Lifespan Hospitals Sexual Assault Medical Management Guidelines and Follow-up

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(Questions: contact Susan Duffy, MD 444-4900, cell (401) 529-5717 or EPIC secure chat. This protocol was developed by collaborators from the Department of Emergency Medicine, Lawrence A. Aubin Sr. Child Protection Center and Departments of Pediatrics and Adult Infectious Disease

1. At Triage

- Offer **IMMEDIATE** advocacy. Day One provides a 24-hour helpline (1-800-494-8100). In addition, advocates **are available to come to the hospital (During Health crisis advocacy may be virtual, depending on acuity of individual situation)** to support and assist victims during the exam and offer follow-up services and support.

2. Complete History and Physical Examination

- Important Elements of the history and physical exam
    - Immediately assess for potential life-threatening physical trauma in addition to the sexual assault
        - Consult trauma and/or gynecologic services as indicated
    - Record the time elapsed from the assault
    - Document a concise history of the physical contact (e.g. penile-anal, digital-vaginal) between the victim and the assailant
    - Document the presence and exchange of blood and/or body fluids or secretions between the victim and the assailant
    - Obtain the medical (including current medications) and social histories of the victim and the assailant, if possible
    - Screen all patients regarding their immediate safety (e.g. domestic violence, threats and intimidation, child physical abuse)

- If the patient is < 18 years or cared for by pediatric providers, consider transfer to Hasbro Children's Hospital ED for care. For all patients <18 years of age, after obtaining a history of sexual abuse or assault, **the child abuse pediatrician on call for The Aubin Center can be contacted for assistance after discussion with the EM attending MD**
    - The on-call child abuse pediatrician may respond to the Hasbro ED or facilitate transfer. This will be determined based on the history and physical exam findings relayed by the ED physician and age of the patient
    - Discuss lab tests and medical interventions as outlined below
    - Schedule follow up appointment at Aubin Center for all children and adolescents
        - College students may choose to follow up at their college health center – advise warm hand-off with the health center with the patient's consent – The Aubin Center or WIH Follow Up Clinic can assist with arranging this and warm hand-off when they make their follow up phone call after ED visit – so make sure one of these centers (Aubin Center for those <18 years, WIH SAFE clinic for those 18yrs and older) is aware that the patient was seen in the ED so they can facilitate follow up

For all adolescents < 18 years call the Aubin Center after completion of the evaluation and prior to discharge from the ED to arrange follow up.

- Determine the need for a Forensic Evidence Kit (Legal Evidence) – if any of the following criteria are met:
    - If assault occurred **<72 hours** from presentation to the ED for pre-pubertal children and **<96 hours for post-pubertal children and adults**
    - If there is physical evidence (e.g. clothing, bedding, bite marks) that are not in police custody

For all patients

- Collect urine **ASAP** if drug facilitated sexual assault (DFSA) is suspected and the patient agrees to testing or there are medical indications for testing:
    - Medical indications for DFSA testing include the following:
        - If a patient has poor recall of events, believes they were drugged, report a level of intoxication beyond what was expected, is impaired or there is a report of impairment at the time of the assault
    - Procedure for collecting DFSA testing:
        - Collect TWO blood and urine SAMPLES :1 sample processed as forensic evidence with SAFECK, sent to DOH State Lab (analyzed only if requested by law enforcement), 1 sample sent to hospital lab for send out analysis – results available to patient and providers in medical record)
    - 1) Order **urine DFSA** (**not "urine drugs of abuse") in EPIC** and send sample to the lab immediately for proper storage. If there are delays in sending, refrigerate sample and block from light exposure
    - 2) If testing for DFSA, save an **additional** urine sample to include with the forensic kit (cover specimen from light and refrigerate until transported to State Lab)
    - All forensic samples sent to the RI State Lab become forensic evidence and are only analyzed if a police complaint is filed or mandated by law

Once the need for a Forensic Evidence Kit is established and it is determined the patient is medically stable and has consented to the exam (POLICE INVOLVEMENT IS NOT REQUIRED to collect evidence BUT POLICE INVOLVEMENT IS REQUIRED FOR FORENSIC ANALYSIS OF THE KIT BY THE STATE LAB), determine if there is a trained **Sexual Assault Examiner** available to respond at the hospital of origin to perform the sexual assault exam and collaborate with further medical management.

