> STOP | | |
| Patient at Risk of HIV | | |
| <ul style="list-style-type: none"> • Counselled on: HIV risk, HIV PEP, follow-up needed • Health history taken - Any health and/or drug contraindications to PEP identified? • Determined if patient is pregnant. Pregnant? – MD to consult Infectious Disease Specialist • HIV PEP Offered • If not offered indicate why: _____ • HIV PEP accepted • If not accepted indicate why: _____ | | |
| Patient at-risk who decline HIV PEP | | |
| <ul style="list-style-type: none"> • Reviewed HIV follow-up information • Counselled on precautions to prevent HIV transmission to sexual partner(s) • Recommended taking baseline blood sample (for storage, or testing at Initial Visit) • Recommended HIV testing at 4-6 weeks, 3 months, and 6 months post-assault | | |
| Patient at-risk who accepts HIV PEP | | |
| <ul style="list-style-type: none"> • Dispensed starter kit and ensure MD/NP/SATC places order for continuing therapy • Drug Regime _____ • Comments _____ | | |
| <ul style="list-style-type: none"> • IF patient is < 12 years of age and < 50 kg Consulted MD to determine drug dosages • Review Client Information Booklet: medication info; follow-up process • Obtained blood for HIV PEP bloodwork (CBC, electrolytes, blood sugar, creatinine, AST, ALT, ALP, bilirubin, CK, amylase, STAT serum beta-HCG (for women)) • Obtained urine for urinalysis • Obtained blood for baseline HIV test OR Counselled re: HIV testing at following visit • Scheduled 1st Follow-up appointment (2-4 days after Initial Visit) • Recommended HIV testing at 4-6 weeks, 3 months, and 6 months post-assault • Counselled on precautions to prevent HIV transmission to sexual partner(s) | | |

Nurse's Signature and Designation _____ **Initials** _____

SATC: Sexual Assault Treatment Centre including Thunder Bay SADV, ACT, James Bay area SADV, Kenora SADV etc

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HEALTH CANADA
First Nations and Inuit Health Branch - Ontario Region
APPENDIX B – Suspected Drug Facilitated Sexual Assault Checklist

First Nations Inuit Health Branch – Ontario Region

Suspected Drug Facilitated Sexual Assault Checklist

Guidelines:

1. To be completed if as Appendix to Adult Sexual Assault Documentation Form
2. Areas with a check box require a check mark (check all that apply).

Place Patient Label or Write Identifying Data

Date: _____ Time: _____

1. Why does the patient suspect drugging? (check all that patient experienced/is experiencing).

- ☐ Amnesia Hangover inconsistent with alcohol/drugs consumed
- ☐ Confusion Impaired judgment
- ☐ Conscious paralysis Impaired motor skills
- ☐ Delirium/Hallucinated Impaired vision
- ☐ Disinhibition/Loss of consciousness – How long? _____
- ☐ Dizziness Nausea/Vomiting
- ☐ Drowsiness Slurred speech
- ☐ Other: _____

2. Suspected involuntary drug ingestion-Date: _____ Time: _____

3. Why does the client suspect sexual assault?

- ☐ Reported by witness to have been seen in compromised circumstances
- ☐ Feeling that sexual acts occurred
- ☐ Clothing altered
- ☐ Body injuries
- ☐ Genital injuries
- ☐ Body fluids/foreign material
- ☐ Other _____

4. Within the last 72 hours did the client voluntarily consume alcohol?

☐ Yes ☐ No

If Yes Date: _____ Time: _____
Type /Amount _____

5. Within the last 72 hours did the client voluntarily consume any street drugs/over the counter drugs/prescription medications or has marijuana been used within the last 7 days?

☐ Yes ☐ No

If Yes Date: _____ Time: _____
Type /Amount _____

6. Diagnostic Testing

Urine drug-tested in the community? ☐ Yes ☐ No

Results _____

Urine sent for drug testing? ☐ Yes ☐ No

Urine for Sexual Assault Evidence Kit (SAEK) collected ☐ Yes ☐ No

Blood for toxicology for SAEK collected: ☐ Yes ☐ No

Continue on Adult Sexual Assault Documentation Form

Nurse's Signature and Designation _____ Initials _____

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HEALTH CANADA
First Nations and Inuit Health Branch - Ontario Region
APPENDIX C – Strangulation Checklist

First Nations Inuit Health Branch – Ontario Region

Strangulation Checklist

Place Patient Label or Write Identifying Data

Guidelines:

1. To be completed if patient indicates they were strangled or choked.
2. Areas with a "box" require a check mark (check all that apply).

Date: _____ Time: _____

☐ Strangulation suspected/unknown Comments: _____

METHOD AND/OR MANNER OF STRANGULATION:

How was victim strangled?

- ☐ One hand ☐ Right hand ☐ Left hand ☐ Two hands ☐ Knee ☐ Foot ☐ Right Forearm
☐ Left Forearm ☐ Uncertain ☐ Ligature (Describe) _____
☐ Strangled from in front ☐ Strangled from behind

Length of time of strangulation: _____ ☐ Victim unable to remember / estimate length of time

Was the victim also smothered? ☐ Yes ☐ No

From 1 to 10, how hard was the suspect's grip? (Soft) 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 (Hard)

Multiple attempts? ☐ Yes ☐ No Multiple methods? ☐ Yes ☐ No

Was the victim shaken during strangulation? ☐ Yes ☐ No

Was the victim strangled in a manner in which their feet were not touching the ground? ☐ Yes ☐ No

Was the victim's head struck or hit against a wall, floor or ground? ☐ Yes ☐ No

Describe _____

What did the suspect say to the victim during strangulation? _____

What did the victim think was going to happen? _____

How or why did the suspect stop strangling the victim? _____

Any previous strangulation attempts by the same perpetrator? ☐ Yes ☐ No

If yes, when did the incident(s) occur? _____

Is the patient pregnant? ☐ *Yes ☐ No

If yes is physician/NP aware? ☐ Yes

If over 20 weeks, does physician/NP want patient sent out for obstetrical assessment? ☐ Yes ☐ No

Is the patient experiencing any cramping or vaginal bleeding? ☐ Yes ☐ No

Describe _____

Nurse's Signature and Designation _____ Initials _____

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HEALTH CANADA
First Nations and Inuit Health Branch - Ontario Region
APPENDIX C – Strangulation Checklist

First Nations Inuit Health Branch – Ontario Region

Strangulation Checklist

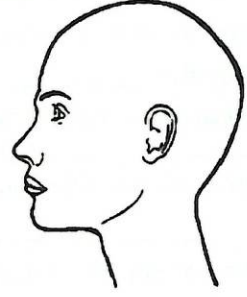
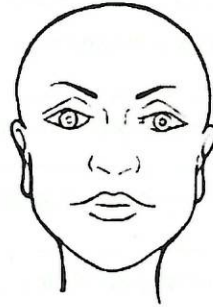
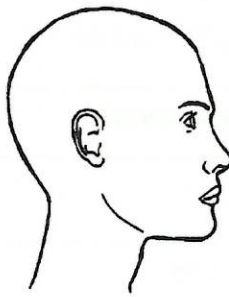
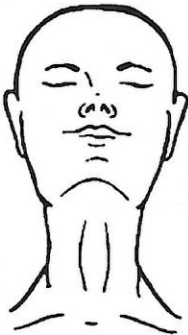
Place Patient Label or Write Identifying Data

Guidelines:

1. To be completed if patient indicates they were strangled or choked.
2. Areas with a "box" require a check mark (check all that apply).

