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# **CHILD PROTECTION AND CHILD ABUSE MANUAL**

## **Part II The Physician's Role**

**Manitoba  
Family Services  
and Housing**



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# I PHYSICAL ABUSE

It is important to document all information clearly and concisely. Direct quotes from the child (e.g. "Joe slapped my face") should be identified as such and not just paraphrased. All physical marks, and not just the one(s) in question, should be documented for completeness. Sometimes additional history is obtained after the physician's exam; the documentation of other marks may prove helpful.

Marks should be clearly described in terms of:

1. **Type of mark** - contusion, abrasion, petechia, burn, etc.
2. **Size of mark** - measured in centimetres
3. **Presence of pattern** - bite, strap mark, loop mark, etc.
4. **Location of mark** - as precisely as possible
5. **Age** -the approximate age of bruise is difficult to estimate. Bruise evolution depends on several factors, including depth and site of the bruise. If yellow colouration is present then the bruise is at least 24 hours old.

In all cases, the physician should attempt to determine if the injury fits the explanation provided. Where no history is obtained, the physician should attempt to determine if the injury seen is likely to be accidental based on the characteristics above, taking into account **the age and expected activities** of the child (e.g. facial bruising on a three-month-old is extremely unlikely to be accidental, whereas minor bruising on the anterior shins of an active six-year-old is common, usually accidental in origin).

In children under 2 years of age, a skeletal survey may be helpful in detecting previous, unreported injuries. In older children, the use of X-rays is based on clinical judgment. Fractures that tend to be more concerning include:

- any fracture, particularly long bone, in a child under one year of age;
- spiral fractures;
- depressed skull fractures;
- fractures in unusual locations (for example, sternum, scapula);
- epiphyseal-metaphyseal fractures;
- bilateral rib fractures;
- multiple fractures in various stages of healing.

As with soft-tissue injuries, the physician should determine if the fracture is compatible with the history, taking into account the child's age and activity. Children's Hospital Child Protection Centre (Winnipeg, Manitoba) is available for consultation on injuries.

## II. SEXUAL ABUSE

The management of children who have been sexually abused depends in part on when the abuse has occurred and whether or not the child has any medical symptoms.

An immediate genital exam is not necessary in a child or adolescent who has just disclosed sexual abuse *which occurred in the past and who has no complaints of vaginal discharge, bleeding or amenorrhea*. In these situations, it is often helpful to delay the examination until after some of the immediate stress related to the disclosure and subsequent events (e.g. apprehension) has settled. The examination can be done by the child's physician if he/she is comfortable with the examination, the medical report, and the possible need to explain the findings in court. The Child Protection Centre is also a source of referral, if required.

***The management of children who have been acutely (less than 72 hours) sexually assaulted***, more often falls onto the primary physician. An immediate examination is often required in these cases. The closer the examination is to the actual assault, the more likely that the forensic evidence will be useful.

**Forensic evidence is to be collected in cases where the assault has occurred within the previous 48 hours. Prophylactic medications however can be given up to 72 hours post assault.**

### GENERAL INFORMATION

1. **See the child immediately.** Even though no physical trauma may be present, victims of sexual abuse should receive high priority.
2. **Provide private facilities** for the victim and protect them wherever possible from additional emotional trauma. Complete registration there.
3. **Obtain consent** for care from the non-offending parents/legal guardian where possible. If such consent cannot be obtained, contact the child and family services agency. Explain to the child (patient) and the parents/guardians, the reasons for questions asked, types of medical/legal tests needed, and possible treatment. Examination of the adolescent should not be done without her/his consent unless a life-threatening emergency exists.
4. **Contact the child and family services worker/ police immediately**, as crisis intervention is often required. Discuss reporting to police and/ or the child and family services agency. Police should be contacted to come to the emergency room for an initial report.
5. **Provide maximum support** to non-offending parent/guardian, as well as to the child/adolescent victim. Do not be judgmental or allow emotional responses (e.g. anger, outrage) to interfere with providing optimal care.

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## **MEDICAL EVALUATION**

The information obtained using the CASA form is not intended to be a detailed history of the patient and his/her problems. Rather, it is designed to elicit information that is relevant to the acute assault and will guide the physician in his/her examination. Child and family services and/or police are responsible for conducting a thorough "forensic" interview.