It is important for the survivor to know that once the kit is collected, they can decide later whether they would like to pursue police involvement. They do not have to decide at the time of the kit evidence collection. Timely evidence collection is important and will give them options later on if they would like to pursue a legal case.

For Adult RIH ED patients or ED patients from other Lifespan hospitals when there is no available on-call trained Sexual Assault Examiner, Contact the **RIH ED charge RN** (Anderson ED 255-5734) to determine if a **trained Sexual Assault Examiner** member is on duty in the RIH ED and can be released from other responsibilities to complete the forensic exam. Otherwise, the **RIH ED charge RN** will page the on-call **GYN Advanced Practice Provider (APP) consultant** (350-7575) and coordinate plan of care. If a transfer is planned contact the Transfer and Access line to arrange (Express Care: 401-444-3000)

For all **OR bound patients** requiring a Forensic Evidence Kit page the on call **GYN APP consult** (350-7575).

For All **Adult Inpatients** requiring a Forensic Evidence Kit page the on call **GYN APP consult** (350-7575

3. Laboratory Tests (see EPIC sexual assault order set)

- Consider STI testing in adults and Recommend STI testing in Adolescents – testing establishes baseline STI status
    - GC, Chlamydia and Trichomonas nucleic acid amplification testing (NAATs) – vaginal swab is preferred over urine sample, urine acceptable if vaginal swab not feasible or acceptable to patient (consider if patient symptomatic or patient requests testing)
    - Testing establishes baseline STI status
    - Urinalysis
    - UCG (if pubertal) or HCG
    - Hepatitis B (sAg, cAb, sAb), Hepatitis C (HCV Ab) serologies
        - Serum testing establishes baseline hepatitis status and need for post exposure prophylaxis
    - Treponemal Antibodies for Syphilis
    - HIV Ab/Ag test
        - Serum test establishes baseline HIV status.
        - Counsel patient (and family when applicable) about the testing and meaning of the results. Assure that the patient will receive test results in person. (see Lifespan Policy for HIV testing and consent)
    - Results from baseline STI testing are provided to the patient/family during follow-up or according to ED follow up guidelines. Treat as confidential information in EMR. Of note, if the patient is <16 years old then that parent has access to the medical record.

- **Additional** testing if planning to start HIV PEP (see below and EPIC ORDER set)
    - CBC with differential – establish baseline prior to any potential side effects to medication
    - LFTs – to establish baseline LFTs prior to any elevation secondary to medications
    - BUN/Cr – in order to dose HIV PEP based on renal function

- Toxicology Screen
    - When history or examination indicates - examples may include:
        - Patient does not remember assault
        - Patient appears impaired
        - Patient reports an unexpected degree of intoxication
        - Reports from other sources that patient was impaired at the time of the assault
    - The most common substances used to facilitate sexual assault are alcohol and prescription medicines.
        - Consider urine toxicology screen for drugs of abuse and serum blood alcohol level (BAL) if medically indicated or only after a discussion with the patient about disclosure of medical information and that the determination of presence of substance will be helpful to document cognitive impairment around the time of the assault
    - If drug facilitated sexual assault (DFSA) is suspected order **urine DFSA**. This test will be sent to an outside laboratory for testing.
        - Two samples of urine and blood should be collected (one for the Forensic Examination Kit (Sexual Assault Forensic Examination Collection Kit - SAFECK)

and one for the hospital Send Out lab) Send first voided **urine** for DFSA and drug testing

- The specimen that is for the SAFECK should be placed in a biohazard bag with a patient label and evidence sticker and stored in the refrigerator, covered to minimize light exposure and should be marked as part of the SAFECK.

ALL components of the medical record, including drug testing are forensic evidence and "discoverable during the investigation of a criminal complaint".

- Discuss the utility of drug testing with the patient before proceeding unless the testing is medically indicated.

