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| Health Care Facility: _____ | Date of Exam: _____                      |
| Patient MRN #: _____        | Sexual Assault Forensic Exam Kit # _____ |

## **MEDICAL FORENSIC EXAM WITH EVIDENCE COLLECTION: INFORMATION AND OPTIONS**

### **A. Medical Forensic Exam With Evidence Collection: Access and Payment**

- While you may be billed for some medical treatments as a result of this sexual assault, you will not be billed for the medical forensic exam and evidence collection. The State of Wisconsin will incur the full out-of-pocket costs of the medical forensic exam. If you receive a bill for the forensic exam and evidence collection, **you can call the Wisconsin Department of Justice, Office of Crime Victim Services at 1-800-446-6564 for assistance.**
- Under federal law you can be provided with a medical forensic exam whether or not you choose to participate in the criminal justice system or cooperate with law enforcement.
- The Crime Victim Compensation program may be able to pay for your out-of-pocket expenses related to this crime. To be eligible for the program, you must make a report to law enforcement within 5 days of the sexual assault and cooperate with the investigation and prosecution of this crime.

### **B. Advocacy Services**

There are many factors to consider when deciding whether to make a report to law enforcement. A sexual assault advocate can help you with your decision by:

- Providing emotional support to help you cope with stress and trauma;
- Talking with you about what may happen after making a report to law enforcement;
- Explaining how the justice system works;
- Helping you fill out paperwork and/or compensation applications;
- Locating service agencies, support groups, counseling and other resources

Local Sexual Assault Advocacy Agency: \_\_\_\_\_

Phone Number : \_\_\_\_\_

☐ I would like an advocate to follow-up with me by:

☐ Phone: \_\_\_\_\_

Is it safe to leave a message and for advocate to identify self?

☐ Yes    ☐ No    ☐ OK to leave message with phone number only, no name

☐ Mail: \_\_\_\_\_

☐ Email: \_\_\_\_\_

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### C. Deciding Whether to Report to Law Enforcement

If you **report now, law enforcement:**

If you **do not report now:**

- Will have the opportunity to interview you about the assault.
- Will have the opportunity to interview suspect(s) and collect evidence from them.
- Will transport the evidence collected from your examination to the Wisconsin State Crime Laboratory for analysis.
- Can help you address safety concerns.
- Cannot guarantee that your case will result in a criminal charge and conviction.

- Crime scene evidence of the sexual assault will not be collected, photographed, or documented and may be permanently lost.
- Blood and urine specimens will not be collected for forensic analysis to determine whether drugs or alcohol were used to facilitate the sexual assault.
- Witnesses will not be interviewed in a timely manner and they may not be available at a later time.
- It may be more difficult to successfully prosecute your case.

### D. Options for Medical Forensic Exam with Evidence Collection

- ☐ I want evidence collected and I want to report this incident to law enforcement. LE Case# \_\_\_\_\_
- OR**
- ☐ I am unsure if I want to report this incident to law enforcement, but I want evidence collected and stored for up to ten years while I make my decision. I understand that if I select this option to store the evidence:
- My personal identifying information will be sealed and stored with the evidence at the Wisconsin State Crime Laboratory.
  - My personal identifying information will not be released to law enforcement without my consent.
- ☐ I understand that if during the next nine and a half years I decide to report this incident to law enforcement, it is my responsibility to contact the agency identified below.
- ☐ I understand that after ten years, the Wisconsin State Crime Laboratory will destroy the evidence from my medical forensic exam without any further notification to me.

**Nine and a half years from the date of my exam is:**

Local law enforcement agency and phone :

Print Patient Name: \_\_\_\_\_ Patient Signature & Date: \_\_\_\_\_

Print Health Care Provider Name: \_\_\_\_\_ Health Care Provider Signature & Date: \_\_\_\_\_