Comprehensive Toxicology Testing Guidelines – (See Right Hand Corner Below)

Do Not Test Unless Indicated

REPORTED TO LAW ENFORCEMENT

- **Testing Indicated**
  - Informed Consent Discussed/ Testing Option Offered
    - Patient does consent to testing
      - *Urine Sample 60 cc's
      - *Blood Sample 2 gray top tubes
    - Patient does not consent to testing
      - Do Not Test
- **Testing Contraindicated**
  - Do Not Test
  - Pt still would like sample tested
    - RCC Advocate for Support

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  - Informed Consent Discussed/ Testing Option Offered
    - Patient Consents to Testing
      - *Urine Sample 60 cc's
      - *2 Blood Sample 2 gray top tubes
        - Six weeks after ED visit results can be obtained by calling 866.269.4265 and providing kit number.
    - Patient does not consent to testing
      - Do Not Test
- **Testing Contraindicated**
  - Do Not Test
  - Pt still would like sample tested
    - RCC Advocate for Support

- All Samples submitted with kit should be stored in locked refrigerator or freezer to minimize degradation
- All Samples submitted with kit should be labeled with kit number, signed, dated and sealed
- All Samples should be obtained ASAP
- Urine Sample should be placed in clean, sealable, liquid tight container
- Before collecting urine sample, instruct patient not to wipe after urinating to prevent destruction of possible evidence.
- 2 Gray top tubes should contain sodium fluoride and potassium oxylate and should be filled to maximum volume.
- Six weeks after ED visit results can be obtained by contacting the victim witness advocate from the district attorney's office.

Guidelines for Offering Testing

Indicated

- ❑ Amnesia or confused state with suspicions that she/he was sexually assaulted.
- ❑ Amnesia or confused state after minimal or no consumption of alcohol, or with no known consumption of mind-altering substances.
- ❑ Suspected ingestion of Sexual Assault Drugs within 72 hours of Emergency Department visit.

Contraindicated

- ❑ If patient presents after 72 hours of suspected ingestion.
- ❑ No signs or symptoms consistent with ingestion of Sexual Assault Drugs, i.e. no report of amnesia/loss of consciousness.

Commonwealth of Massachusetts
Department of State Police Crime Laboratory
Sexual Assault Evidence Collection Kit

CONSENT FOR COMPREHENSIVE TOXICOLOGY TESTING

Affix kit number label here on both white and yellow copies

DO NOT WRITE PATIENT'S NAME ON THIS FORM;
DO NOT RUN THIS FORM THROUGH ADDRESSOGRAPH

Examining Clinician:

Please ensure your patient reads the entire consent form and understands all segments before signing it to consent to toxicology testing. All information must be reviewed with ample time given for the patient to have questions answered.

If the patient chooses to consent to the comprehensive toxicology testing:

(1) *Please complete the information requested below.*
(2) *Ensure your patient signs **with her/his initials only** where indicated on form.*
(3) ***Print and sign** your name only where indicated on form.*

•Date of evidence collection: ____/____/____
•Time of evidence collection: _____: _____ ☐a.m. ☐ p.m.
•Has the sexual assault been reported to law enforcement? ☐Yes ☐Not at this time
•Is the patient a smoker? ☐ Yes ☐ No
•Is the patient taking any prescriptions? ☐Yes ☐ No
If yes, names of drug(s): _____
_____
Date and time drug(s) last taken: ____/____/____ _____: _____ ☐*a.m.* ☐*p.m.*
•Is the patient taking any over the counter drug(s)? ☐Yes ☐ No
If yes, names of drug(s): _____
_____
Date and time drug(s) last taken: ____/____/____ _____: _____ ☐ *a.m.* ☐ *p.m.*
(Contraceptives need not be listed)

Name of Hospital: _____

For the patient:

Please read the following and review each segment with your examining clinician. If you choose to consent to comprehensive toxicology testing, please sign with ***your initials only*** on the page where indicated.

☐ ***I consent and authorize*** _____ ***(name of examiner) to obtain urine and blood samples for the purpose of detecting the presence of drugs or other substances that may have caused sedation and/or amnesia in the setting of a suspected sexual assault.***

☐ I understand this sample must be obtained within 72 hours of ingestion.

☐ I understand that my samples will be transferred to the State Police Crime Laboratory and that information regarding the results of the drug testing may be released to the defense, prosecution, and other law enforcement officials.

☐ The drug test that I consent to will include a full toxicology panel which may detect any substances, medications, or drugs, both legal and/or illegal (such as marijuana, cocaine, alcohol, amphetamines, barbiturates, opiates, antidepressants, antihistamines, and others) that I may have taken in the weeks prior to the assault.

☐ Once I report the assault to law enforcement officials, law enforcement officials will have access to my test results even if I change my mind about voluntary participation in prosecution of the assailant(s).

☐ I understand that this blood and urine sample will be tested and will be discarded within 6 months of this evidence collection.

☐ If I have reported this assault to the police, the results will be available to law enforcement officials within approximately 6 weeks of testing. I understand that I must contact the victim witness advocate from the District Attorney's office working on my case if I want to find out these test results.

☐ If I have not reported this assault to the police, the results will be available to a confidential service approximately six weeks after testing. The service will receive my kit number and test result but not my name or any other identifying information. I understand that I must contact the confidential service listed under the aftercare instructions on the Treatment and Discharge form, and provide my kit number if I want to find out these test results.

☐ I have discussed toxicology testing with the medical provider and have had an opportunity to ask questions and discuss concerns.

_____
Patient's Initials ONLY

_____ ____/____/____
Printed name of clinical provider or S.A.N.E. Date

_____ _____
Signature of clinical provider or S.A.N.E. If applicable, certified S.A.N.E. number of the examiner

RE2MA: CCTT.3 2/03

RETAIN WHITE COPY OF FORM FOR HOSPITAL RECORDS

PUT YELLOW COPY OF FORM IN STEP 3 ENVELOPE IN TOXICOLOGY KIT BOX