Patient Care Plan and Nursing Discharge Instructions

Patient Label

Website: http://sak.cji.in.gov

Kit Number: ____ PIN: _____________________

Thank you for trusting our emergency department with your care. You were seen by a forensic nurse for a medical forensic examination. It is our priority to ensure your health and safety, both during your visit and after you are discharged.

The following information describes the course of treatment and care that was provided to you, as well as, next steps for you to take once you leave the hospital. Should you have any questions about your visit please contact us at ____.

MEDICAL TESTS

During your course of treatment, the following medical tests may have been completed. Not all test results may have been available at the time of your visit; if results are pending, we will contact you (with your permission) with those results upon receiving them.

Completed	Test	Negative	Positive	Results Pending
	Chlamydia (urine sample)			
	Chlamydia (vaginal/penile culture swab)			
	Gonorrhea (urine sample)			
	Gonorrhea (vaginal/penile culture swab)			
	HCG Pregnancy (urine sample)			
	HCG Pregnancy (serum blood draw)			
	Hepatitis B Test (serum blood draw)			
	HIV Test (serum blood draw)			
	Syphilis Test (serum blood draw)			
	Trichomonas (urine sample)			
	Trichomonas (vaginal/penile culture swab)			
	Other: ____________________________________			

HIV RISK ASSESSMENT

A risk assessment tool has been utilized to screen your risk of potential exposure to HIV. This tool is used to determine if antiretroviral HIV post-exposure prophylaxis medications (PEP) are recommended for your treatment plan. Moderate to high risk exposure is recommended for 28-day medication treatment and follow up testing. Based on your medical history and risk factors, your assessment results are documented below.

HIV Risk Assessment	LOW	MODERATE	HIGH

HIV PEP	Not indicated	Accepted	Declined

MEDICATIONS

The following medications were given to you for prophylactic treatment of certain sexually transmitted infections or for other indications. These are each given as a single dose and do not require a prescription for any additional treatment unless otherwise noted or directed by a medical provider.

Completed	Drug, Dosage, Route, Instructions
	Acetaminophen 500mg (by mouth)
	Azithromycin 1g (by mouth)
	Ceftriaxone 500mg with Lidocaine 1% (intramuscular injection)
	Rx Doxycycline 100 mg (2 times a day for 7 days-by mouth)
	Hepatitis B Vaccination 1 of 3 (intramuscular injection) *Follow up required for additional doses*
	HPV Vaccination 1 of 2 (intramuscular injection) *Follow up required for additional dose*
	Rx Metronidazole 500mg (2 times a day for 7 days-by mouth) *Warning: * Do not consume alcohol within 24 hours (before or after) of taking this medication!*
	Metronidadole 2g (by mouth) *Warning: * Do not consume alcohol within 24 hours (before or after) of taking this medication!*
	Rx Metronidazole 2g (by mouth) *prescription given to take single dose at home* *Warning: * Do not consume alcohol within 24 hours (before or after) of taking this medication!*
	Ondansetron 4mg (sublingual)
	Rx Ondansetron 4mg (sublingual) *prescription given for 5 days (take every 6 hours as needed for nausea/vomiting)*
	Raltegravir 400mg (by mouth)
	Rx Raltegravir 400 mg (by mouth) *prescription given for 28-day regimen (take twice daily)*
	Tenofovir DF 300 mg with Emtricitabine 200 mg (by mouth)
	Rx Tenofovir DF 300 mg with Emtricitabine 200 mg (by mouth) *prescription given for 28-day regimen (taken once daily)*
	Tetanus Vaccination (intramuscular injection)
	Other: ______
	Other: ______

Medication Treatment Alternatives Due to Documented or Reported Medication Allergy:	
	Rx Doxycycline 100mg (by mouth) 2x/day for 7 days *prescription required*
	Gemifloxacin 320mg (by mouth) with Azithromycin 2g (by mouth)
	Gentamicin 240 mg (intramuscular injection) with Azithromycin 2g (by mouth)
	Ibuprofen _____ mg (by mouth)

FOLLOW UP CARE

___You have genital/anal or other findings that require re-assessment by a forensic nurse/clinician. Please return to the hospital ER for re-evaluation. * *Do NOT register as an ER patient for this visit. Please let the triage desk know that you have a scheduled follow up appointment with the forensic nurse.*

Date: __________________________ Time: ______________________________

Nurse/Provider: _______________________________________ Phone: __________________

___You have an appointment scheduled with:

Provider: _____________________________________ Phone: __________________________

Address: ____

Date: _________________________________ Time: _________________________________

___Please contact your primary care physician/gynecologist, local health department, or walk-in clinic for a follow up appointment within the next 7-14 days for evaluation and follow up testing.