Nursing Assessment: (* indicates more serious findings)

- | | |
|--|--|
| <input type="checkbox"/> * Neck pain <input type="checkbox"/> * Bruising to neck <input type="checkbox"/> * Abrasions to neck <input type="checkbox"/> * Red Spots / Petechia <input type="checkbox"/> * Neck swelling <input type="checkbox"/> * Subcutaneous emphysema <input type="checkbox"/> * Difficulty breathing <input type="checkbox"/> * Stridor <input type="checkbox"/> * Voice changes (raspy, hoarse, unable to speak) <input type="checkbox"/> Coughing <input type="checkbox"/> Sore throat <input type="checkbox"/> * Difficulty /pain with swallowing <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> * Loss of control of bladder <input type="checkbox"/> * loss of control of bowels | <input type="checkbox"/> * Fainting or loss of consciousness <input type="checkbox"/> Lightheaded <input type="checkbox"/> Dizziness <input type="checkbox"/> * Subconjunctival haemorrhage <u>Right</u> <u>Left</u> <input type="checkbox"/> * Vision changes Comment: _____ <input type="checkbox"/> Headache <input type="checkbox"/> Tinnitus <input type="checkbox"/> * Weakness or numbness of extremities Comment: _____ <input type="checkbox"/> Loss of memory <input type="checkbox"/> Mental status change <input type="checkbox"/> Anxiety |
|--|--|



For suspected head injury, assess:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> hemotympanum | <input type="checkbox"/> 'racoon' eyes | <input type="checkbox"/> Battle's Sign (bruising behind ears) | <input type="checkbox"/> vomiting ≥ 2 episodes |
| <input type="checkbox"/> amnesia of ≥ 30 minutes for pre event time period | <input type="checkbox"/> fall from ≥3 feet or 5 stairs | <input type="checkbox"/> age ≥65 | |

DOCUMENT ALL INJURIES ON BODY MAPS ☐ No injuries observed

Description of strangulation injuries _____

Physician/NP Notified of findings ☐ Yes Physician/NP Name _____
 Sent out for further assessment/testing? ☐ No ☐ Yes, Schedevac ☐ Yes, Medevac

Other _____
 Comments _____

Nurse's Signature and Designation _____ **Initials** _____

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HEALTH CANADA
First Nations and Inuit Health Branch - Ontario Region
APPENDIX D – Safety Planning Tool

First Nations Inuit Health Branch – Ontario Region

Safety Planning Tool

Guidelines:

1. Complete for patients that report intimate partner violence
2. A copy is retained in the chart and the patient takes a copy if safe to do so
3. The patient may also give a copy to a trusted friend or family member

Place Patient Label or Write Identifying
Data – Label chart copy only. do not label
patient's copy.

- *The purpose of a safety plan is to help an abused person and their loved ones stay safe from abuse.*
- *Fill in the blanks with the information that applies to you*
- *Use the "To Do" Lists in this plan*
- *The nurse, mental health worker, or any person you trust can help you complete this plan.*

Things that usually trigger abuse or happen before my abuser hurts me: _____

This is the safest way to enter or leave my home: _____

If I can't leave my home I can go to these rooms if I am in danger: _____

If I need to call for help, telephones are located in these places: _____

Safe places to go close by: _____

A place I can stay overnight: _____

A code word I can use to tell my friends/family I am in trouble _____

What is the plan if I call a friend/family member and tell them my code word? _____

Make sure you discuss the code word and plan with your trusted family/friends

HEALTH CANADA
First Nations and Inuit Health Branch - Ontario Region
APPENDIX D – Safety Planning Tool

First Nations Inuit Health Branch – Ontario Region

Safety Planning Tool

Guidelines:

1. Complete for patients that report intimate partner violence
2. A copy is retained in the chart and the patient takes a copy if safe to do so
3. The patient may also give a copy to a trusted friend or family member

Place Patient Label or Write Identifying
Data – Label chart copy only, do not label
patient's copy

Numbers I Can Call for Help

| People I can call for help: | |
|-----------------------------|--------|
| Name | Number |
| | |
| | |
| | |
| | |
| | |

Organizations I can call for help

| Name | Number | Website |
|--|----------------|----------------------|
| Police | | |
| Health Centre | | |
| Talk 4 Healing | 1-855-554-4325 | www.talk4healing.com |
| Mental Health Counsellor Name _____ | | |
| Closest Shelter Name _____ Place _____ | | |
| | | |
| | | |
| | | |

HEALTH CANADA
First Nations and Inuit Health Branch - Ontario Region
APPENDIX D – Safety Planning Tool

First Nations Inuit Health Branch – Ontario Region

Safety Planning Tool

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To Do

- ☐ Hide originals of important documents in a safety deposit box or with someone you trust (health card, status card, banking papers, court orders).
- ☐ Keep copies of all court orders like a restraining order, peace bond, or access order with you at all times.
- ☐ Practice getting my emergency bag and leaving my home (See the last page of this checklist for things to pack).
- ☐ Add telephone numbers to my cell phone for support people I can call. I can use a fake contact name if I don't want anyone to know I may contact a shelter.
- ☐ Memorize important phone numbers.
- ☐ Tell family my code word for when I need help and practice my plan.

Other Things I can do if I DO NOT live with my abuser

- ☐ Change the locks on my home if the abuser might have a key.
- ☐ Add extra security, such as window bars or more locks.
- ☐ Let someone know when I am leaving my house and when I get home safely.
- ☐ Tell family, friends and employers not to share my contact information or tell anyone where I am.
- ☐ If there is no reason for my abuser to come to my home (such as picking up or dropping off kids) tell my neighbours to call me when they see my abuser.
- ☐ Have someone with me for when my abuser must come to the house, such as picking up or dropping off children.

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Keeping Children Safe

(complete only if you have children)

My child's code word to leave the home or to call for help is: _____

This is the safest way for my child to enter or leave the home: _____

A safe place that my child can go: _____

If my child can't leave the home, they can go to these rooms if they are in danger: _____

| People my child can call for help if they don't feel safe | |
|---|--------|
| Name | Number |
| | |
| | |
| | |

To Do

- ☐ Tell the school/daycare etc who is allowed to pick up my child. Give them a copy of the court orders
- ☐ Tell the school/daycare etc not to share my contact info with anyone.

Depending on my child's age and situation, I can:

- ☐ Teach them a code word for when they need help
- ☐ Teach them my code word for when I need help, and what I want them to do
- ☐ Teach them how to call the police
- ☐ Tell them who is allowed to pick them up from school/daycare
- ☐ Tell them if I want them to answer the door or pick up the phone

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Staying Safe at Work

Who can I tell about my abusive situation: _____

This is the safest way to go to and leave my work: _____

Where can I go if my abuser comes to my work: _____

How to contact security or my coworkers if I feel unsafe: _____

To Do

- ☐ Practice the safest way to get to and leave work
- ☐ Avoid stairwells and other quiet areas when I am alone
- ☐ Ask someone to walk with me to work or to my car
- ☐ Ask my employer/coworkers not to share my contact information or tell my abuser where I am
- ☐ Ask someone to screen my calls at work
- ☐ Show my coworkers a photo of my abuser if they don't know who they are
- ☐ Other: _____

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Staying safe online and when using my phone

To Do

- ☐ Change passwords to online bank accounts, emails etc that my abuser knows or can easily figure out (www.lukesplace.ca/resources/keep-safe-online).
- ☐ Make my facebook or other social media accounts private, or delete these accounts and make new accounts.
- ☐ Limit what I share on social media
- ☐ Not share my location on social media and ask others to do the same
- ☐ Turn off or disable the GPS function on my cell phone or tablet.
- ☐ Block my abusers phone number
- ☐ Not accept calls from private or blocked numbers
- ☐ Set an anonymous voicemail message or have someone set it for me
- ☐ I will learn how to delete my browsing history.
- ☐ I will learn how to delete my internet cookies.
- ☐ If I live with my abuser I will use a computer at _____ instead of at home.