4. Medical Interventions

- STI antibiotic prophylaxis (PROPHYLAXIS or "Empiric Treatment" FOR ALL WHO ARE AT RISK OF STI BASED ON EXPOSURE HISTORY – exposure to potentially hazardous body fluids)
  - Gonorrhea infection prophylaxis/treatment
    - Ceftriaxone 500 mg IM X1 dose (for patients with weight ≥150 kg administers 1g)

  Chlamydia infection, prophylaxis/treatment:
    - Doxycycline 100 mg PO (2.2 mg/kg max 100 mg) 2X per day x 7 days for Chlamydia infections, especially in penile-rectal contact
    - Azithromycin 1gm PO X1 dose (or 20/mg/kg) – consider in patients with penile-vaginal contact instead of doxycycline if 7-day therapy might decrease risk of completing the course of treatment
  - Trichomonas vaginalis infections and bacterial vaginosis (FEMALES ONLY)
    - Metronidazole 500 mg PO 2X per day for 7 days (15 mg/kg, max 2 g) (May cause GI upset – consider 2g po x 1 dose if a 7-day course might decrease risk of completing the course of treatment, despite potential lower efficacy, especially if baseline trichomonas testing is negative)

See CDC STD treatment site for alternative regiments: https://www.cdc.gov/std/treatment-guidelines/default.htm

HIV Post-exposure Prophylaxis (PEP) Risk Assessment Guidelines
(see drugs and dosage in table below)

These are general guidelines to aid in your decision making process, however, the decision to start HIV PEP is decided on a case-by-case basis and through discussion with: For Adults (Adult ID via on call system, or Dr. Erica Hardy 582-9995 pager) and For adolescents, page The Aubin Center pediatrician and/or Pediatric Infectious Disease.

(For additional guidance: Call National Clinician's Exposure Prophylaxis Hotline (PEP LINE) 888-448-4911)

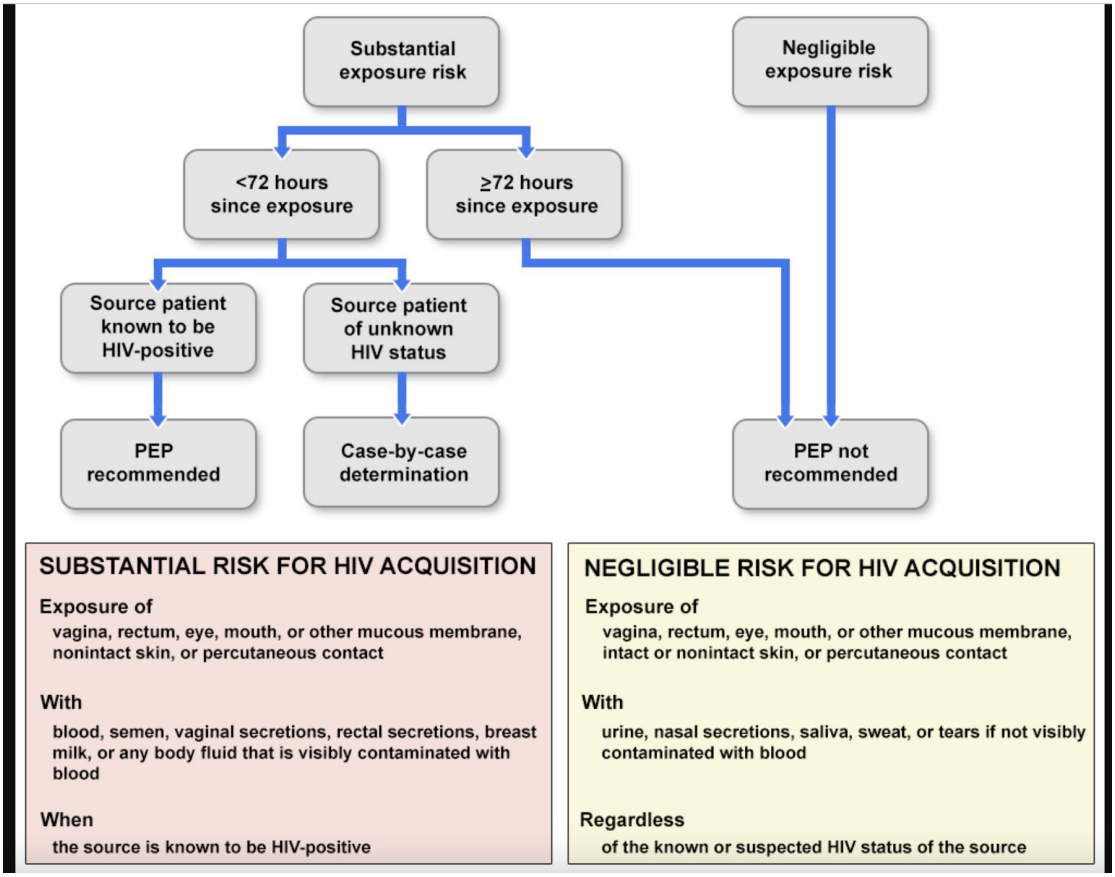
Consider HIV nPEP if sexual assault is ≤72hours prior to evaluation