Follow up testing schedule:

We recommend the following testing schedule. You may use this space as a place to keep track of your upcoming appointments and results.

2 WEEKS

Check if applicable	Test	Date	Results
	Chlamydia		
	Gonorrhea		
	HCG Pregnancy Test		
	Trichomonas		

3 MONTHS AND 6 MONTHS

Check if applicable	Test	Date	Results	Date	Results
	HIV				
	Syphilis				

Follow up immunizations:
Please schedule the indicated immunizations to complete your vaccination series. If you miss a dose in the series, you will not be fully protected and may have to receive additional doses for adequate protection.

Check if applicable	Immunization	Dose #2	Dose #3
	HPV	1-2 Months	6 Months
	Hepatitis B	1 Month	6 Months

ADVOCACY AND SUPPORT SERVICES

___You spoke with an advocate/victim assistant during your visit. We encourage you to stay in touch to ensure you have the resources you need moving forward. Your advocate was:

Name: ______________________________ Facility: ________________________________

Phone: ______________________________ Crisis Line: ______________________________

___An advocate was not available during your visit, or you requested to speak to someone at another time. Victim advocates are valuable resources to answer questions, offer support, and assist you as you move forward. You may reach out to any victim serving organization. The following facility serves your area:

Organization: _______________________________________ Phone: ______________________

24/7 Help is Available!
1-800-656-HOPE (4673)
Live Chat at www.rainn.org

LAW ENFORCEMENT

___Police Report Filed

Agency: ____________________________ Case# _____________________________________

Phone Number: _____________________________ Detective: ___________________________

___ Department of Child Services Notified

DCS authorized release of child (Name/Phone) _______________________________________

Family Case Manager: _________________________ Phone: ___________________________

___ Police Report Has **Not** Been Filed. You have not yet filed a police report. Your sexual assault kit will be stored for up to 1 year. Within that timeframe, if you choose to report to law enforcement you will contact____________________________[Police agency where crime occurred] by calling _________________________ [Non-emergency phone number for police agency]. Please let the officer or detective know that you had a medical forensic exam done at our facility and provide them with the kit number and PIN.

NEXT STEPS

___ Contact Counseling Services.

___ Track the location of your Sexual Assault Evidence Kit at http://sak.cji.in.gov. Click on "View Kit Status" and enter kit number and PIN, located on page 1 of this form.

___ Results from the Sexual Assault Evidence Kit will be obtained from the law enforcement agency. It may take several months to receive these results. If you have questions regarding the status and/or results of your kit, please call the law enforcement agency handling your case.

___ If you change your phone number/location, please notify your detective. They are unable to support you, if they cannot reach you.

COUNSELING ORGANIZATIONS

[INSERT contact information for area therapists, Medicaid/Medicare providers, support groups, and victim advocacy agencies.]

If you or someone you know is struggling or in crisis, help is available. Call or text 988 or chat 988lifeline.org.

Behavioral Health Services Treatment Locator
www.findtreatment.samhsa.gov

LONG-TERM SYMPTOMS

Initially following the assault, you may not have any physical or mental health concerns, however, you should be aware that it is very common to experience symptoms long after the assault. Some signs and symptoms can include anxiety, depression, mood swings, insomnia, nightmares, phobias and somatic symptoms, which may present as physical symptoms such as pain, gastrointestinal upset, headaches, weakness and more. Many individuals think they are "going crazy" as time goes on and are not aware that healing is a process and under these circumstances have experienced similar feelings and concerns. We encourage you to keep a log of your symptoms and discuss them with your doctor, therapist, trusted friend or victim advocate.

No one will understand exactly how you are feeling but we do know the importance of having support. Please reach out to a victim advocate, or trusted friend or family member to assist you with taking the necessary steps to remain safe and healthy and find healing. We are also available to address any questions or concerns you may have regarding your visit and follow up care. Please contact us at ____________________.

If you have moderate to heavy bleeding, excessive pain, dizziness, shortness of breath, fever, thoughts of harming yourself or someone else, or other urgent health concerns, return to the emergency department immediately.

______________________________	______________
Patient Signature	**Date**
______________________________	______________
Forensic Nurse/Clinician Signature	**Date**