

ALCAMS Pediatric SANE Data Collection Form

Exam Site							
Exam Date/Time				Examiner			
Patient Demographics							
Age:	____ Years or Months			Gender	Female		Male
Race (circle):	WH	BL	BIR	Unk	Ethnicity	Non-His	His AP NA Unk
County of Residence				County of Occurrence			
Relationship of adult caretaker present with child	Parent		Foster parent		Other relative		
	Legal guardian		Agency support person				
Reported Assault History							
Time since assault (hrs)			Assault Location	Home	Other residence	Business	School
				Vehicle	Outside	Other: _____	
Alleged Perp(s)	Single	Mult (#_____)	Unk	Gender	Male	Female	Both
Relationship of perpetrator(s) (Circle all that apply)	Adult acquaintance		Peer	Stranger	Parent	Sibling	
	Aunt/Uncle		Grandparent	Other Relative	Other: _____		
Drug/alcohol exposure:	Yes	No	Unk	Human trafficking screen:	negative	positive	
Sexual Contacts Reported (check all that apply)							
<input type="checkbox"/>	Fondling	<input type="checkbox"/>	Oral-genital, perp to victim	<input type="checkbox"/>	Oral-genital, victim to perp		
<input type="checkbox"/>	Finger-genital, perp to victim	<input type="checkbox"/>	Finger-genital, victim to perp	<input type="checkbox"/>	Finger-anal, perp to victim		
<input type="checkbox"/>	Finger-anal, victim to perp	<input type="checkbox"/>	Penile-vaginal	<input type="checkbox"/>	Penile-anal		
<input type="checkbox"/>	Object penetration, vaginal	<input type="checkbox"/>	Object penetration, anal	<input type="checkbox"/>	Other:		
Symptoms Developed During/After Assault (check all that apply)						None <input type="checkbox"/>	
<input type="checkbox"/>	Genital pain	<input type="checkbox"/>	Genital discharge	<input type="checkbox"/>	Genital bleeding		
<input type="checkbox"/>	Rectal Pain	<input type="checkbox"/>	Rectal bleeding	<input type="checkbox"/>	Other:		
Medical History							
<input type="checkbox"/> No significant past medical history				<input type="checkbox"/> No history available			
Health Problems	Problem #1: _____			Problem #3: _____			
	Problem #2: _____			Problem #4: _____			
Females (SMR3-5 only)	#Days since LMP _____			Contraceptive use: Yes No N/A			
HBV up to date	Yes	No	Unknown	HPV up to date	Yes	No	N/A Unknown

Physical Examination						
Examination completed			Refused examination (Part All)			
Sexual Maturity Rating (Tanner Stage)						
Breast (female): 1 2 3 4 5			Pubic Hair: 1 2 3 4 5		Genitalia (male): 1 2 3 4 5	
Physical Injuries Identified: <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, check all that apply below)						
	Site of Injury	Type of Injury (circle)				
	HEENT	Abrasions	Lacerations	Bruising	Fractures	Other
	Neck	Abrasions	Lacerations	Bruising	Fractures	Other
	Chest/Back	Abrasions	Lacerations	Bruising	Fractures	Other
	Abdomen	Abrasions	Lacerations	Bruising	Fractures	Other
	Genital/Anal	Abrasions	Lacerations	Bruising	Fractures	Other
	Extremities	Abrasions	Lacerations	Bruising	Fractures	Other
Other (specify):						
Acute Psychiatric Concerns: <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, circle) Seen onsite Admitted Referred						
Forensic Evidence Collected <input type="checkbox"/> No <input type="checkbox"/> Yes			If not, reason: >72 hrs Pt Refusal Other			
Agency Involvement						
Law Enforcement						
DHR (County)						
Other (list)						
Laboratory Tests (check all performed)						
Pregnancy test: Neg Pos			Wet prep: Neg Pos		Trich BV Sperm	
Urine NAAT: Neg Pos		NG CT Trich	Vaginal NAAT: Neg Pos		NG CT Trich	
Rectal NAAT: Neg Pos		NG CT	Throat NAAT: Neg Pos		NG CT	
RPR/VDRL: Neg Pos			HIV: Neg Pos			
Urine/blood drug testing: Neg Pos			Other culture: Neg Pos			
Other lab tests:						
Treatment						
STI Prophylaxis		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Offered, but declined		
HIV Prophylaxis		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Offered, but declined		
Emergency Contraception		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Offered, but declined		
Surgical Repair/Exploration		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Offered, but declined		
Other, list						