☐ Other: _____

☐ Other: _____

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Staying Safe in Public

To Do

☐ Have my cell phone and charger with me at all times

☐ Ask someone to come with me

☐ If I have to be somewhere alone call _____ when I leave or arrive safely

☐ If I use public transit, sit near the driver or the emergency alarm

☐ Call one of these taxi phone numbers if I feel unsafe taking public transit

☐ Avoid places where my abuser might be such as: _____

☐ Change my routines that might make it easy for my abuser to find me

☐ Learn the exits of the places I normally visit

☐ Learn the addresses for police stations nearby

☐ Other: _____

☐ Other: _____

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Staying Safe in My Car

- ☐ Have my cell phone and charger with me at all times
- ☐ Call someone when I leave or arrive safely
- ☐ Check the back seat before getting into my car
- ☐ Check if there is a GPS tracking device on my car
- ☐ Check if my car's navigation system tracks where I go and if I can delete that history
- ☐ Have someone walk me to my car
- ☐ Keep my keys in my hand when going to my car
- ☐ Make sure my gas tank is full
- ☐ Know different routes to get to home, work, or other places I normally go
- ☐ If taking a long journey or an isolated route (ie winter road) bring someone with you.
- ☐ If my abuser is following me I can drive to _____

☐ Other: _____

☐ Other: _____

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My Emergency Bag Checklist

Use this checklist to help you pack a bag in case you need to leave your home in a hurry.

Keep this bag somewhere safe in your home or with a trusted friend or family member. You should leave immediately if you have safety concerns. Only get your bag if you are able to do so safely.

☐ Copies or photographs of important items

- | | | |
|--|--|-----------------------------|
| • Birth certificates for you and your children | • Work permits | • Medical records |
| • Marriage certificate | • Banking books and records | • Insurance |
| • Immigration papers | • Mortgage or lease documents for home and car | • Copies of court documents |
| • passports | • car registration | • status card |

☐ Extra sets of keys that I need, like car, home and work keys

☐ Medications and prescriptions

☐ Change of clothes

☐ Special items like family photos or important jewellery

☐ Children's important items such as medications and prescriptions, vaccination records, special toys and a change of clothes

☐ Other: _____

Keep my wallet and purse in a spot where I can get them quickly. Make sure I have my:

- | | | |
|----------------|-------------------|---------------------------------|
| • Credit cards | • Health card | • Social insurance number (SIN) |
| • Debit Cards | • Drivers Licence | • Cell phone and charger |
| • Status Card | • Some cash | • Cheque book |

HEALTH CANADA
First Nations and Inuit Health Branch - Ontario Region

APPENDIX E- Intimate Partner Violence Assessment and Documentation Tool

First Nations Inuit Health Branch – Ontario Region

**Intimate Partner Violence
Assessment and Documentation Tool**

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Guidelines: To be completed by Community Health Nurse for patients Treated for intimate partner violence. Retain all forms in numbered order in the patient's health file..

| | |
|---|-------------|
| Confidentiality Agreement The information you provide to us is private. Your information is discussed only in relation to your medical and psychological needs with those persons involved in your medical care which could include the community health nurse, the nurse practitioner, and the physician. The nurses will ask for your written consent before releasing information to persons not directly involved in your care such as the police, or community resources such as a counselling centre. There are exceptions to confidentiality where information may be given without your consent. These include: 1. Cases of suspected child abuse or neglect which must be reported to the appropriate child welfare agency. This includes a domestic violence situation where there is a child residing in the same home. 2. Reasonable belief that informing is necessary to prevent a risk of death or serious injury. 3. A subpoena, summons or warrant is served by the court. If a police investigation is initiated, any documentation and evidence collection related to the visit can be subject to a warrant. 4. When you disclose suicidal ideation or a suicide attempt. Confidentiality Clause Reviewed <input type="checkbox"/> No <input type="checkbox"/> Yes | |
| As Intimate Partner Violence requires 1:1 nursing attention, please ensure that you do not see or speak with any other patients until you have finished caring for this client. If required, have second nurse take all calls during this time. | |
| If your patient has significant injuries or requires immediate medevac, please initiate transfer prior to beginning this documentation tool. Initiate medical care such as pain relief, wound care etc prior to starting form. | |
| Administrative Information | |
| Date: _____ | Time: _____ |
| Name of Attending CHN: _____ | |
| Name of Any Supporting CHNs: _____ | |
| Patient Referred by: <input type="checkbox"/> self <input type="checkbox"/> family/friend <input type="checkbox"/> police <input type="checkbox"/> other _____ | |
| Accompanied by: <input type="checkbox"/> alone <input type="checkbox"/> family/friend <input type="checkbox"/> other _____ | |
| Is Assailant with Patient? Y_N_ If so ask partner/assailant to wait outside the room in a designated waiting area. | |
| Police Involved: <input type="checkbox"/> No <input type="checkbox"/> Yes Occurrence number _____ Officer's Name _____ | |
| Police Service : <input type="checkbox"/> Anishinabek Police Service <input type="checkbox"/> Nishnawbe-Aski Police Service <input type="checkbox"/> Ontario Provincial Police <input type="checkbox"/> Thunder Bay City Police <input type="checkbox"/> Other _____ | |
| Reminder: If the patient chooses police involvement and police are present, they should be outside the room during the CHN's history and examination. They may do their own interview of the patient before or after the CHN's assessment. | |
| Support Services/Person offered? <input type="checkbox"/> Declined <input type="checkbox"/> Accepted Name of Agency/Individual: _____ | |
| Interpreter called: <input type="checkbox"/> NA <input type="checkbox"/> Yes Name/Agency _____ | |
| Child Protection Involved: <input type="checkbox"/> No <input type="checkbox"/> Yes Worker name: _____ | |
| Sexual Assault/Domestic Violence Centre Consulted? <input type="checkbox"/> Yes <input type="checkbox"/> No Time: _____ <input type="checkbox"/> ACT Team <input type="checkbox"/> Thunder Bay SADV <input type="checkbox"/> Other _____ | |
| Name of Consultant: _____ | |
| Reason for consult and advice: _____ _____ _____ | |

Nurse's Signature and Designation _____

Initials _____

SATC: Sexual Assault Treatment Centre including Thunder Bay SADV, ACT, James Bay area SADV, Kenora SADV etc.