- a) *Where possible, take a history from the patient alone.* Other information may also be obtained from parents/guardians and/or social workers, etc.
- b) *Use vocabulary appropriate for age and developmental level.* Use patient's words to describe and explain meaning if needed, i.e. "He put his 'thing' in me." (penis)
- c) *Obtain a direct history of the abuse/assault.* Do not ask "why" questions, e.g. "Why did you go to his house?" Phrase questions in terms of "who, what, where, and/or when." Ask "what happened" and use "supportive" questions to fill in details, e.g. "How long ago did it happen?"; "How long has it been going on?" Be non-directive. Try to avoid leading questions.

## **SEXUAL ASSAULT FORM**

### **PERSONAL HISTORY**

This section provides information on the patient that allows for interpretation of physical findings. (For example, an adolescent with a history of voluntary sexual activity may sustain fewer physical injuries to the genital area than a non-sexually active adolescent who has been assaulted.)

### **ASSAULT DATA**

Information obtained in this section outlines the details of the assault and will guide the physician as to some of the relevant parts of the physical exam. (For example, an adolescent who clearly gives a history of no forced oral intercourse does not routinely need an oral swab/smear done.)

The medical chart may be legal evidence. "Hearsay" statements from those who first see the child/adolescent may be admissible in court. All statements should be accurate, objective and legible. Any direct quotations from a patient's history should be clearly indicated, for example, by use of quotation marks.

# EXAMINATION AND SPECIMEN COLLECTION

## IN GENERAL:

- a) **Be gentle and empathetic.** Explain what you are doing in a calm manner and voice. Take time to relax the apprehensive patient.
- b) If supportive, have parent stay with child during the examination. Allow the adolescent the option of having whom s/he wishes to be present.
- c) **Allow the patient to feel as much in control of his/her body during the exam as possible.** Verbalize an understanding of his/her anxiety.
- d) Use appropriate gowns and drapes to ensure modesty and decrease feelings of vulnerability.
- e) **Use a REASONABLE approach.** As much of an examination should be done as soon as possible **without additional trauma to the child/ adolescent.** Use only those parts of the protocol appropriate for age of child and type of assault. In many cases, visual examination will suffice and instruments should not be used. A speculum examination of a prepubescent is not indicated as part of the routine examination.
- f) **Document the emotional status of the patient.**

## FORENSIC EXAM:

All samples are to be submitted to police/RCMP and should be labelled with patient's name, dates and initialled by the examiner.

### A. Clothing

If the child has not changed clothing since the alleged assault, these items are to be collected. Use discretion regarding large items of clothing such as jackets, overcoats and footwear (as the patient doesn't get any items back quickly).

- a) Have child stand on a piece of paper and remove each item separately.
- b) Place each article of clothing in a separate small plastic bag (as removed – label, date and initial each bag).
- c) Carefully fold the paper to enclose any debris, place in bag and label.
- d) Place all of these small bags in the large green bag.

### B. General Exam

Documentation of any cutaneous injuries should be done at this point. Injuries should be characterized by type of mark, size, location, pattern, age (see Section I Physical Abuse).

### C. Body Evidence

1. **Foreign material** includes any materials that may have been left by the perpetrator (e.g. hair, fibres from clothing, lubricants, etc.)

2. **Seminal stains** on skin are more readily visible if the skin is examined with a Wood's lamp. If this is unavailable, areas of the body should be swabbed based on history. A moistened cotton swab is used to rub the area; it is air-dried, and placed in a container. Do not use alcohol.
3. **Hair**
  - a) Have the child vigorously rub his/her scalp with the comb provided and place any loose hair and the comb in a ziploc bag and label.
  - b) Have the child pluck 3 or 4 scalp hairs. Place hair in a separate ziploc bag and label.
4. **Fingernail scrapings** (if the history indicates victim may have scratched assailant.)

Have the child scrape under the nails of right and left hand. Put any scrapings and the pick into a ziploc bag.
5. **Oral swab and smear** (if history of fellatio)
  - a) Swab the area around the mouth if indicated. Collect dried secretions with a swab moistened with distilled water. Collect moist secretions with a dry swab to avoid dilution of the specimen.
  - b) Collect two swabs from the oral cavity up to six hours post assault for seminal fluid if indicated by history. Recommended areas to swab in the mouth include the gum to the tonsillar fossae, the upper first and second molars, behind the incisors and the fold of the cheek.
  - c) Smear slide and allow to air dry.

