Charting Tips
Reference Guide for SANEs

Remember: Rules that apply to paper charting in general apply to medical-forensic examination paper charting as well. If you make a mistake, draw a single line through the mistake and add your initials. You may draw a single line through blank lines (such as in the narrative or injury log), but wait until you are sure you will not need them. Do not mark "not applicable" unless something is truly not applicable: typically this is only the case concerning anatomy that the patient does not have.

Neutral language is important:

- "Declined" instead of "refused"
- "States" instead of "claims"
- "History" instead of "story"
- "Unable" instead of "noncompliant"
- "Reported" instead of "alleged"

Demographics:
If "time of assault" is reported as a range of time, document that range. "Hours post assault" will then also be a range.

Mandatory reporting:
This section is for documenting any mandatory reporting required for medical professionals: who it was reported to and the time/date it was reported. Reporting may have occurred prior to the patient's arrival at the medical facility; documentation must still be completed. Always verify with the agency.

I. Since the time of the assault:
Document what activities the patient has engaged in since the assault. This may suggest the patient's state of mind or where injuries may be located. It also gives context to what evidence may be collected. If clothing was left at home or if law enforcement has already collected it, that can be documented here as well as a description of the clothing.

II. Report of incident:
Document the patient's history of events. This may be events leading up to and including the assault or what they have been told by others. Patients often do not give a sequential history. Information may be paraphrased; quotations are useful to include where possible. Patients who do not remember details should be assured that this is normal.

III. Pertinent/recent health history:
Include anything that may affect the exam, such as hysterectomy, biopsies, genital surgery, or hormones. Gynecological and sexual health information provides guidance to the examiner. Information about consensual partners is relevant as their DNA may be found in addition to the assailant's.

IV. Information pertaining to assault:
Include as much information as the patient is able to give. This is not for investigative purposes, but to help guide the assessment and ensure clarity. If they have no memory, document no memory. Information regarding drugs and alcohol helps document the patient's ability or inability to consent and provides context for the patient's ability to understand what occurred.

V. Assailant information:
This is not for investigative purposes, but to inform a thorough assessment and evidence collection. Color and length of hair are important, as the assailant's hair may be found on the patient's body during the examination. Tattoos may be helpful to distinguish an unknown assailant. Use the patient's own words to document their relationship with the assailant. If there are multiple assailants, label (a), (b), etc. for the rest of the charting to clarify who did what.

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VI. Acts described by the patient:
If the patient reports memory loss, nothing can be ruled out with certainty. Include explanatory descriptions where applicable; this is particularly helpful for context when acts are marked "unsure" or "attempted." Direct quotations from the patient can be very helpful here. Remember to think broadly in considering threats, which may or may not include threat of physical force.

VII. Strangulation assessment:
Every patient is assessed for strangulation, including when memory loss has occurred. Even if the patient denies that strangulation occurred, assess for any signs and symptoms. If memory loss has occurred, include discharge education on signs and symptoms to seek medical care for. Remember that patients may erroneously refer to strangulation as "choking" – match their language, but ensure clarity.

VIII. Drug-facilitated sexual assault:
If the patient reports any memory loss or other suspicion of drug facilitation, collect both blood and urine with their permission. Write "unknown" for suspected substance if the patient is unsure what they might have been given. If blood, urine, or both are not collected, document the reason.

IX. Head-to-toe exam and bodygrams:
Affect is a common subject of testimony. Always document anything you observe regarding the patient, during the history as well as the exam. Document objective observations rather than subjective interpretations. Refer to *Affect Documentation Reference Guide*. You may write "See injury log" in the general physical assessment section.

If an area of the patient's body is tender or red, it cannot be marked "within normal limits" (WNL). If you did not examine an area of the body, document "Not assessed."

Label each injury with a number that links illustrations to full descriptions in the injury log. Shade tender areas. When the patient states an injury was present prior to the assault, document this statement and what the patient said about the injury.

X. Anogenital exam:
If an area of the patient's body is tender or red, it cannot be marked "within normal limits" (WNL). If you did not examine an area of the body, document "Not assessed." You may draw a line through sections and bodygrams of

XI. Injury log:
Every numbered entry should match an injury or finding on a bodygram. Document the type of injury as well as the color, size, and pain assessment. You may use the abbreviation key. For tenderness, document whether it is present continuously or to touch only.

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XII. Evidence collection:
If evidence is not collected, document the reason why. If fewer swabs are collected than is standard, document this with an explanation. You may mark that clothing was not collected because law enforcement collected it prior to your arrival. If a camera is not available or if photographs are not part of your facility's protocol, document this. Remember to always document where swabs were collected from and why. There is no need to write in that you collected blood and/or urine for DFSA here, as this has already been charted in Section VIII.

XIII. Police department release of evidence:
Law enforcement should sign the form even when they are picking up a non-reporting kit, but remember to cover up the name in this case to protect patient privacy. If you lock up the evidence per protocol and have checked this box, no signature is needed.

XIV. HIV risk assessment:
Each line must be answered, even if the patient does not remember what happened. You may put patient statements in quotations to help explain, particularly for "Unsure" answers. Do not check "Yes" if the patient does not know for sure.

XV. Treatment:
List the name, dosage, and route of each medication administered. If a medication is not given or is substituted for another medication, document this along with an explanation. If the patient is up to date on their vaccines, this may be given as the reason for those medications not to be administered. If HIV nPEP is administered, document the date and time of the first dose.

XVI. Follow-up and referrals:
The patient must always be given the name of a provider or clinic where they may follow up.

Page 16:
Do not give the final page of the SANE exam form (page 16, as of the Fall 2020 state exam form update) to law enforcement or include it in the SAFE kit. This page is considered personal health information and should be protected as part of the patient's medical treatment.

Review your charting!
Is the patient's label on every page? Have you left any blanks? Have you initialed every page?