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HEALTH CANADA
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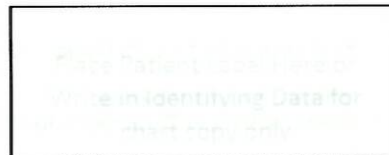
APPENDIX E- Intimate Partner Violence Assessment and Documentation Tool

First Nations Inuit Health Branch – Ontario Region

**Intimate Partner Violence
Assessment and Documentation Tool**

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Guidelines: To be completed by Community Health Nurse for patients
Treated for intimate partner violence. Retain all forms in numbered order
in the patient's health file.



| | |
|--|---|
| Physician or NP Consult (mandatory) <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Provide physician/NP with a copy of this documentation tool. You may wish to complete the health history and assault history sections and consult SATC prior to consulting the physician/NP. | |
| Name of consultant: _____ Time of Consult: _____ | |
| Reason for consult and orders: _____ | |
| | |
| | |
| | |
| Relevant Health History – Inform the patient that this information is necessary for performing a thorough assessment | |
| Allergies | <input type="checkbox"/> No <input type="checkbox"/> Yes Describe: _____ |
| Immunizations | <input type="checkbox"/> None <input type="checkbox"/> Current/up to date (including Hep B series) If immunizations not up to date offer all missing immunizations. If Hep B not up to date patient should be offered Hep B Immune Globulin – discuss with Sexual Assault Treatment Centre or Consulting MD/NP. |
| Medical history | <input type="checkbox"/> diabetes <input type="checkbox"/> kidney disease <input type="checkbox"/> lung disease <input type="checkbox"/> asthma <input type="checkbox"/> epilepsy <input type="checkbox"/> hepatitis <input type="checkbox"/> liver disease <input type="checkbox"/> Other _____ Comments: _____ |
| Medications | |
| Include prescription, non prescription, over the counter, recreational, herbal | |
| Physical disability | <input type="checkbox"/> No <input type="checkbox"/> Yes Describe: _____ |
| Developmental Disability | <input type="checkbox"/> No <input type="checkbox"/> Yes Describe: _____ |
| Relevant Hospitalizations : (with dates if known) | |
| Surgery: | <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Tubal ligation <input type="checkbox"/> Other: _____ |
| Last menstrual period: _____ Cycle: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular Cycle length: _____ | |
| Is the patient | Pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes Due Date: _____ Breast feeding? <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Sexually active: <input type="checkbox"/> No <input type="checkbox"/> Yes | Previous pelvic exam: <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Contraception: <input type="checkbox"/> No <input type="checkbox"/> Yes Method: _____ | |
| Date of last consensual intercourse: _____ Condom used: <input type="checkbox"/> No <input type="checkbox"/> Yes | |
| Inform the patient that this information is required to determine risk of pregnancy, STIs and to guide evidence collection if SAEK being performed. | |

Nurse's Signature and Designation _____ **Initials** _____
 SATC: Sexual Assault Treatment Centre including Thunder Bay SADV, ACT,
 James Bay area SADV, Kenora SADV etc. Dec 2017 Page 2 of 24

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First Nations Inuit Health Branch – Ontario Region

**Intimate Partner Violence
Assessment and Documentation Tool**

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Guidelines: To be completed by Community Health Nurse for patients
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| Current Assault History | |
|--|--|
| Date of assault: | Time of assault: |
| Location: (check all that apply) <input type="checkbox"/> Patient's home <input type="checkbox"/> Assailant's home <input type="checkbox"/> Friend's home <input type="checkbox"/> Relative's home <input type="checkbox"/> Vehicle <input type="checkbox"/> Outside <input type="checkbox"/> Other _____ Address: _____ (if known) | |
| Relationship to Victim: <input type="checkbox"/> Spouse <input type="checkbox"/> Common Law Partner <input type="checkbox"/> Same gender couple <input type="checkbox"/> Girlfriend <input type="checkbox"/> Boyfriend <input type="checkbox"/> Ex-Spouse <input type="checkbox"/> Ex-Common Law Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Separated (includes common law or dating relationships) | |
| How long have you been a couple? _____ Days/Months/Years (please circle) | |
| Has there been a recent separation or change in the relationship? <input type="checkbox"/> No <input type="checkbox"/> Yes Describe: | |
| Does the person who assaulted you presently reside in the home? If No, where? <input type="checkbox"/> No <input type="checkbox"/> Yes | |
| Information Pertaining To Children | |
| Do you have biological children with your partner? Ages? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Do you or your partner have children from another relationship? Ages? Where do they reside? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Do you have children living in the home under the age of 16 years? <small>If yes, ensure Child and Family Services is notified</small> | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Is there access between your partner and the children? Comment: | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Is there a recent change in that contact/access between your partner and the children? Comment: | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Has your partner ever threatened to remove children from your care? Comment: | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have your children ever been assaulted, and/or have they experienced emotional or sexual abuse by your partner? Comment: | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have your children ever witnessed abuse? Comment: | <input type="checkbox"/> No <input type="checkbox"/> Yes |

| | |
|--|-------------------------|
| Nurse's Signature and Designation _____ | Initials _____ |
| SATC: Sexual Assault Treatment Centre including Thunder Bay SADV, ACT, James Bay area SADV, Kenora SADV etc. | Dec 2017 Page 3 of 24 |

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Place Patient Label Here or
Write Identifying Data for
chart copy only

| | | |
|---|--|--|
| Nature of present assault: (as reported by patient) | | |
| <input type="checkbox"/> Pushing <input type="checkbox"/> Punching <input type="checkbox"/> Slapping <input type="checkbox"/> Kicking <input type="checkbox"/> Biting <input type="checkbox"/> Cutting <input type="checkbox"/> Burning <input type="checkbox"/> Hair pulling <input type="checkbox"/> Objects thrown <input type="checkbox"/> Strangulation (Complete Strangulation Checklist) <input type="checkbox"/> Sexual Assault (Complete Nursing Documentation Form for Sexual Assault ; Offer SAEK) <input type="checkbox"/> Restraining (method) _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Verbal threats(describe) _____ | | |
| What is bothering you the most right now? _____ | | |
| Alcohol/Drugs Consumed by Patient: <input type="checkbox"/> No <input type="checkbox"/> Yes When: _____ What/How much: _____ | | |
| Describe any physical or mental impairment experienced prior to, during, or after the assault. When were these symptoms experienced? _____ | | |
| Alcohol/Drugs Consumed by Accused: <input type="checkbox"/> No <input type="checkbox"/> Yes When: _____ What/How much: _____ | | |
| Thoughts of self-harm or suicide? Comment: _____ | | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Did the person who assaulted you threaten : | | |
| to kill you? | | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| to harm family or friends? | | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| to use a weapon? | | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Did the person who assaulted you, use a weapon? | | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Weapon used: <input type="checkbox"/> None <input type="checkbox"/> Gun <input type="checkbox"/> Knife <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____ <input type="checkbox"/> Weapon indicated but not seen by victim | | |
| Are there any firearms in the home? | | <input type="checkbox"/> Don't know <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Does the person who assaulted you have access to firearms? | | <input type="checkbox"/> Don't know <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Has there been a recent change in his/her employment status? | | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Victim Vulnerability | <input type="checkbox"/> Geographical/community isolation <input type="checkbox"/> Language barrier <input type="checkbox"/> Disability <input type="checkbox"/> Lack of access to phone or other communication <input type="checkbox"/> Child issues <input type="checkbox"/> Lack of access to transportation <input type="checkbox"/> Other(describe) _____ | |
| Will you be able to provide food/shelter for yourself/family if your partner goes to jail? | | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Are you currently living with or reliant on your partner's family for shelter or support? | | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Is this community your place of residence? | | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| If not, what is your home community? _____ | | |

Nurse's Signature and Designation _____ Initials _____
 SATC- Sexual Assault Treatment Centre including Thunder Bay SADV, ACT,
 James Bay area SADV, Kenora SADV etc. Dec 2017 Page 4 of 24

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**Intimate Partner Violence
Assessment and Documentation Tool**

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Guidelines: To be completed by Community Health Nurse for patients
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| | |
|---|--|
| History of Previous Domestic Violence | |
| To the best of your knowledge has your partner assaulted or been emotionally or sexually abusive with any previous spouse/partners from another relationship? Comment: | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you been assaulted at other times by this person? Comment: | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Did any of the past assaults occur when your partner knew you were pregnant? Comment: | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Did any of the previous assaults involve choking or strangling? On approximately how many occasions did this occur? _____ Did any of the previous assaults result in head injury or concussion? Comment: | <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you had any injuries from previous assaults? Comment: | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you ever received medical treatment for injuries because you were assaulted? Comment: | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| As far as you can remember, how long has the relationship been abusive? Comment: | |
| Has the abuse become more frequent? Comment: | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Has the abuse become more violent? Comment: | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have the police been called to respond to any domestic situations involving your partner prior to this incident? Describe: | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Does your partner : | |
| Show extreme possessiveness, control or jealousy? ie saying things like 'If I can't have you, then no one can.' Describe: | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Limit or refuse your access to money or bank accounts, spend or take your money, demand that you explain when you spend money? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Limit or refuse you access to family and friends? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Refuse to let you go out in public or check up on you when you are out? | <input type="checkbox"/> No <input type="checkbox"/> Yes |