The decision to begin nPEP is based on:

-The nature of the exposure
-The victim's ability to complete the regimen
-The knowledge of HIV status of the alleged assailant
-Time from assault to evaluation

See “Appendix A” for Adult and “Appendix B” for Pediatric nPEP recommendations For Adult Patients a 3 drug nPEP regimen is routinely recommended For Patients < 13 years Consider a 3 rather than 2 drug regimen and consult pediatric ID IF	
IF alleged perpetrator ○ Known HIV positive ○ High risk ▪ History of incarceration ▪ Intravenous drug use ▪ Multiple sexual partners or prostitution ▪ Male-male sex	IF patient reports/has ○ Multiple perpetrators ○ Vaginal/anal mucosal injury ○ Anal penetration regardless of injury ○ Is pregnant
*RR of HIV transmission from a single incident of unprotected receptive anal intercourse with a man of unknown HIV status is 1/10,000 *RR of HIV transmission from a single incident of unprotected vaginal receptive vaginal intercourse with a man of unknown HIV status is 2/100,000	

Source MMWR Mobid Mortal Wkly Report,2016. 65(17):p.458



- Give first dose of nPEP in ED (Truvada 200mg/300mg tablet AND dolutegravir 50mg tablet)
- Have hospital pharmacy prepare a 6-day HIV PEP starter pack for the patient to have in hand at discharge:
- Truvada (Tenofovir disoproxil 300mg and Emtricitabine 200 mg) and dolutegravir 50 mg for patients >12 years.
- If patient < 13 years and > 35 kg Starter Pack prepared by pharmacy will contain Truvada +/- Raltegravir (weight-based dosing in pill or liquid).

- **If HIV prophylaxis is started**

- Emphasize to the patient and family the necessity of follow up and completing the entire course (28 days total) of medication – let them know that they will be prescribed 30 days (due to pharmacy restrictions, and if they take 30 days instead of 28 that will be fine)
- Discuss potential side effects (include in discharge forms) – generally GI upset is most common and is short-lived. Can prescribe anti-emetic if needed.
- Inform patients that for adolescent patients the Aubin Center in collaboration with Pediatric Infectious Disease will monitor the medication (401) 444-3996,
- For adult patients Dr. Hardy will monitor HIV nPEP and other medications in follow up (page 582-9995, office (401) 453-7950 – Can message Dr. Hardy via EPIC as well to assure follow up.
- Most initial follow-up appointments are scheduled within 72 hours after prophylaxis is started in adults and for adolescents 5-10 days after prophylaxis is started. Phone contact is made the next business day. Telehealth can be arranged instead of in person visit if this is easier for the patient – they are given the option.
- If a prescription is written at discharge check with patient's pharmacy to assure that medications are available (available through Lifespan pharmacy)

- **If HIV Prophylaxis is not started because patient or parent declines medication**
  - Arrange follow up within 24 hours of discharge to review
- **Pregnancy Prophylaxis**
  - Offer to pubertal patients who present within **120 hours** from assault and **UCG is negative**
    - Consult GYN if presentation between 120 hours and 5 days for consideration of IUD placement or alternative medical therapies
  - Instruct patient that if menses do not occur within 21 days, a pregnancy test should be repeated
  - Therapies for pregnancy prophylaxis
    - **Ulipristal (Ella) 30 mg oral once** For patient > 200 lbs. Ella is administered in the ED (recommended 1st line)
    - **Levonorgestrel** (**Plan B) 0.75 mg**, for patients <200 lbs. Plan B tab(s) administered in the ED. The drug reduces the risk of pregnancy by 89%. Low incidence of nausea and vomiting.
  - Mechanism of action: prevents fertilization, ovulation and implantation. Patients should expect withdrawal bleeding within 21 days