**D. Genital Exam**

Careful inspection of the external genitalia and peri-anal area is important. Bruising, lacerations, abrasions and erythema should be carefully documented. Previous injuries (e.g. healed hymenal clefts from previous sexual activity) should also be documented

The genital examination is done: *(1) to document injuries, (2) to determine the presence of any infections, and (3) to collect forensic specimens that may aid in identifying the perpetrator.*

**1. Hair**

Plucked hairs are used to compare with free hairs submitted in the combed sample (i.e. potential perpetrator hairs). Where patients are extremely reluctant or uncomfortable, this step (plucked hairs) may be omitted. If the need arises, this sample can be obtained at a later date. In prepubescent children, any hairs found in the genital region should be placed in a specimen bag and submitted

For the postpubertal child:

- a) Have the child comb pubic hair and place the comb and any hairs in a Ziploc bag.
- b) Have the child pluck 10-12 pubic hairs and place in a separate Ziploc bag and label.

**2. Vaginal/vulvar swab and smear**

- a) A cotton swab is used to swab the introital area.
- b) After rolling the swab on a slide, both are allowed to air-dry **without fixative** before being placed together in a specimen bag. These will be used for detection of seminal products.
- c) If indicated by history, a similar swab/slide is obtained from the anus. A swab with a container (hanging drop type) is generally used for these tests.

Adolescents who are comfortable enough to tolerate it should have a speculum examination. At this time, STD testing and a PAP smear are taken. These tests are to be submitted for routine assessment and are not part of the forensic work-up submitted to law enforcement personnel.

**3. Vaginal wash**

- a) Using a 3 cc. syringe and plastic tubing, several cc's of sterile fluid are instilled into the vaginal vault then aspirated back.
- a) A few drops of this can be used to prepare a wet mount that the physician can look at for the presence of sperm.
- b) The remainder of the wash is labelled and submitted as part of the forensic work-up.

In prepubescent children, and anxious or uncomfortable adolescents, these tests are done **without** a speculum. Vaginal swabs, using a moistened, fine-tipped Calgi swab, are adequate in children. High vaginal swabs, although not ideal, will suffice in adolescents. The vaginal aspirate specimen can be obtained using a syringe with a butterfly needle attached. The needle is cut off leaving a fine catheter. 1-2 cc's of fluid are instilled into and withdrawn from the vagina.

**E. Other Investigations**

- 1. Urine – drug screen – 20 ml of urine is required.
- 2. Blood - blood work requested for **forensic** work-up:

DNA Testing	1-2 drops	blotter card	Give to Police
Drug & Alcohol Screen	3x10 ml <i>Use Iodine (not alcohol) swab for skin prep</i>	Gray top tube	Give to Police

All forensic specimens should be handed directly to attending law enforcement personnel after the examination. There is no need for law enforcement personnel to be present during the examination. The forensic specimens should not be left unattended. If the physician is unable to give the specimens directly, they should be given to and signed for by designated medical personnel, who will in turn submit them to the attending officers. Obtain signatures from the officers who have received the specimens.

## MEDICAL TESTS:

These specimens are not submitted to law enforcement personnel.

### 1. Bacterial Cultures

- a) Using Genprobe, swab cervix/urethra for Gonorrhea and Chlamydia (single specimen).
- b) Prepubescent females, obtain high vaginal swab for Genprobe and Gonorrhea culture.
- c) If indicated by history:
  - Using microtrak, swab throat and rectum for Chlamydia
  - Using chocolate agar, swab throat and rectum for Gonorrhea

If a child is currently on antibiotics, a urine for PCR (GCand Chlamydia) may also be sent

### 2. Blood

a) Hepatitis B and C, VDRL	2 – 3 ml	Red top tube	Send to Cadham Lab
b) HIV Testing	2 ml	Red top tube	Send to Cadham Lab

### 3. Other

Pregnancy, PAP, etc., as required.

## TREATMENT:

The following medications can be given up to **72 hours** post assault (even if a forensic exam is not done).

- a) Chemoprophylaxis for Gonorrhea and Chlamydia is recommended in acute sexual assault. The current recommendations are found in the CASA form
- b) Consideration may also be given to the use of a post-coital pill as outlined on the CASA form.
- c) Prophylaxis for Hepatitis B (Hepatitis B immunoglobulin/HBIG) and vaccination should be considered.
- d) An HIV post exposure prophylaxis kit is available from Manitoba Health. It includes 5 days of medication (Lamivudine 3TC 150 mg and Zidovudine AZT 300 mg). A second prescription for a further 23 days is required. This can be given as Combivir (1 tab po BID x 23 days). Payment can be arranged through Manitoba Compensation for Victims of Crime at (204) 945-0889.