Nurse's Signature and Designation _____

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| | |
|---|---|
| Limit or refuse to let you go to work or school freely? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Check your emails, facebook account, cell phone call or text logs or monitor, control or limit your computer activities? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Listen to your phone conversations? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Limit or refuse you free access to your phone? Ever broken, hid, unplugged or torn the phone from the wall? Take, break or hide your cell phone? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Limit or refuse to let you use the motor vehicle or check the mileage? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Control your hairstyle, use of makeup or what you wear? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Threatened to, or destroyed, or damaged any of your belongings or contents of your home or a pet to intimidate you? Describe: | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Limit or refuse to let you practice your religion or cultural or spiritual beliefs? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Forced sexual activity when you did not wish it or demand you participate in sexual acts you were not comfortable with? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have possession of your passport or other important items i.e. debit card, OHIP card, marriage license, legal papers, keys, pet, etc? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Has Your Partner: | |
| Ever been charged with any criminal behaviour? Comment: | <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know |
| Disobeyed any court order, such as bail conditions or a restraining order, any criminal order? Comment: | <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know |
| Engaged in any stalking behaviour with you in the past? example: harassing phone calls, watching, following, frequenting workplace Comment: | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Ever tried to persuade you not to contact police or not to testify in previous court proceedings? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Ever received counselling for drugs, alcohol or gambling? Comment: | <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know |
| Forcibly confined you, or prevented you from using the phone, leaving the house or contacting family or friends? Comment: | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Threatened to kill or harm you, other family members, children, friends or helping professionals? Comment: | <input type="checkbox"/> No <input type="checkbox"/> Yes |

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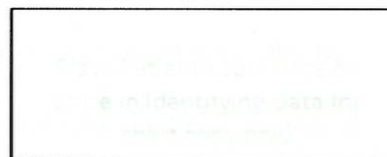
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| | |
|--|---|
| Ever attempted to act on such threats? Comment: | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Attempted or threatened to commit suicide? Comment: | <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know |
| Been under psychiatric care, now or in the past? | <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know |
| Are you afraid of your partner's friends, family or associates? Comment: | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Do you believe your partner is capable of severely injuring or killing you (or your children)? | <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know |

| Health Concerns | |
|--|--|
| Are you dependant on your partner for medication, alcohol or street drugs? Comment: | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| If so, are you worried you could go into withdrawal Comment: | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Are you worried that your partner may have cheated on you? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Would you like testing for sexually transmitted and blood borne infections? | <input type="checkbox"/> No <input type="checkbox"/> Yes |

| Care Options | Discussed | Chosen |
|---|-----------|--------|
| Physical examination | | |
| Injury documentation (written only) | | |
| Written documentation of injuries | | |
| Forensic evidence collection | | |
| Police Involvement | | |
| Photography by Police | | |
| Diagnostic testing (include STI testing if client concerns) | | |
| Safety Plan | | |
| Community Referrals | | |

| Safety Plan – see Appendix A | |
|---|--|
| Does patient want to complete safety plan at this time? Comment: | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| If yes, would they like assistance from CHN or other person? Comment: | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| If no, would they like to plan a time to return to complete plan? Comment: | <input type="checkbox"/> No <input type="checkbox"/> Yes |

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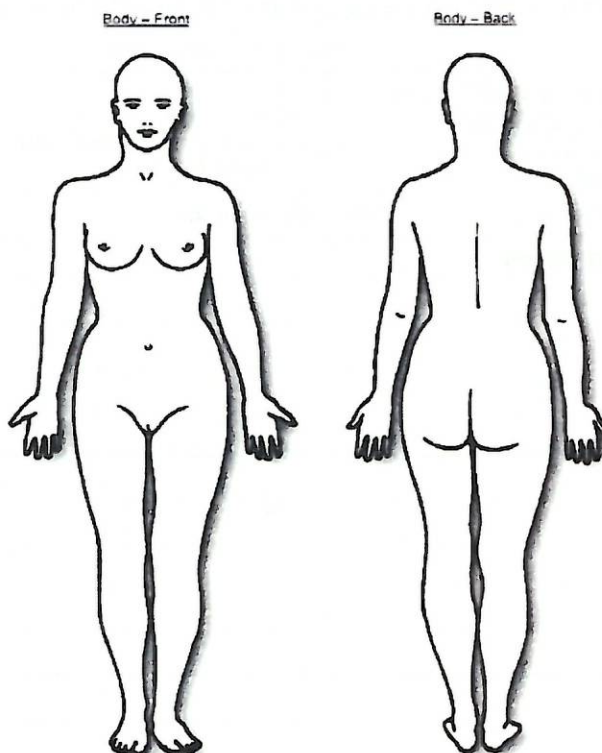
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Mark all injuries relevant to the assault as well as areas of tenderness. Describe colour, appearance and size of injuries. Provide a brief history of injuries.
USE QUOTATION MARKS IF YOU ARE USING THE EXACT WORDS OF THE VICTIM.
Examples of terminology: Contusion/Bruise; Laceration/Tear; Abrasion/Scratch; Incision/Cut; Penetrating Injury; Symmetry; Tenderness; Instability; Redness;
Swelling.

DESCRIPTION OF INJURIES: FEMALE BODY FRONT AND BACK



- ☐ No visible physical injuries noted
☐ Not applicable – male diagram used

- ☐ Photographs Taken ☐ Area not examined

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FNIHB Patient Label Here or
Place in Identifying Data for
chart copy only

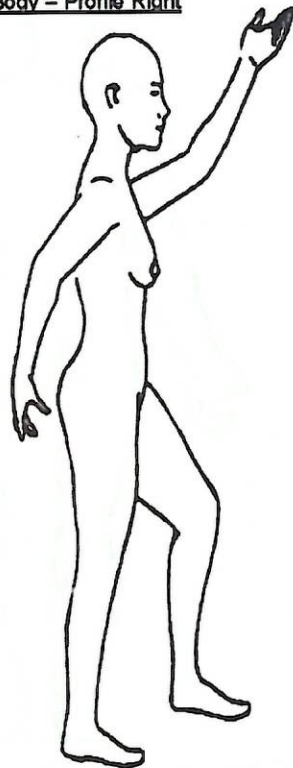
Mark all injuries relevant to the assault as well as areas of tenderness. Describe colour, appearance and size of injuries. Provide a brief history of injuries.

USE QUOTATION MARKS IF YOU ARE USING THE EXACT WORDS OF THE VICTIM.

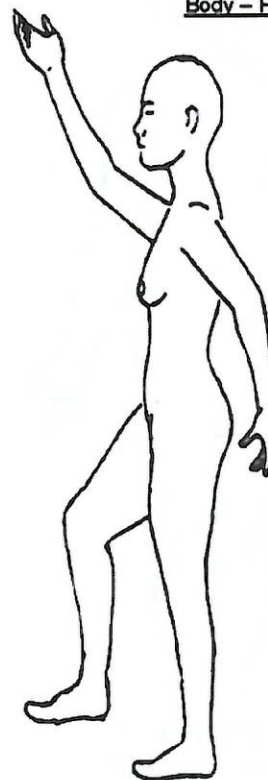
Examples of terminology: Contusion/Bruise; Laceration/Tear; Abrasion/Scratch; Incision/Cut; Penetrating Injury; Symmetry; Tenderness; Instability; Redness; Swelling.

