



MINISTRY OF HEALTH

POST RAPE CARE FORM (PRC)
MOH 363

PART A & B

County: _____

Sub-County: _____

Facility: _____

Start Date: _____ **End Date:** _____

POST RAPE CARE FORM (PRC)

PART A



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PRC FORM IS **NOT** FOR SALE

Ministry of Health National Rape Management Guidelines: Examination documentation form for survivors of rape/sexual violence (to be used as clinical notes to guide filling in of the P3 form)

Date	Day	Month	Year	County Code	Sub-county Code			OP/IP No.				
					Facility Name			MFL Code				
Name(s) (Three Names)					Date of birth	Day	Month	Year	<input type="checkbox"/> Male			
									<input type="checkbox"/> Female			
Contacts (Residence and Phone number) _____												
Disabilities (Specify) _____							Marital Status (specify) _____					
Orphaned vulnerable child (OVC) <input type="checkbox"/> Yes <input type="checkbox"/> No							Citizenship _____					
Date and time of Examination					Date and Time of Incident					No. of perpetrators		
Day	Month	Year	Hr	Min	<input type="checkbox"/> AM	Day	Month	Year	Hr		Min	<input type="checkbox"/> AM
					<input type="checkbox"/> PM							<input type="checkbox"/> PM
Alleged perpetrators <input type="checkbox"/> Male <input type="checkbox"/> Female Estimated Age _____												
<input type="checkbox"/> Unknown <input type="checkbox"/> Known (specify the relationship) _____												
Where incident occurred												
Administrative location: County _____ Sub-county _____ Landmark _____												
Chief complaints: Indicate what is observed _____												
Indicate what is reported _____												
Circumstances surrounding the incident (survivor account) remember to record penetration (how, where, what was used? Indication of struggle?) _____												

Type of Sexual Violence <input type="checkbox"/> Oral <input type="checkbox"/> Vaginal <input type="checkbox"/> Anal <input type="checkbox"/> Other (specify) _____	Use of condom? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Incident already reported to police? <input type="checkbox"/> No <input type="checkbox"/> Yes (indicate name of police station) _____
	Date and time of report	
	Day	
	Month	
	Year	
Hr		
Min		
<input type="checkbox"/> AM		
<input type="checkbox"/> PM		
Attended a health facility before this one? <input type="checkbox"/> No <input type="checkbox"/> Yes (Indicate name of facility) _____		Were you treated? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date		Were you given referral notes? <input type="checkbox"/> Yes <input type="checkbox"/> No
Day		
Month		
Year		
Hr		
Min		
<input type="checkbox"/> AM		
<input type="checkbox"/> PM		
Significant medical and/or surgical history		
Comments: Indicate additional information provided by the client or observed by clinician		

PHYSICAL EXAMINATION [indicates sites and nature of injuries bruises and marks outside the genitalia]
Please use the body map below to indicate injuries, inflammations, marks on various body parts of the survivor

BODY MAP	Comments
Anterior View	
Posterior view	
Female Genitalia	
Male Genitalia	

OB /GYN History	Parity	Contraception type	LMP	Known Pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last consensual sexual intercourse
General Condition	BP	Pulse Rate	RR	Temp	Demeanor /Level of anxiety (calm, not calm)
FORENSIC					
Did the survivor change clothes? <input type="checkbox"/> Yes <input type="checkbox"/> No		State of clothes (stains, torn, color, where were the worn clothes taken)?			
How were the clothes transported? <input type="checkbox"/> a) Plastic Bag <input type="checkbox"/> b) Non Plastic Bag <input type="checkbox"/> c) Other (Give details) _____					
Were the clothes handed to the police? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did the survivor go to the toilet? <input type="checkbox"/> Long call? <input type="checkbox"/> Short call?			
Did the survivor have a bath or clean themselves? <input type="checkbox"/> No <input type="checkbox"/> Yes (Give details) _____					
Did the survivor leave any marks on the perpetrator? <input type="checkbox"/> No <input type="checkbox"/> Yes (Give details) _____					
GENITAL EXAMINATION OF THE SURVIVOR -indicate discharges, inflammation, bleeding Describe in detail the physical status Physical injuries (mark in the body map) _____ Outer genitalia _____ Vagina _____ Hymen _____ Anus _____ Other significant orifices _____					
Comments _____ _____ _____					
Immediate Management	PEP 1st dose <input type="checkbox"/> No <input type="checkbox"/> Yes (No of tablets)	ECP given <input type="checkbox"/> No <input type="checkbox"/> Yes	Stitching /surgical toilet done <input type="checkbox"/> No <input type="checkbox"/> Yes(Comment) _____	STI treatment given <input type="checkbox"/> No <input type="checkbox"/> Yes(Comment) _____	
Any other treatment / Medication given /management?					
Referrals to <input type="checkbox"/> Police Station <input type="checkbox"/> HIV Test <input type="checkbox"/> Laboratory <input type="checkbox"/> Legal <input type="checkbox"/> Trauma Counseling <input type="checkbox"/> Safe Shelter <input type="checkbox"/> OPD/CCC/HIV Clinic <input type="checkbox"/> Other (specify)					
LABORATORY SAMPLES	Sample Type	Test	Please tick as is applicable		Comments
			National government Lab	Health Facility Lab	
	Outer Genital swab	Wet Prep Microscopy			
	Anal swab	DNA			
	Skin swab	Culture and sensitivity			
	Oral swab				
	Specify				
	High vaginal swab	Wet Prep Microscopy			
	Urine	Pregnancy Test			
		Microscopy			
		Drugs and alcohol			
		Other			
	Blood	Haemoglobin			
		HIV Test			
		SGPT/GOT			
VDRL					
DNA					
Pubic Hair	DNA				
Nail clippings	DNA				
Foreign bodies	DNA				
Other (specify)					
CHAIN OF CUSTODY					
These /All / Some of the samples packed and issued (please specify)					
By	Name of Examining Officer (Doctor/Nurse/Clinical officer)	Signature	Day	Month	Year
To	Police Officer's Name	Signature	Day	Month	Year
PSYCHOLOGICAL ASSESSMENT		Complete psychological assessment section in Part B			