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The physician should discuss side-effects (e.g. nausea) and possible teratogenic effects to fetus should pregnancy occur despite medication. Do not prescribe if there has been other unprotected intercourse during this cycle or any possibility of pre-existing pregnancy. Documentation of treatment and follow-up should be completed.

**FINAL DISPOSITION:**

- a) Verbally express concern and availability for help as needed.
- b) Reinforce social worker information; reinforce that patient is physically intact and is not responsible for the assault/abuse.
- c) Discuss medical problems that may arise and encourage family to call as needed.
- d) Convey your impressions to attending law enforcement/police personnel.

**FOLLOW-UP:**

- a) If examined within 24 hours of an assault, a follow-up examination is indicated within 72 hours. This is to document any bruising that may not have been evident at first.
- b) Appropriate STD follow-up should be done where indicated.
- c) HIV testing and counselling should be considered and followed up as required.
- d) A follow-up pregnancy test is recommended at 2 – 4 weeks.

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### III. EMOTIONAL AND BEHAVIOURAL MANAGEMENT OF ABUSED CHILDREN AND THEIR FAMILIES

The disclosure of abuse is a crisis for the victim. It changes the world of the child and those around the young person. Whether the abuse is of a physical, sexual or emotional nature-whether the perpetrator is in the home or in the community-there will be elements of dysfunction for the family and the child. The psychological and/or psychiatric needs of the child and the family should be carefully considered by the attending physician.

A good general approach is to try to determine the nature and degree of urgency involved in each specific case. The **following list of behaviours** would be considered high-risk in nature and, although not always directly caused by the abuse, may be largely attributed to it:

- running away
- substance abuse
- suicidal thoughts or behaviour
- homicidal thoughts or behaviour
- delusions
- hallucinations (rare)
- depersonalization
- psychotic episodes
- dissociation

These behaviours or problems in thinking should be looked for, and when found, prompt referral to an appropriate resource should be made. These behaviours are not always specific to child abuse and may be seen in other situations.

The **more subtle emotional needs of children** who have been abused often include loss of self-esteem, lack of trust, and a sense of worthlessness and hopelessness. These are common to all abused children. Emotional support, offered by the physician or upon referral to a colleague in psychology or social work, is vital.

Family needs are important as well, and resources to help families can usually be accessed through the same resource that would help with individual therapy for the abused child.

It is important to remember that therapy will begin to be effective only when proper notification of the abuse has taken place, and the child is safe from ongoing harm.

**ADDENDUM**

Crime Report # \_\_\_\_\_  
Medical Record # \_\_\_\_\_

(PLEASE COMPLETE)

**SEXUAL ASSAULT FORM**  
**(For examination within 48 hours of assault)**

**CONSENT DATA**

I, \_\_\_\_\_ consent to and authorize Dr. \_\_\_\_\_  
And/or the medical staff of \_\_\_\_\_ Hospital to obtain a medical history, to  
perform examination and administer treatment  
on \_\_\_\_\_.

I further authorize the aforementioned Physician and/or staff of this Hospital to take all the necessary samples, including  
blood for forensic examination, to notify the police of this occurrence and to turn over to the police all forensic samples  
and information necessary for the investigation of this occurrence.

Did police accompany patient to hospital:         Yes         No    \_\_\_\_\_  
Patient or Parent/Guardian signature

DATE: \_\_\_\_\_ TIME: \_\_\_\_\_ hours

WITNESS SIGNATURE: \_\_\_\_\_

**PERSONAL DATA**

Admission \_\_\_\_\_ Time \_\_\_\_\_ to  
Emergency \_\_\_\_\_ hours

Victim's \_\_\_\_\_ Surname: \_\_\_\_\_ Given  
Name(s): \_\_\_\_\_

Birthdate: \_\_\_\_\_ Phone \_\_\_\_\_ No:  
(Home) \_\_\_\_\_ (Bus) \_\_\_\_\_

Address: \_\_\_\_\_

(No., Street, City, Province, Postal Code)

Next of Kin/Guardian: \_\_\_\_\_ Victim's MHSC No: \_\_\_\_\_

MHSC \_\_\_\_\_ Subscriber's \_\_\_\_\_ surname \_\_\_\_\_ and  
Initial: \_\_\_\_\_

Subscriber's Phone No: (Home) \_\_\_\_\_ (Bus) \_\_\_\_\_

Address: \_\_\_\_\_

—  
(No., Street, City, Province, Postal Code)