DESCRIPTION OF INJURIES: FEMALE SIDE PROFILE

Body – Profile Right



Body – Profile Left



- ☐ No visible physical injuries noted
☐ Not applicable – male diagram used

- ☐ Photographs Taken ☐ Area not examined

DESCRIPTION OF INJURIES: MALE: FRONT AND BACK

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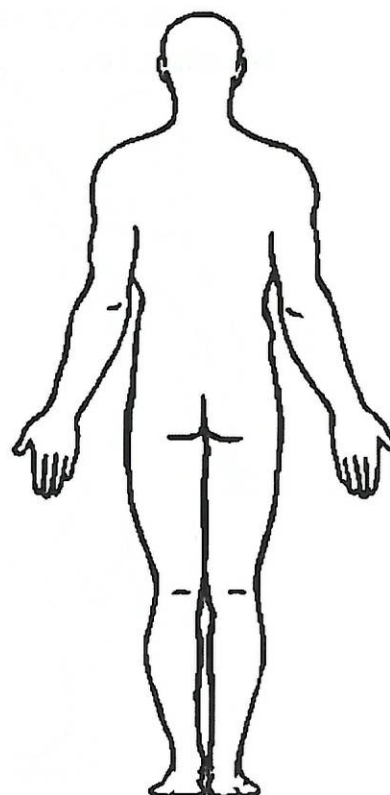
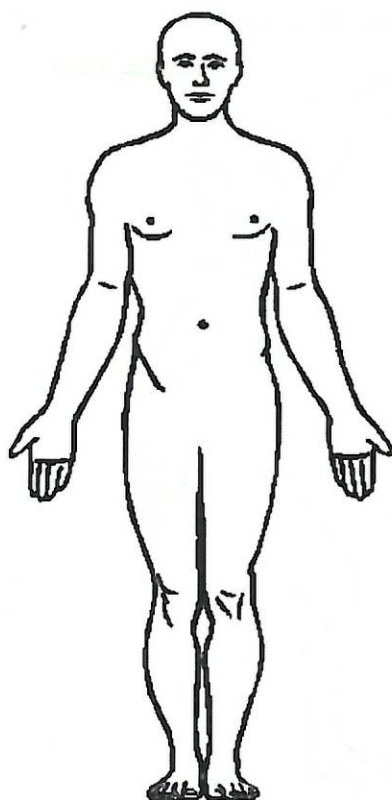
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Mark all injuries relevant to the assault as well as areas of tenderness. Describe colour, appearance and size of injuries. Provide a brief history of injuries.
USE QUOTATION MARKS IF YOU ARE USING THE EXACT WORDS OF THE VICTIM.
Examples of terminology: Contusion/Bruise; Laceration/Tear; Abrasion/Scratch; Incision/Cut; Penetrating Injury; Symmetry; Tenderness; Instability; Redness; Swelling.



☐ No visible physical injuries noted
☐ Not applicable – male diagram used

☐ Photographs Taken ☐ Area not examined

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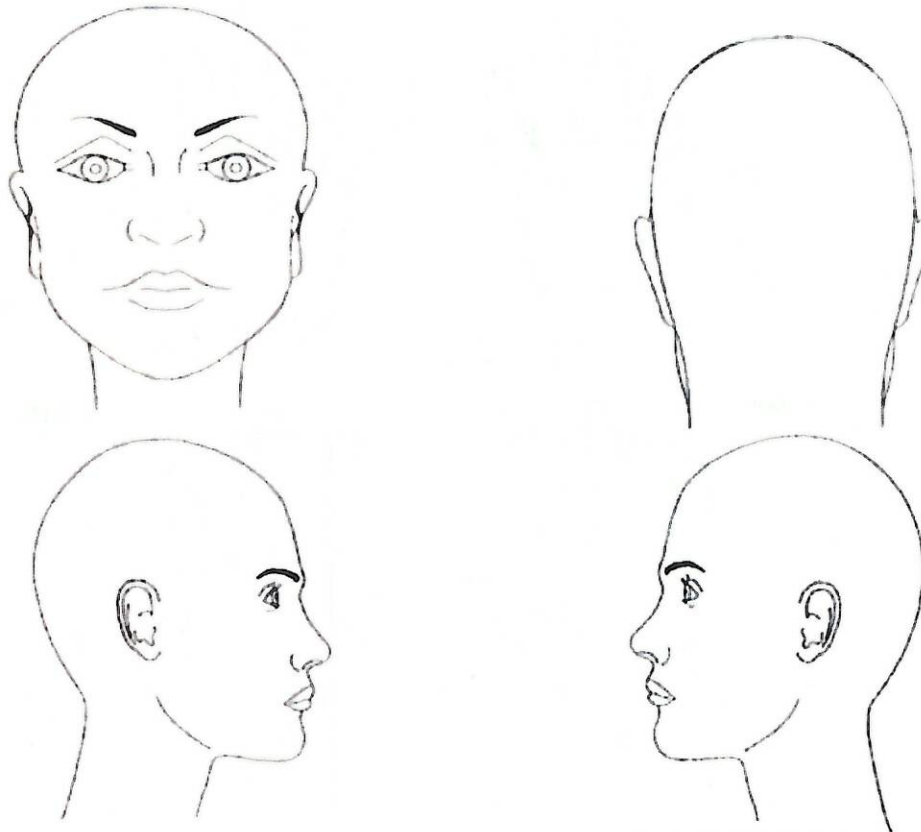
Place Patient's Legal Name or
Write in Identifying Data for
chart copy only

Mark all injuries relevant to the assault as well as areas of tenderness. Describe colour, appearance and size of injuries. Provide a brief history of injuries.

USE QUOTATION MARKS IF YOU ARE USING THE EXACT WORDS OF THE VICTIM.

Examples of terminology: Contusion/Bruise; Laceration/Tear; Abrasion/Scratch; Incision/Cut; Penetrating Injury; Symmetry; Tenderness; Instability; Redness; Swelling.

DESCRIPTION OF FACIAL INJURIES



☐ No visible physical injuries noted

☐ Photographs Taken

☐ Area not examined

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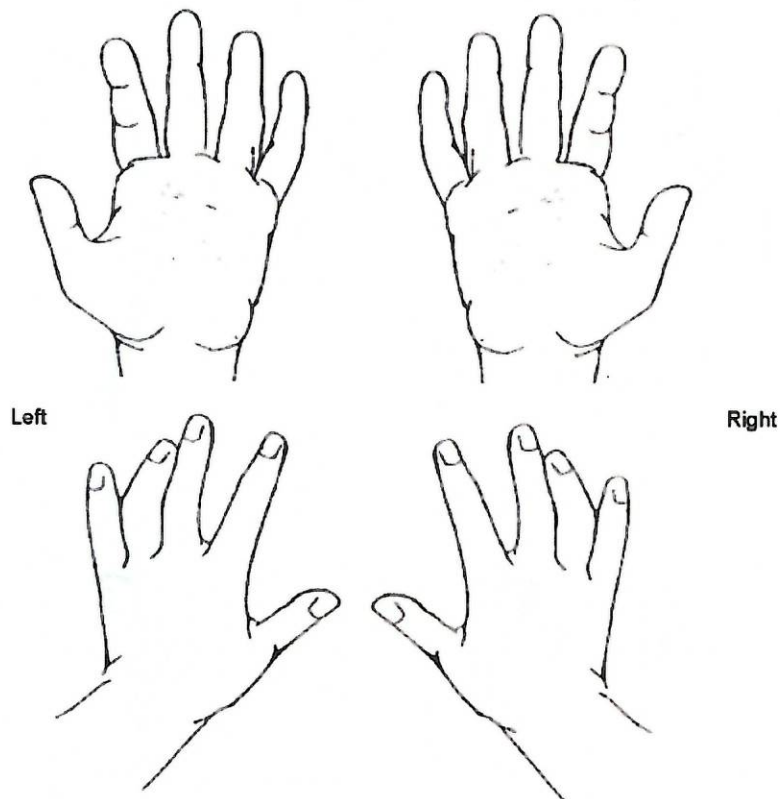
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Mark all injuries relevant to the assault as well as areas of tenderness. Describe colour, appearance and size of injuries. Provide a brief history of injuries.
USE QUOTATION MARKS IF YOU ARE USING THE EXACT WORDS OF THE VICTIM.
Examples of terminology: Contusion/Bruise; Laceration/Tear; Abrasion/Scratch; Incision/Cut; Penetrating Injury; Symmetry; Tenderness; Instability; Redness; Swelling.

