SAN DIEGO
FAMILY JUSTICE CENTER

Patient Consent

The nurses and physicians of the Forensic Medical Unit, at the

Family Justice Center
707 Broadway, 2nd Floor
San Diego, CA 92101

May release the following information:

1. I understand that a forensic medical examination for evidence of domestic violence can, with my consent, be conducted by a healthcare professional to discover and preserve evidence of the assault. If conducted, the report of the examination and any evidence obtained will be released to law enforcement authorities.
_____ (initial)

2. I understand that collection of evidence may include audio/visual recordings and photographing injuries and that these photographs may include the genitalia.
_____ (initial)

3. I hereby consent to a forensic medical examination for evidence of domestic violence.
_____ (initial)

4. I understand that anonymous data from this report may be collected for health and forensic purposes, and provided to health authorities and or other qualified persons with a valid educational or scientific interest.
_____(initial)

5. I authorize the staff at the Forensic Medical Unit to discuss my information as it pertains to my well being and safety with domestic violence professionals located at the Family Justice Center.
_____(initial)

6. I may withdraw this consent at any time before the forensic medical unit complies and or releases this medical information
_____ (initial)

Print name_____ **Date of birth**_____

Signature_____**Date**_____

The City Of San Diego
SAN DIEGO POLICE DEPARTMENT
DOMESTIC VIOLENCE UNIT
707 Broadway, MS 759
San Diego, CA 92101
Phone: (619) 533-3500
Fax: (619) 533-3502

DATE:_____ CASE NUMBER:_____

AUTHORIZATION TO RELEASE PATIENT RECORDS

I,_____, here by authorize_____ to disclose
Print Patient's Name Print Name of Hospital, Physician, Clinic

and photocopy any and all records, without limitation, obtained in the course of my diagnosis and treatment for medical care on or about the dates of _____, including all photographs, nurses records, and records of emergency service providers to:

☐ The San Diego Police Department

☐ The City Attorney's Office

☐ The District Attorney's Office

This disclosure of records is required for the criminal investigation of domestic violence charges.

I may withdraw this authorization at any time before the Hospital or Medical Facility compiles and releases the information.

_____ _____ _____
Date Print Patient's Name Patient's Date of Birth

_____
Patient's Signature

Instruction: For use when any DV victim requires or receives medical treatment. Have the patient sign and date this authorization, and forward it with the case report to the Domestic Violence Unit, MS 759.

GOVERNOR'S OFFICE OF CRIMINAL JUST[illegible] PLANNING

SUSPICIOUS INJURY REPORT

OCJP-920 (12/03)

STATE OF CALIFORNIA

INFORMATION DISCLOSURE

This form is for law enforcement use only and is confidential in accordance with Section 11163.2 of the Penal Code. This form shall not be disclosed except by local law enforcement agencies to those involved in the investigation of the report or the enforcement of a criminal law implicated by this report. In no case shall the person identified as a suspect be allowed access to the injured person's whereabouts. The person making this report shall not be required to disclose his/her identity to their employer (PC 11160).

Part A: PATIENT WITH SUSPICIOUS INJURY

1. PATIENT'S NAME (Last, First, Middle)	2. BIRTH DATE	3. GENDER ☐ M ☐ F	4. SAFE PHONE NUMBER ( )

5. PATIENT'S RESIDING ADDRESS (Number and Street / Apt – NO P.O. Box) City State Zip

6. PATIENT SPEAKS ENGLISH ☐ Y ☐ N – Identify language spoken:	7. DATE AND TIME OF INJURY Date: Time: ☐ am ☐ pm ☐ Unknown

8. LOCATION / ADDRESS WHERE INJURY OCCURRED, IF AVAILABLE – Check here if unknown: ☐

9. PATIENT'S COMMENTS ABOUT THE INCIDENT – Include any identifying information about the person the patient alleges caused the injury and the names of any persons who may know about the incident. ☐ ADDITIONAL PAGES ATTACHED

