

# Sexual Assault Response Services of Southern Maine

## Medical Accompaniment Hotline Form

Crisis Management     Support Services    Date Received: \_\_\_\_\_ (office use only)

Advocate: \_\_\_\_\_ Date: \_\_\_\_\_ AS Operator: \_\_\_\_\_

Time: \_\_\_\_\_ a.m. or p.m. Phone: \_\_\_\_\_ City: \_\_\_\_\_

Caller: \_\_\_\_\_ Victim (if not caller): \_\_\_\_\_

Reason for Accompaniment \_\_\_\_\_

### Victim Information

Age Now: \_\_\_\_\_ Unknown:  Child  Adult    Gender:  Female  Male  Unknown  Trans

Age at Assault: \_\_\_\_\_ Unknown:  Child  Adult    Orientation:  G/L  Straight  Unknown

### Assault Information

Acquaintance     Stranger     Marital     Incest     Child  
 Gang Acquaintance     Gang Stranger     Live-in Partner     Ritual/Cult Abuse  
 Harassment     Stalking     Unknown     Other: \_\_\_\_\_

Is this the first report of this assault     Victim of multiple assaults     Victim of ongoing assault  
 Were drugs or alcohol used to incapacitate the victim? Please specify \_\_\_\_\_  
 Was perpetrator using drugs/alcohol/weapons? Please specify \_\_\_\_\_

### Actions by Victim

When was a police report made?     this month     this year     prior to this year     unknown  
When were medical services received?     this month     this year     prior to this year     unknown  
When was a DHS report made?     this month     this year     prior to this year     unknown  
If multiple assaults, when?     this month     this year     prior to this year     unknown

### Time Lapse Between Assault & Medical Attention

Immediate (within 24 hrs)     Within 1 week     Within 1 month     Within 6 months  
 Within 1 year     1-5 years     5-10 years     Over 10 years     Other: \_\_\_\_\_

### Advocate Interventions (Specify agency/person)

Medical Services \_\_\_\_\_     Law Enforcement \_\_\_\_\_  
 Legal Services \_\_\_\_\_     DHS Referral \_\_\_\_\_  
 Other \_\_\_\_\_

**Case Results** (Does not have to have happened this month)

Police Report     Indictment     Conviction     Protection Order     Arrest  
 Dismissal     Arraignment     Other: \_\_\_\_\_

**Medical Accompaniment:** ([complete separate form if law enforcement at hospital](#))

Location \_\_\_\_\_

**Advocate Time spent with on-site Contacts:**

Total 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 Other \_\_\_\_\_  
Victim 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 Other \_\_\_\_\_  
Nurse 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 Other \_\_\_\_\_  
Doctor .5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 Other \_\_\_\_\_  
Concerned Other 1.0 1.5 2.0 2.5 3.0 3.5 4.0 Other \_\_\_\_\_  
Concerned Other 1.0 1.5 2.0 2.5 3.0 3.5 4.0 Other \_\_\_\_\_

**Brief Summary** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Victim Feedback**

Did the victim state that you helped them? Yes No Unknown

Did the victim receive the "hospital packet"? Yes No

Did the victim receive jogging suit? Yes No Sm Med Lg XL XXL XXXL

[Did you inform them of how](#) to utilize [the SART Advocate?](#) Yes No

Would the victim like additional literature sent in a plain brown envelope? Yes No

Name: \_\_\_\_\_

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

City, State, Zip: \_\_\_\_\_

Type of Literature: \_\_\_\_\_

Who did you pass this along to at the office? \_\_\_\_\_ Completed

Would the victim like a follow-up call? Yes No

What date/time? \_\_\_\_\_

Who did you pass this along to at the office? \_\_\_\_\_ Completed

**Please return by the 3<sup>rd</sup> of the month to: SARS, P.O. Box 1371 Portland, ME 04104**