DESCRIPTION OF HAND INJURIES



☐ No visible physical injuries noted

☐ Photographs Taken

☐ Area not examined

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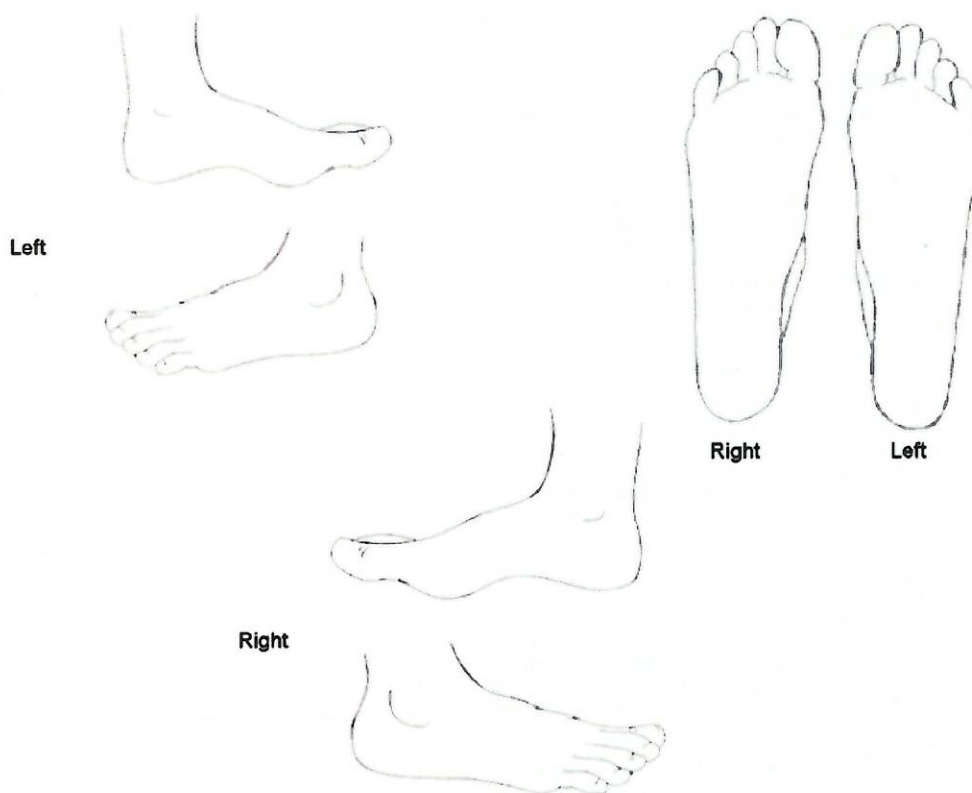
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Place Patient Label Here or
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Mark all injuries relevant to the assault as well as areas of tenderness. Describe colour, appearance and size of injuries. Provide a brief history of injuries.
USE QUOTATION MARKS IF YOU ARE USING THE EXACT WORDS OF THE VICTIM.
Examples of terminology: Contusion/Bruise; Laceration/Tear; Abrasion/Scratch; Incision/Cut; Penetrating Injury; Symmetry; Tenderness; Instability; Redness; Swelling.

DESCRIPTION OF FOOT INJURIES



☐ No visible physical injuries noted

☐ Photographs Taken

☐ Area not examined

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DISCHARGE INFORMATION – you may give patient a copy of this form if safe to do so.

Check if copy given ☐

If patient requires further communicable disease testing (ie. HIV and Hep C at 3 and 6 months, gonorrhea/chlamydia test of cure in 4 weeks) when are these due: _____

Give patient this page or appointment card with next testing appointment date.

Recommended Follow-up:

☐ Physician/NP (If a strangulation or head injury event has occurred, the patient is advised to follow up at 1-2 weeks and 1 month)

☐ CHN

☐ SATC (ie Thunder Bay SADV, Meno-Ya Win ACT) Number: _____

☐ Mental Health Service: _____ Number: _____

Have appointments been made with these services? ☐ Yes ☐ No

If yes when and with who: _____

If no, who is responsible for making follow-up appointments? _____

If patient is to make own appointment, do they have all required contact information? ☐ Yes ☐ No

Was safety plan completed? ☐ Yes ☐ No

If not completed today when/how will this be completed? _____

Is it safe for patient to take copy of safety plan? ☐ Yes ☐ No

If safe have they been given copy? ☐ Yes ☐ No

Patient agrees to Follow-up phone call by CHN in 5-7 days: ☐ Yes ☐ No

If no, does patient prefer to call: ☐ Yes ☐ No

Phone number: _____ Is it ok to leave a message? ☐ Yes ☐ No

Alternate phone number: _____

Other means of contact acceptable to patient? _____

Written Information provided:

☐ Strangulation What you Need To Know Sheet

☐ Head Injury General Information Sheet

☐ Helpers in Your Community Phone Number Sheet

☐ Women's Shelter Number/Pamphlet Name/Number: _____

☐ Crisis line - Assaulted Women's Helpline /Talk 4 Healing/Good 2 Talk/ Kids Help Phone Line

Number _____

☐ Other _____

Education

☐ Safety Issues discussed

☐ Discussed information re: the police and justice system

☐ Reviewed coping strategies and importance of self care

☐ Reviewed Signs & Symptoms of Post Traumatic Stress Disorder (PTSD)

☐ Identified client supports (are they available on discharge?) _____

Discharge Plan : Discharged at: _____ (Time) To: _____ (Place)

Transportation: ☐ Family/friend ☐ own ☐ police ☐ taxi ☐ other

Or

Transferred care to Ornge/EMS at: _____ (Time)

Accompanied by: ☐ Family/friend ☐ self ☐ police ☐ agency worker ☐ other

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Place Patient's Last Name or
Initials in Identifying Data for
chart copy only

Appendix A- Safety Planning Tool

- *The purpose of a safety plan is to help an abused person and their loved ones stay safe from abuse.*
- *Fill in the blanks with the information that applies to you*
- *Use the "To Do" Lists in this plan*
- *The nurse, mental health worker, or any person you trust can help you complete this plan.*

Things that usually trigger abuse or happen before my abuser hurts me: _____

This is the safest way to enter or leave my home: _____

If I can't leave my home I can go to these rooms if I am in danger: _____

If I need to call for help, telephones are located in these places: _____

Safe places to go close by: _____

A place I can stay overnight: _____

A code word I can use to tell my friends/family I am in trouble _____

What is the plan if I call a friend/family member and tell them my code word? _____