10. NAME OF SUSPECT – If identified by the patient	11. RELATIONSHIP TO PATIENT, IF ANY

12. SUSPICIOUS INJURY DESCRIPTION – Include a brief description of physical findings and the final diagnosis. ☐ ADDITIONAL PAGES ATTACHED

Part B: REQUIRED – AGENCIES RECEIVING PHONE AND WRITTEN REPORTS

13. LAW ENFORCEMENT AGENCY NOTIFIED BY PHONE (Mandated by PC 11160)	14. DATE AND TIME REPORTED Date: Time: ☐ am ☐ pm

15. NAME OF PERSON RECEIVING PHONE REPORT (First and Last)	16. JOB TITLE	17. PHONE NUMBER ( )

18. LAW ENFORCEMENT AGENCY RECEIVING WRITTEN REPORT (Mandated by PC 11160)	19. AGENCY INCIDENT NUMBER

Part C: PERSON FILING REPORT

20. EMPLOYER'S NAME	21. PHONE NUMBER ( )

22. EMPLOYER'S ADDRESS (Number and Street) City State Zip

23. NAME OF HEALTH PRACTITIONER (First and Last)	24. JOB TITLE

25. HEALTH PRACTITIONER'S SIGNATURE:	26. DATE SIGNED:

Forensic Medical Unit Initial Exam: page 1/2

Patient (Pt) Allergies: _____
Reason for Visit: _____

Brief Medical Hx: _____
Medications: _____
Primary Healthcare Provider: _____ Last Visit: _____

Vital Signs

Temp: _____ Blood Pressure: _____ Pulse: _____ Respirations: _____ Oxygen Saturation: _____
Pain (1-10 Scale): _____ / 10 Location: _____ Duration: _____

Assessment

Respiratory Lung Sounds: R_____ L_____ Voice Changes
Comments: _____

Cardiovascular ☐ Heart Sounds WNL ☐ Pulses Equal ☐ Murmurs ☐ Gallops
Comments: _____

Genitourinary ☐ Hematuria ☐ Dysuria ☐ CVA tenderness
Comments: _____

Gastrointestinal Bowel Sounds: x_____ quadrants ☐ Soft ☐ Tender ☐ Nausea/Vomiting ☐ Diarrhea
Comments: _____

Neurological ☐ HA ☐ Blurry Vision ☐ Numbness/Tingling ☐ LOC ☐ Faint/Dizzy
Comments: _____

Musculoskeletal ☐ Stability ☐ Strength/Tone ☐ Gait/Station ☐ ROM
Comments: _____

Skin Bruising/Induration/Masses/Abrasions/Tenderness/Scratches/Burns/Cuts/Punctures ☐ See Body Map
Comments/Location: _____

OB/GYN Last Menstrual Period: _____ Pregnant: Y N Gravida: _____ Para: _____
Comments: _____

Psychiatric ☐ Depression ☐ Anxiety Does Pt have a support system? Y N
Comments: _____

Safety Does Pt have a safe place to stay? Y N Other family members threatened? Y N
Weapons in home? Y N Does Pt/Children/Other Family Members live with offender? Y N
Prior domestic violence threats or events? Y N Substance use? Y N Disabilities? Y N
Comments: _____

Additional Care:

Patient Teaching:

Referrals/Communication with Other Providers:

Follow-Up Visit:

RN Print: _____ Date: _____
RN Signature: _____ Time: _____

Patient Identification

Name: _____
DOB: _____

Forensic Medical Unit Initial Exam: page 2/2

Event Documentation:

Pt relationship to offender: _____ x _____ Years/Months/Weeks/Days

How is the offender related to the children in the home? _____

Event date: _____ Event time: _____ Location: _____

What precipitated the Event? _____

Comments: _____

How did the event end? _____

RN Print: _____ Date: _____

RN Signature: _____ Time: _____

Patient Identification

Name: _____

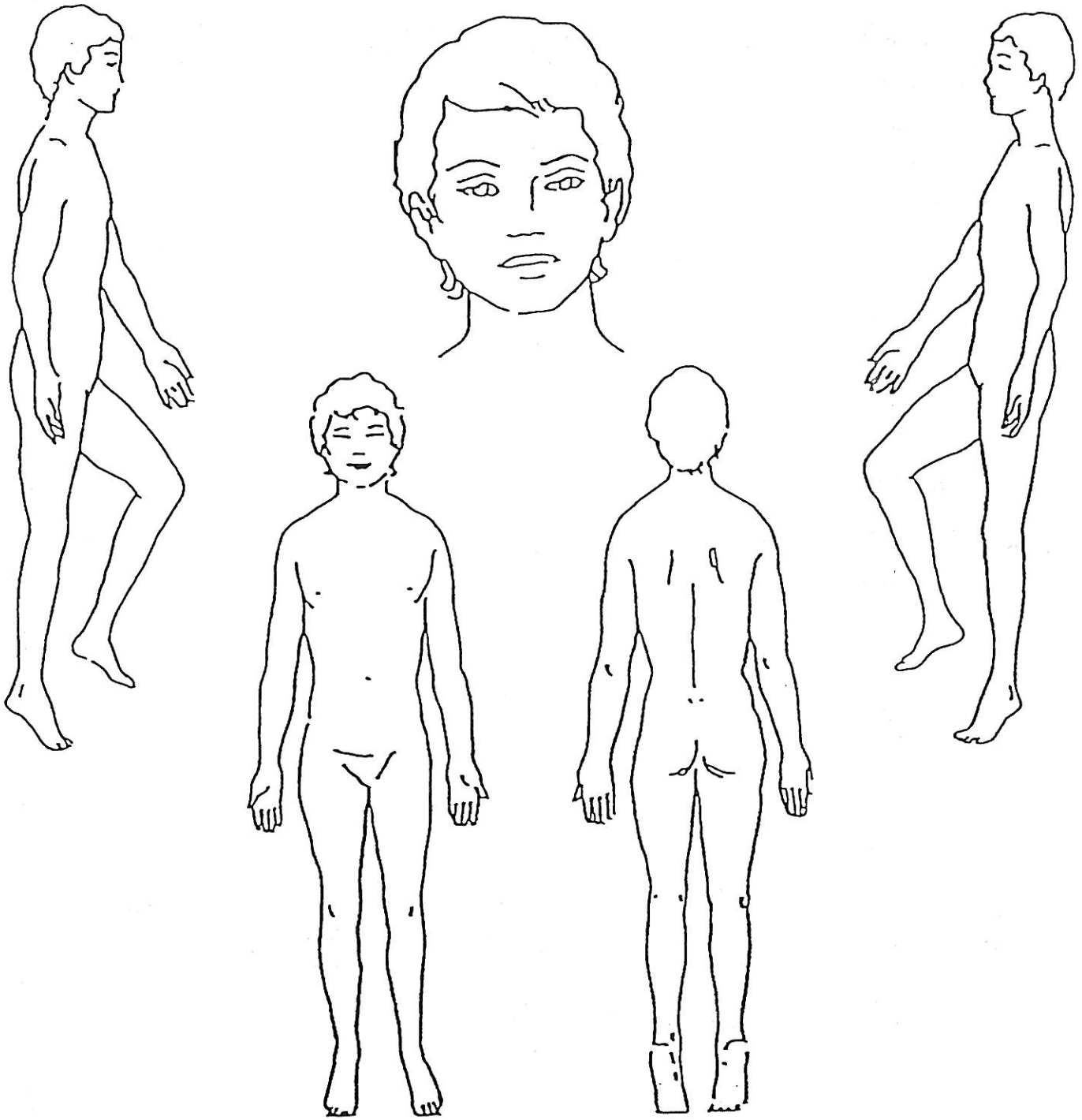
DOB: _____

Grossmont Hospital SHARP

Family Justice Center

Forensic Medical Unit

PHYSICAL FINDINGS



Description of injuries: _____

_____

_____

_____

Photos taken by: _____ Date of assessment: _____

Grossmont Hospital SHARP®

PROGRESS NOTES

DATE	Notes Should Be Signed By Provider