**PERSONAL HISTORY**

Victim's age: \_\_\_\_\_ Gender: Male \_\_\_\_\_ Female \_\_\_\_\_

Menstrual history: Menarche: \_\_\_\_\_ Cycles: \_\_\_\_\_ Menses: \_\_\_\_\_

History of voluntary sexual activity: Yes \_\_\_\_\_ No \_\_\_\_\_

Gestation (No. of Weeks): \_\_\_\_\_ Para: \_\_\_\_\_ Gravida: \_\_\_\_\_ LNMP: \_\_\_\_\_

Other relevant surgical or medical history: \_\_\_\_\_

\_\_\_\_\_

Current medications: \_\_\_\_\_ Allergies: \_\_\_\_\_

**ASSAULT DATA**

Assault – Location: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ hrs

Assailants (No. and Gender): \_\_\_\_\_

Relationship of assailant to victim: Stranger \_\_\_\_\_ Acquaintance \_\_\_\_\_ Friend \_\_\_\_\_ Relative \_\_\_\_\_

Was condom used? Yes \_\_\_\_\_ No \_\_\_\_\_ Unsure \_\_\_\_\_

Was there penetration of: (Vagina \_\_\_\_\_ Ejaculation \_\_\_\_\_) (Anus \_\_\_\_\_ Ejaculation \_\_\_\_\_) (Mouth \_\_\_\_\_ Ejaculation \_\_\_\_\_)

Did cunnilingus take place? Yes \_\_\_\_\_ No \_\_\_\_\_

Describe pertinent data of assault (fondling, weapon, etc.) \_\_\_\_\_

\_\_\_\_\_

Did victim injure the assailant in any way? I.e., scratch, bite, kick, etc.?

(Describe) \_\_\_\_\_

Was douche, shower or bath taken between assault and doctor's examination? Yes \_\_\_\_\_ No \_\_\_\_\_ No Time: \_\_\_\_\_

Date of last voluntary intercourse: \_\_\_\_\_

Was douche, shower or bath taken between assault and last previous intercourse? Yes \_\_\_\_\_ No \_\_\_\_\_

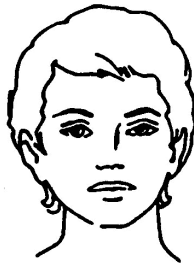
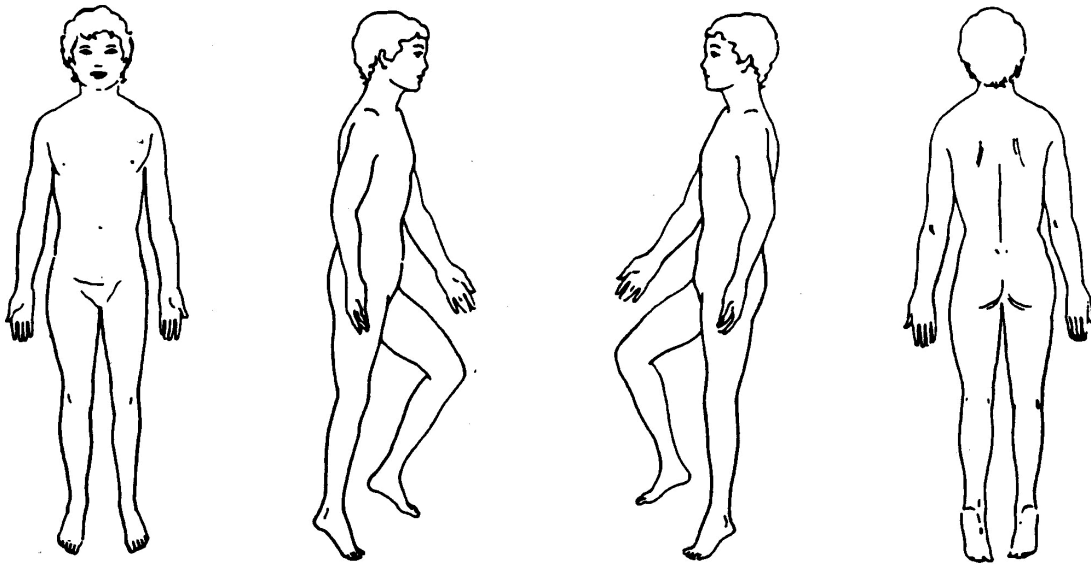
Has patient urinated or defecated since assault? Yes \_\_\_\_\_ No \_\_\_\_\_