Make sure you discuss the code word and plan with your trusted family/friends

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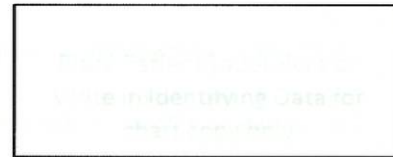
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Numbers I Can Call for Help

| People I can call for help: | | |
|-----------------------------|--------|--|
| Name | Number | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| Organizations I can call for help | | |
|--|----------------|----------------------|
| Name | Number | Website |
| Police | | |
| Health Centre | | |
| Talk 4 Healing | 1-855-554-4325 | www.talk4healing.com |
| Mental Health Counsellor Name _____ | | |
| Closest Shelter Name _____ Place _____ | | |
| | | |
| | | |
| | | |

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To Do

- ☐ Hide originals of important documents in a safety deposit box or with someone you trust (health card, status card, banking papers, court orders).
- ☐ Keep copies of all court orders like a restraining order, peace bond, or access order with you at all times.
- ☐ Practice getting my emergency bag and leaving my home (See the last page of this checklist for things to pack).
- ☐ Add telephone numbers to my cell phone for support people I can call. I can use a fake contact name if I don't want anyone to know I may contact a shelter.
- ☐ Memorize important phone numbers.
- ☐ Tell family my code word for when I need help and practice my plan.

Other Things I can do if I DO NOT live with my abuser

- ☐ Change the locks on my home if the abuser might have a key.
- ☐ Add extra security, such as window bars or more locks.
- ☐ Let someone know when I am leaving my house and when I get home safely.
- ☐ Tell family, friends and employers not to share my contact information or tell anyone where I am.
- ☐ If there is no reason for my abuser to come to my home (such as picking up or dropping off kids) tell my neighbours to call me when they see my abuser.
- ☐ Have someone with me for when my abuser must come to the house, such as picking up or dropping off children.

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Keeping Children Safe
(complete only if you have children)

My child's code word to leave the home or to call for help is: _____

This is the safest way for my child to enter or leave the home: _____

A safe place that my child can go: _____

If my child can't leave the home, they can go to these rooms if they are in danger: _____

| People my child can call for help if they don't feel safe | |
|---|--------|
| Name | Number |
| | |
| | |
| | |

To Do

- ☐ Tell the school/daycare etc who is allowed to pick up my child. Give them a copy of the court orders
- ☐ Tell the school/daycare etc not to share my contact info with anyone.

Depending on my child's age and situation, I can:

- ☐ Teach them a code word for when they need help
- ☐ Teach them my code word for when I need help, and what I want them to do
- ☐ Teach them how to call the police
- ☐ Tell them who is allowed to pick them up from school/daycare
- ☐ Tell them if I want them to answer the door or pick up the phone

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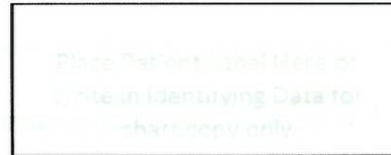
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Staying Safe at Work

Who can I tell about my abusive situation: _____

This is the safest way to go to and leave my work: _____

Where can I go if my abuser comes to my work: _____

How to contact security or my coworkers if I feel unsafe: _____

To Do

- ☐ Practice the safest way to get to and leave work
 - ☐ Avoid stairwells and other quiet areas when I am alone
 - ☐ Ask someone to walk with me to work or to my car
 - ☐ Ask my employer/coworkers not to share my contact information or tell my abuser where I am
 - ☐ Ask someone to screen my calls at work
 - ☐ Show my coworkers a photo of my abuser if they don't know who they are
 - ☐ Other: _____
- _____

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Staying safe online and when using my phone

To Do

- ☐ Change passwords to online bank accounts, emails etc that my abuser knows or can easily figure out (www.lukesplace.ca/resources/keep-safe-online).
- ☐ Make my facebook or other social media accounts private, or delete these accounts and make new accounts.
- ☐ Limit what I share on social media
- ☐ Not share my location on social media and ask others to do the same
- ☐ Turn off or disable the GPS function on my cell phone or tablet.
- ☐ Block my abusers phone number
- ☐ Not accept calls from private or blocked numbers
- ☐ Set an anonymous voicemail message or have someone set it for me
- ☐ I will learn how to delete my browsing history.
- ☐ I will learn how to delete my internet cookies.
- ☐ If I live with my abuser I will use a computer at _____ instead of at home.
- ☐ Other: _____
- _____
- ☐ Other: _____
- _____

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Place Patient Label Here or
Write in Identifying Data for
chart copy only

Staying Safe in Public

To Do

- ☐ Have my cell phone and charger with me at all times
- ☐ Ask someone to come with me
- ☐ If I have to be somewhere alone call _____ when I leave or arrive safely
- ☐ If I use public transit, sit near the driver or the emergency alarm
- ☐ Call one of these taxi phone numbers if I feel unsafe taking public transit

- ☐ Avoid places where my abuser might be such as: _____

- ☐ Change my routines that might make it easy for my abuser to find me
- ☐ Learn the exits of the places I normally visit
- ☐ Learn the addresses for police stations nearby

☐ Other: _____

☐ Other: _____

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Staying Safe in My Car

- ☐ Have my cell phone and charger with me at all times
- ☐ Call someone when I leave or arrive safely
- ☐ Check the back seat before getting into my car
- ☐ Check if there is a GPS tracking device on my car
- ☐ Check if my car's navigation system tracks where I go and if I can delete that history
- ☐ Have someone walk me to my car
- ☐ Keep my keys in my hand when going to my car
- ☐ Make sure my gas tank is full
- ☐ Know different routes to get to home, work, or other places I normally go
- ☐ If taking a long journey or an isolated route (ie winter road) bring someone with you.
- ☐ If my abuser is following me I can drive to _____

☐ Other: _____

☐ Other: _____

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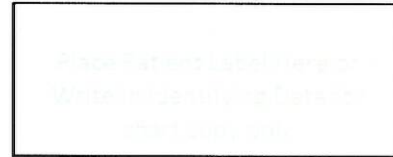
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Assessment and Documentation Tool**

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Guidelines: To be completed by Community Health Nurse for patients
Treated for intimate partner violence. Retain all forms in numbered order
in the patient's health file..



My Emergency Bag Checklist

Use this checklist to help you pack a bag in case you need to leave your home in a hurry.

Keep this bag somewhere safe in your home or with a trusted friend or family member. You should leave immediately if you have safety concerns. Only get your bag if you are able to do so safely.

☐ Copies or photographs of important items

- | | | |
|--|--|-----------------------------|
| • Birth certificates for you and your children | • Work permits | • Medical records |
| • Marriage certificate | • Banking books and records | • Insurance |
| • Immigration papers | • Mortgage or lease documents for home and car | • Copies of court documents |
| • passports | • car registration | • status card |

☐ Extra sets of keys that I need, like car, home and work keys

☐ Medications and prescriptions

☐ Change of clothes

☐ Special items like family photos or important jewellery

☐ Children's important items such as medications and prescriptions, vaccination records, special toys and a change of clothes

☐ Other: _____

Keep my wallet and purse in a spot where I can get them quickly. Make sure I have my:

- | | | |
|----------------|-------------------|---------------------------------|
| • Credit cards | • Health card | • Social insurance number (SIN) |
| • Debit Cards | • Drivers Licence | • Cell phone and charger |
| • Status Card | • Some cash | • Cheque book |

Nurse's Signature and Designation _____ **Initials** _____
SATC- Sexual Assault Treatment Centre including Thunder Bay SADV, ACT, James Bay area SADV, Kenora SADV etc. Dec 2017 Page 24 of 24