- Zofran (Ondansetron)
  - Please give 1 dose (0.15 mg/kg max dose 8mg) in ED prior to administering antibiotics, Plan B and/or HIV PEP
- HBIG (0.06 ml/kg IM)
  - Postexposure hepatitis B vaccination (without HBIG) if the hepatitis status of the assailant is unknown and the survivor has not been previously vaccinated.
  - If the assailant is known to be HBsAg positive, unvaccinated survivors should receive both hepatitis B vaccine and HBIG. The vaccine and HBIG, if indicated, should be administered to sexual assault survivors at the time of the initial examination, and follow-up doses of vaccine should be administered 1–2 and 4–6 months after the first dose. Survivors who were previously vaccinated but did not receive postvaccination testing should receive a single vaccine booster dose (see Hepatitis B Virus Infection).

    - If vaccination status of patient is unknown AND assault involved a VERY high-risk exposure (e.g. exchange of significant bodily secretions and/or perpetrator known or suspected to be infected with Hepatitis B, or known IV drug abuser)
- Hepatitis B vaccine if patient has not received hepatitis B vaccine series
- HPV vaccine if patient has not received vaccine series for survivors < 26 years of age

5. Reporting

- If a patient is ≥ 16-year-old AND perpetrator is not a caretaker AND the patient does not want to make a report to Police, there is no mandate in RI to notify the Police, but reporting to the police should be discussed and encouraged in most circumstances

- Report to the Police in the jurisdiction where the assault occurred is **mandatory IF:**
    - If sexual assault involved a caretaker
    - If patient is < 14 years old
    - If patient is 14 or 15 years old AND alleged perpetrator is ≥ 18 years old

- In patients <18 years: Contact Department of Children, Youth and Families (DCYF) and file a PRE (1-800-RI CHILD) if:
    - Assault involved a caretaker or relative
    - Family is not protective/supportive/believing patient
    - Other children may be at risk for sexual assault by same alleged perpetrator
    - There are any concerns of child abuse or neglect
    - Alleged perpetrator is > 18 years old and patient is < 16 years

- In patients >60 years: Contact Division of Elderly Affairs Protective Services Unit (401) 462-0555
- Any patient with a developmental disability: Contact the QA/QI unit Department of Behavioral Healthcare Developmental Disabilities and Hospitals (BDHDDH) Hotline (401) 462-2629

OPTIONS for medical follow-up after sexual assault Emergency Department visit:

- Contact the victim's primary care physician to arrange follow up

- For Adult victims: Dr. Hardy's team will provide follow up by phone 24-48 hours from the ED visit to answer questions and discuss follow up (if HIV PEP prepare the patient to plan for in person follow up in 3-5 days)

- Advise patients that for adolescent victims, the Aubin Center will telephone them at home in 24-48 hours from the ED visit to answer questions and discuss follow-up (if HIV PEP prescribed, will arrange specific follow up in 3-5 days)
    - **Obtain a working phone number and best contact #** from patient/family and inform Dr. Hardy and child abuse pediatrician from the Aubin Center. Document Phone number in the Medical record

- Offer Resources of Day One
    - Give all patients business card with resource (www.dayoneri.org)
    - Provide FAQ Resources of RI Statewide Task Force to Address Adult Sexual Assault (www.dayoneri.org/task-force/index.html#top)

6. Discharge and Follow-up

- For Adult Patients: Contact Dr. Erica Hardy at page: page 582-9995 for urgent questions, can send secure chat via EPIC for non-urgent questions or sign-out/warm hand-off, or her office (401) 453-7950 (Infectious Disease clinic – WIH: SAFE Clinic – Sexual Assault Follow Up and Evaluation) Lifespan email: Ehardy@lifespan.org (use PHI if referring to specific patient, or use EPIC inbox messaging) or ehardy@wihri.org
- For Adolescent Patients <18 years old:
    - Contact the child abuse pediatrician from the Aubin Center to discuss evaluation (e.g. exam findings, PEP started, patient uninsured, patient refusing prophylaxis) prior to discharge from ED (see attached Aubin Center Follow up Guidelines)
    - Arrange medical follow-up at the Aubin Center with the child abuse pediatrician on call
        - Most follow-up appointments occur 1-4 weeks following the assault depending on circumstances of the assault but patients will be contact in 24- 48 hours
            - The Lawrence A. Aubin Sr. Child Protection Center
            - Potter Building Basement (Suite 005)
            - (401)-444-3996
            - Fax 401-444-3804