Has patient noted bleeding/pain? Yes \_\_\_\_\_ No \_\_\_\_\_

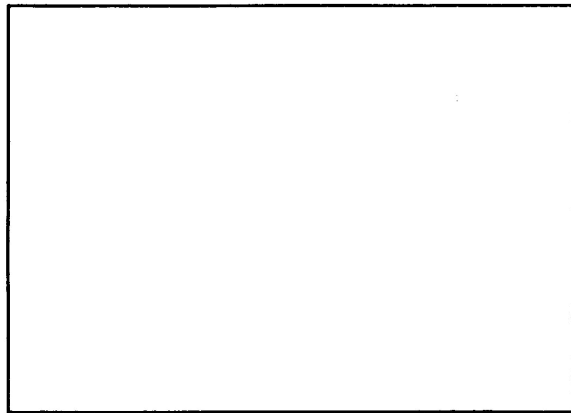
Were clothes changed? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, are they available? Yes \_\_\_\_\_ No \_\_\_\_\_

Were they washed or repaired? Yes \_\_\_\_\_ No \_\_\_\_\_  
Drugs or alcohol use by victim? Yes \_\_\_\_\_ No \_\_\_\_\_ Type \_\_\_\_\_

**GENERAL EXAMINATION: TRAUMAGRAM**



Tanner Stage \_\_\_\_\_



Detailed diagram, if required

**EXAMINATION AND SPECIMEN COLLECTION**

Clothing

Note:Articles of clothing must be placed in individual (paper or plastic) bags, with each item labeled with the patient's name, the date and time collected and properly initialed by the examiner.

The patient may stand on an open sheet while removing clothes (to collect evidence that may fall off – this sheet may also be submitted as evidence.)

- |          |          |
|----------|----------|
| A. _____ | E. _____ |
| B. _____ | F. _____ |
| C. _____ | G. _____ |
| D. _____ | H. _____ |

**Body Evidence**

Collect as indicated by history.

Submit each in separate, labeled bags (which must be dated and initialed and have the patient's name on) to law enforcement agency.

	DONE	NOT DONE
1. Foreign material on body (place in separate labeled bags)		
2. Seminal stains on skin (rub area with moistened Q-tip)		
3. Scalp hairs – rubbed		
Scalp hairs - plucked		
4. Fingernail scrapings – right hand		
Fingernail scrapings – left hand		

**PROCEDURES**

**Forensic**

Specimens to be collected **if indicated by history** and submitted to law enforcement agency.

	<b>DONE</b>	<b>NOT DONE</b>
1. Seminal deposits in pubic hair/vulva (Collect with moistened swab and place in tube.)		
2. Pubic hair – combed		
Pubic hair – plucked		
3. Foreign material (Place in separate, labeled bags.)		
4. Vaginal/vulvar swab and smear (Allow to air-dry before placing swab in tube and slide in holder. For prepubertal children use fine-tipped Calgi swab.)		
5. Vaginal aspirate (in prepubescent children, a butterfly with the needle cut off can be used as a catheter. Only 1 – 2 cc's of fluid are required. Do only if patient is comfortable enough to allow procedure.)		
6. Anal swab and smear (Allow to air-dry before placing swab in tube and slide in holder)		
7. Oral swab and smear (Allow to air-dry before placing swab in tube and slide in holder)		
8. Blood for drug/alcohol screen (3x10ml, gray top tube)		
9. Blood for DNA (1-2 drops, blotter card)		
10. Urine sample (20 ml) for drug screen		

**Medical**

These tests are for medical use only and are not submitted to law enforcement agency.

	DONE	NOT DONE
1. <u>Genprobe (Gonorrhea and Chlamydia)</u> : Male urethral swab Female cervical swab <b>or</b> Prepubescent female – vaginal swab: Gonorrhea culture Genprobe	_____ - _____ - _____ - _____	_____ _____ _____ _____ _____
2. Urine PCR for Gonorrhea and Chlamydia (if recently treated with antibiotics)		
3. Hanging drop examination (trichomonas, yeast, clue cells)		
4. Anal swab – Gonorrhea - Microtrak (Chlamydia)	_____ _____	_____ _____
5. Oral swab – Gonorrhea - Microtrak (Chlamydia)	_____ _____	_____ _____
6. PAP smear		
7. Other lab testing as indicated (e.g., V.D.R.L., H.I.V., Hepatitis B and C, pregnancy) List: _____		

**TRANSFER OF SPECIMENS**

Specimens received **from**:

NAME: \_\_\_\_\_ TITLE: \_\_\_\_\_

LOCATION: \_\_\_\_\_ DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

Specimens received **by**:

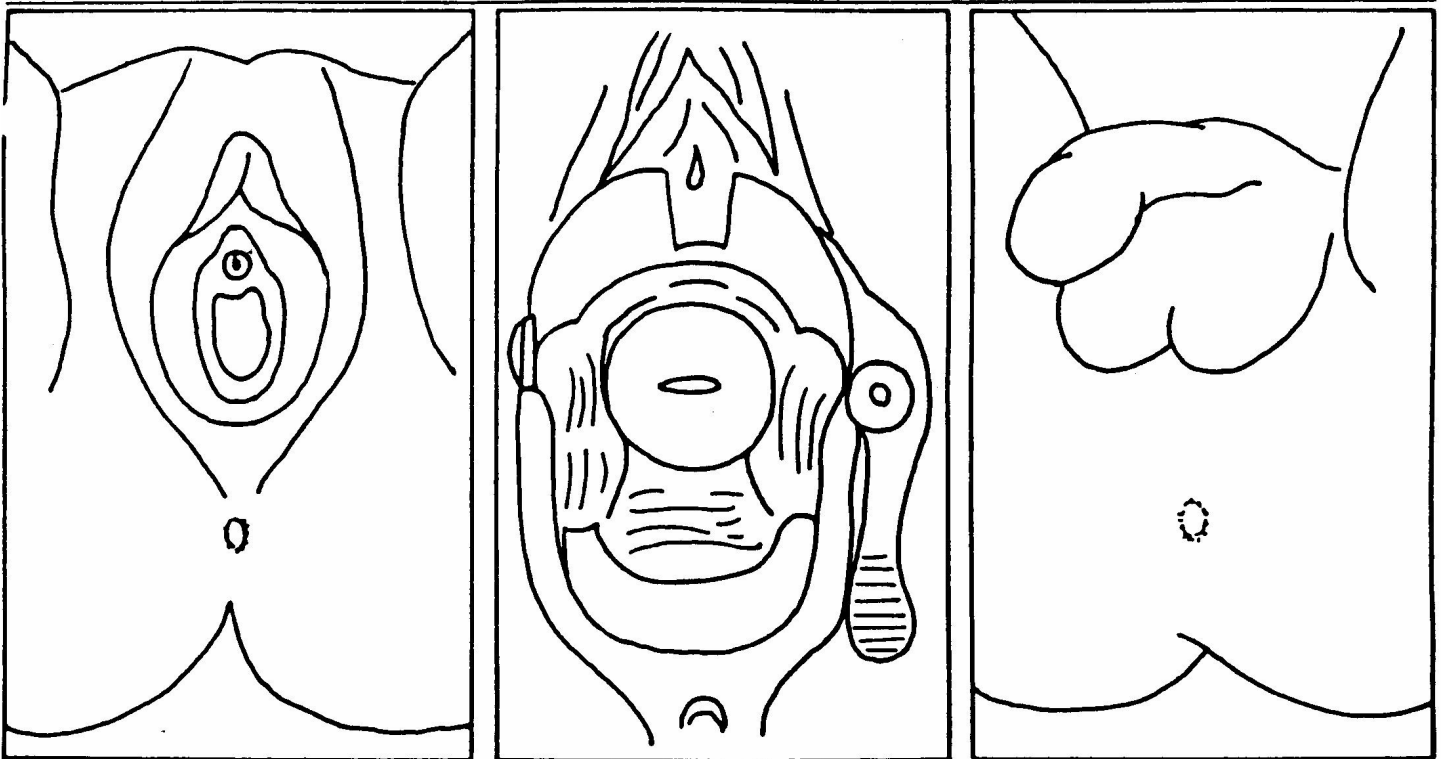
NAME: \_\_\_\_\_ BADGE #: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

**GENITAL AND ANAL EXAMINATION**

Date: \_\_\_\_\_ Time: \_\_\_\_\_ hours

**NOTE: SPECULUM EXAMINATION SHOULD NOT BE DONE ON PREPUBESCENT FEMALES.**



labia  
major \_\_\_\_\_

labia  
minora \_\_\_\_\_

posterior fourchette \_\_\_\_\_

introitus \_\_\_\_\_

vagina \_\_\_\_\_

-

cervix \_\_\_\_\_

anus/rectum \_\_\_\_\_

–

**TREATMENT RECORD AND GUIDELINES**

**1) Prophylactic STD therapy**

- a) Chlamydia: Doxycycline 100 mg. po BID x 7 days (>9 years old) **or**  
Azythromycin 1 gm po x 1 (10 mg/kg po x 5 days (if < 9 years old).
- b) Gonorrhea: Cefixime 400 mg po x 1 (8 mg/kg/po x 1).
- c) Syphilis: Ceftriaxone 125 mg i.m. x 1.