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PSYCHOLOGICAL ASSESSMENT



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Part B is intended to assess the mental status of a client in order to be able to offer holistic care. This should inform the management and subsequent follow up of the client and hence should be filled in at presentation.

Psychological assessment should be done by trained health care providers including Medical Officers, Nurses, Clinical Officers, Psychiatrists, Psychological Counselors and Medical Social Workers duly recognized by the Ministry of Health.

The Medical Officers and other persons designated by law as expert witnesses in court (Nurses and Clinical Officers) should be the ones to sign off both the Part A and B of the PRC form.

General appearance and behavior

Note appearance (appear older or younger than stated age), gait, dressing, grooming (neat or unkempt) and posture.

Rapport

Easy to establish, initially difficult but easier over time, difficult to establish.

Mood

How he/she feels most days (happy, sad, hopeless, euphoric, elevated, depressed, irritable, anxious, angry, easily upset).

Affect

Physical manifestation of the mood e.g. labile (emotions that are freely expressed and tend to alter quickly and spontaneously like sobbing and laughing at the same time), blunt/ flat, appropriate/ inappropriate to content.

Speech

Rate, volume, speed, pressured (tends to speak rapidly and frenziedly), quality (clear or mumbling), impoverished (monosyllables, hesitant).

Perception

Disturbances e.g. Hallucination, feeling of unreality (corroborative history may be needed to ascertain details)

Thought content

Suicidal and Homicidal Ideation (Ideas but no plan or intent; clear/unclear plan but no intent; ideas coupled with clear plan and intent to carry it out); any preoccupying thoughts.

Thought process

Goal-directed/ logical ideas, loosened associations/ flight of ideas/ illogical, relevant, circumstantial (drifting but often coming back to the point), ability to abstract, perseveration (constant repetition, lacking ability to switch ideas).

(For children use wishes and dreams, and art/ play therapy to assess the thought process and content.

-Through drawing and play (e.g. use of toys). Allow the child to comment on the drawing and report verbatim.

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-Assess the unconscious world of the child by asking about feelings e.g. ask the child to report the feeling that he/she commonly experiences and ask what makes him/her feel that way

Cognitive function-

a. **Memory:** Recent memory, long-term and short term memory (past several days, months, years).

b. **Orientation:** to time, place, person i.e. ability to recognize time, where they are, people around e.t.c.

c. **Concentration:** ability to pay attention e.g. counting or spelling backwards, small tasks

d. **Intelligence:** Use of vocabulary (compare level of education with case presentation; above average, average, below average).

e. **Judgment:** Ability to understand relations between facts and to draw conclusions; responses in social situations.

Insight level: Realizing that there are physical or mental problems; denial of illness, ascribing blame to outside factors; recognizing need for treatment (Indicate whether insight level is; present, fair, not present)

Recommendation following assessment		Referral point/s				
Referral uptake since last visit e.g. other medical services, children's department, police, legal aid, shelter e.t.c.						
By	Name of Examining Officer (Doctor/Nurse/Clinical officer)	Signature	Day	Month	Year	
To	Police Officer's Name	Signature	Day	Month	Year	