	If ≥35 kg AND ≥12 years AND can swallow pills	<35 Kg, OR <12 years, AND can swallow pills	Can NOT swallow pills, OR <14 kg[a]
Standard 2 drug PEP[b]	**Truvada® (if creatinine clearance is >60 ml/min)** *(tenofovir 300mg + emtricitabine 200mg tablet)* 1 tablet, once daily If creatinine clearance is 30-59 ml/min: Descovy (emtricitabine 200 mg /tenofovir alafenamide 25 mg) 1 tablet once daily (creatinine clearance must be >29 ml/min)	**Zidovudine + Lamivudine (Combivir®)** *(Combivir ®[zidovudine 300mg + lamivudine 150mg tablet]* *zidouvdine: 100 mg capsule; lamivudine: 150mg tablet)* **≥30kg** Combivir®: 1 tablet, twice a day **25-29.9kg** Zidovudine (100mg caps): 2 capsules, twice a day AND Lamivudine (150mg tabs): 1 tab twice a day **20-24.9Kg** Zidovudine (100mg caps): 2 capsules, twice a day AND Lamivudine (150mg tabs): 0.5 tab q AM, 1 tab q PM **14-19kg** Zidovudine (100mg caps): 2 cap q AM, 1 cap q PM AND Lamivudine (150mg tabs): 0.5 tab, twice a day	**Zidovudine** *(10mg/ml liquid)* 9mg/kg/dose twice a day, max dose 300mg **AND** **Lamivudine** *(10mg/ml liquid)* 4mg/kg/dose, twice a day, max dose 150mg
3rd drug	**Dolutegravir** (*50mg tablet)* 1 tablet, once a day	**Raltegravir[c]** *(25mg and 100 mg chewable tablets)* **≥40kg:** 300mg twice daily **28-<40 kg:** 200mg twice daily **20-<28 kg**: 150mg twice daily **14-<20 kg**: 100mg twice daily	**Raltegravir** *(25mg and 100mg chewable tablets)* **If >2 y/o and 10-<14 kg:** 75 mg twice daily **If 6 mo-2 y/o:** **Kaletra ®** *(lopinavir + ritonavir, 80+20mg/ml)* **15-<40 kg** 10+2.5mg /kg/dose twice daily **<15 kg** 12+3mg/kg/dose twice daily

a- If <9 Kg or <6 months, discuss doses with Pediatric Infectious Disease on call fellow.

b- If known renal or liver disease, please discuss with Pedi ID prior to initiating PEP, as alternative drug regimen may need to be selected.

c- Addition of 3rd drug based on risk assessment and discussion between Child Protection and Pediatric Infectious Disease fellow.

d- If source patient or assailant is known to be HIV infection – call Infectious Disease on call to discuss regimen.

Lab testing:

Time	Clinic visit	Phone call	CBC w/diff, LFTs, BUN/Cr	HIV	HepBsAg	HepBsAb	HepBcAb	HepCAb	RPR, CT, NG, TV[a]
Baseline (in ER)[b]			X[c]	X	X	X	X	X	X with Empiric treatment in post-pubertal patients
In 1st week		X[d]							
Within 2 weeks	X								
4-6 weeks	X			X					
3 months	X			X				X	X (RPR)
6 months	x			X					

a- STI testing should be done as clinically indicated based on symptoms and exposure (i.e. sexual assault vs. needle stick).
b- Baseline testing is not required prior to initiating PEP. For best efficacy, PEP should be initiated as soon as possible.
c- Recommended that these tests are sent at least once at initial or 2 week visit, additional testing based on clinical assessment
d- Within 24-48hr of initiation of HIV PEP

Common side effects

1. Truvada
    - **a.** Renal tubular dysfunction and renal failure with chronic use and/or underlying kidney disease
        - **i.** Do not use in patients with known renal disease
2. Raltegravir or dolutegravir
    a. Rash and hypersensitivity reaction that may progress to Steven-Johnson syndrome(rare)
3. Kaletra
    a. Nausea, vomiting, diarrhea, abdominal pain, GERD
    b. Worse in the 1st week and improves over time
    c. Can use Zofran