Recommendations:

- Prophylactic medication recommended for assaults that have occurred within the previous 72 hours.
- Prophylaxis against syphilis in the adolescent population is only recommended if the assailant is an unknown, adult male.
- If Ceftriaxone is used, there is no need to administer Cefixime concomitantly.

Treatment given: \_\_\_\_\_

**2. Prophylactic HIV therapy**

- a) Two dose regime:  
Lamivudine 150 mg po BID (child: 90mg/m<sup>2</sup>/day divided QID) **and**  
Zidovudine 200 mg po TID (child: 8 mg/kg/day divided q 12 hours).  
**OR**
- b) One dose regime:  
Combivir 1 pill BID (Lamivudine 150 mg plus Zidovudine 300 mg).

Recommendations:

- **HIV prophylaxis indicated only if:**
  - assault has occurred within the previous 48 hours **and**
  - source is HIV positive or known to engage in high risk activities **and**
  - assault consists of non-consensual intercourse (anal or vaginal penetration).
- **HIV prophylaxis is not indicated if**
  - source is unknown or believed to be HIV negative (not engaged in high risk behaviours) **or**
  - no vaginal or anal penetration has occurred **or**
  - assailant used a condom.

(If HIV prophylaxis is requested in these circumstances, the practitioner may elect to provide it at his/her discretion.)

- If source is know to be HIV positive, refer the adolescent to the Pediatric Infectitious Diseases clinic.

Treatment given: 5-day starter kit   
Rx for further 23 days

**3. Prophylactic Hepatitis therapy**

- a) If patient has previously received Hepatitis immunizatin (3 doses), no further treatment is recommended.
- b) For patients not previously immunized or incompletely immunized:
  - I. Prophylaxis: Hepatitis B immune globulin (HBIG) .06 ml/kg i.m.
  - II. Immunization: 1. patient <11 years old, 3 dose regime only: Recombivax 2.5 ug (.25 ml) i.m. **or**  
Engerix B 10 ug i.m. at 0,1 and 6 months.

2. patient 11 – 19 years old, 3 dose regime: Recombivax 5 ug (.5 ml) i.m. **or** Egerix B 10 ug. i.m. at 0, 1 and 6 months.
3. patient 11-15 years old, 3 dose regime as above OR 2 dose regime: Recombivax 10ug (1.0 ml) i.m. 2 doses at 0 and 4-6 months.

Treatment given: HBIG \_\_\_\_\_

Immunization \_\_\_\_\_

**4. Prophylaxis for pregnancy**

Recommended if patient presents within 72 hours of assault and is not pregnant:

Ovral 2 tabs at the time of assessment and repeated 12 hours later.  
 Gravol 50 mg po may be given prior to the second dose to prevent vomiting of medications.

Treatment given \_\_\_\_\_

**5. Prophylaxis against Tetanus**

Tetanus toxoid recommended if lacerations present and patient has not been immunized within past 5 years.

Treatment given \_\_\_\_\_

**6. Psychological Management**

Was patient referred for psychological management? Yes \_\_\_\_\_ No \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

**GUIDELINE**

**Refer to appropriate consulting services for immediate treatment and follow-up within 24 hours for psychological sequelae and related family problems.**

**7. Follow-Up**

Was medical /follow-up arranged? Yes \_\_\_\_\_ No \_\_\_\_\_

Specify Physician's Name: \_\_\_\_\_

and Appointment Date: \_\_\_\_\_

**GUIDELINE**

- Repeat V.D.R.L., HIV, pregnancy tests as indicated medically,
- Follow-up compliance with H.I.V. medications,
- Follow-up to complete Hepatitis B immunizations.

\_\_\_\_\_  
 Examiner's Signature

\_\_\_\_\_  
 (Please print) Examiner's Name

Date

This form has been excerpted from *Child Protection and Child Abuse: Part II The Physician's Role*. Booklets I and II have been prepared in consultation with the Departments of Family Services, Health, Justice and Education and Training through the Provincial Advisory Committee of Child Abuse. (January, 2004)