HIV PEP – Adults:

- Truvada and dolutegravir can be taken with or without food
- **Most common side effects**: nausea, stomach upset
    - Contact a provider if you notice a rash or change in mood
- **Dolutegravir drug-drug interactions**
    - Cation-containing supplements (Ca, Fe, Mg, Zn): take dolutegravir 2h before or 6h after, alternatively take together with food → *for ease, consider instructing patients to separate by at least 6 hours*
- Patient receives med guides with starter kit and in discharge instructions

The Lawrence A Aubin Sr. Child Protection Center Sexual Assault Child and Adolescent Follow-up Guidelines

The ED guidelines for sexual assault require that the Aubin Center get called or paged about all patients seen in the ED.

1. Criteria to respond to the ED for Child Abuse Pediatrics (CAP) fellows are determined on a case by case basis after acquisition of history from ED physician and discussion with attending CAP. The reasons may include but is not limited to genital trauma, vaginal/anal bleeding or other physical exam findings.

2. Criteria for obtaining an FEK
    a. Sexual assault/abuse ≤ 72 hours prior to evaluation AND possibility of gathering perpetrator DNA (sperm, blood, semen, saliva)

3. If CAP fellow does not respond to the ED then
    a. Assess whether the patient needs to be re-examined on the next clinic day. The following are reasons for next clinic day evaluation
        i. There are physical findings documented by the ED that need documentation using colposcopy
        ii. If the child still having genital pain or other symptoms
        iii. Concern for mental health safety

4. Collect the following information and provide to the Aubin Center Nurse or Medical Assistant the following work day
    a. Patient's name and date of birth
    b. Parent's name
    c. Phone number and alternate phone number
    d. Tell the ED physician to provide the family with Aubin Center phone # (444-3996) to call for a follow-up appointment
    e. Review with Aubin Staff so that when the family calls she can set up a chart (sometimes a family will call before you have a chance to call them).

5. On the following workday, review the patient information and Aubin Center RN or MA will call the patient/family. Record the conversation in a telephone encounter in EPIC
   The reason for this phone call is to provide guidance, answer questions, assess medication compliance/side effects, and to help ensure follow-up.
    a. How is the patient/family doing psychologically?
        i. Encourage returning to school

ii. Make referral to mental health intervention if does not already have one.

b. Any physical symptoms? Anal or genital pain, bleeding? Abdominal/pelvic pain? Fever?

c. If on HIV PEP

i. Make sure the patient has access to the medicines. You can provide a couple of days of PEP and then have the patient/family have prescription stamped by the social work office at RIH.

ii. Has the patient started taking HIV PEP?

1. If no, why not?
2. If yes,
    a. Ask the parent/caregiver to read from the medicine bottle(s) or the prescription, the name(s) of the medicine.
    b. Ask about side effects (most commonly nausea, headache, and diarrhea).

iii. Does patient have prescription for Zofran?

iv. PEP is best tolerated when taken with food, and side effect(s) should lessen after about 1 week. Remember that the female patient was likely given other medications (Metronidazole), and this may be the reason for the nausea

v. If the patient is considering not taking the full 28days, he/she should call you/page you to let you know.

vi. If the patient is taking Raltegravir, ask if the parent/caregiver has noticed a rash on the patient. (there is a risk for Steven-Johnson syndrome)

6. Regardless of whether we respond to the ED all patients should be evaluated in the Aubin Center at a later date

a. Patients seen in ED should be on Monday or Friday afternoon for follow-up (CAP physician who evaluated the patient in the ED should do all subsequent follow-up in clinic)

b. Patients not seen in ED should be seen for a full evaluation (usually Tuesday or Wednesday)

i. If on HIV PEP, this appointment should be within 2 weeks

a. If not on HIV PEP, then appointment can be next available unless having symptoms

7. At the Aubin Center visit

a. Gather/review history

b. Exam/re-exam patient as needed

c. Review labs
d. Assess patient safety
e. Answer questions regarding law enforcement, and telephone involved detective if applicable.
f. Make sure she/he has a counseling referral
g. Schedule repeat HIV/RPR/HepC test at 3 months and repeat HIV test at 6 months post assault.
h. For patients started on HIV PEP, a repeat HIV Antibody test should be ordered at 4-6 weeks post assault.