CALIFORNIA MEDICAL PROTOCOL FOR EXAMINATION OF SEXUAL ASSAULT AND CHILD SEXUAL ABUSE VICTIMS

January, 2001

Gray Davis
Governor

Office of
Criminal Justice Planning

CHAPTER XXI

POSSIBILITY OF PREGNANCY

A. ASSESS THE RISK OF PREGNANCY

1. Probabilities

Discuss the probability of pregnancy with the patient given the different variables described below. Females of various ages, social, and religious backgrounds will have differing feelings regarding the treatment options most acceptable to them. Major concerns include the patient's attitude toward conception, emergency contraception, abortion, and the desire to minimize the risk of pregnancy as a result of a sexual assault.

- The probability of conception from a single, random, unprotected intercourse is estimated to be between two and four percent.
- The probability of conception from a single, unprotected, midcycle intercourse (days 11 to 18 of a 28-day cycle) is at least 10 percent, and may be as high as 30 percent if the exposure was on the estimated day of ovulation.
- These numbers are based upon statistical probabilities. Any female with reproductive capacity can potentially become pregnant from any single exposure.

2. Pregnancy risk for adolescents

Pregnancy risk should be considered for all females, Tanner Stage 3 and above, irrespective of menarche.

3. Other variables

Determination of the probability of conception is also dependent on other variables, e.g., the use of contraceptives, regularity of menstrual cycle, fertility of the patient and the alleged perpetrator, time in the cycle of the exposure, and whether the perpetrator ejaculated intravaginally.

B. BASELINE PREGNANCY TEST

If there is any possibility that the patient has reproductive capability, a baseline pregnancy test should be performed at the time of the sexual assault examination to determine pregnancy status.

Baseline Pregnancy Testing:

• Use a sensitive beta-HCG pregnancy test. Most commercially available urine pregnancy tests are very specific and sensitive to about 50 milli-international units/ml and will detect a pregnancy 8-9 days after conception (before a menstrual period is missed).
• If this test is positive, emergency contraception is contraindicated and decisions about other medication (e.g. STD prophylaxis) must be made in consideration of the pregnancy.
• If the test is negative -- and the patient has had unprotected intercourse within the last 10 days and would continue that pregnancy if conception has occurred -- then she must be considered to be pregnant and emergency contraception is contraindicated.

C. ALTERNATIVE TREATMENTS

1. Discuss Treatment Options

- Two Immediate Treatment Options:
  - Postcoital hormonal therapy; or
  - Postcoital insertion of a copper-containing intrauterine device (IUD).
- No Immediate Treatment Decision

  If the patient decides to forego immediate treatment, she must wait a minimum of ten days to determine if conception did occur. Discuss possible outcomes and options:
  - No pregnancy;
  - Menstrual extraction performed within two weeks of conception;
  - Therapeutic abortion; or
  - Continue pregnancy and refer patient to a family planning agency, adoption agency, or county department of social services.

2. Postcoital Combination Therapy

- Emergency Contraceptive Pills (ECPs) are ordinary birth control pills containing the hormones estrogen and progestin. The FDA has recently approved seven brands of combined oral contraceptives for use as emergency contraception.
- The efficacy of these methods has been well established in clinical trials. The risk of unwanted pregnancy can be significantly reduced using ECPs.
- ECPs are extremely safe. The only absolute contraindication is pre-existing pregnancy because ECPs will not work if the patient is already pregnant. ECPs will not cause an abortion. Because these hormone doses are so small and the treatment duration so brief, the standard absolute contraindications to oral contraceptives do not apply.

Relative contraindications to ECPs include:

• Active migraine with neurologic symptoms;
• History of stroke (CVA);
• History of pulmonary embolus (PE); or
• History of deep vein thrombophlebitis (DVT).
• **Note:** If any of these conditions are present, it is safer to use a "Progestin Only" hormone method or insert a Copper-T IUD.

Dosage Schedule - all hormonal methods require two doses:

• The first dose is given at the time of the examination and must be given within 72 hours of the exposure. Effectiveness decreases if the exposure-treatment initiation interval is over 72 hours.
• The second (and final) dose is given 12 hours later.

Regimens for emergency contraception using combination (estrogen/progesterone) oral contraceptives:

Brand	Pills per dose	Ethynyl estradiol per dose (mg)	Levonorgestrel per dose (mg)
Ovral®	2 white pills	100	0.50
Alesse®	5 pink pills	100	0.50
Nordette®	4 light-orange pills	120	0.60
Levlen®	4 light-orange pills	120	0.60
Lo/Ovral®	4 white pills	120	0.60
Triphasil®	4 yellow pills	120	0.50
Tri-levlen®	4 yellow pills	120	0.50

- **Side Effects**
  - ECPs are generally well tolerated. Some patients, particularly adolescents, will experience mild nausea and may vomit. To reduce the risk of vomiting, the pills may be taken with food.

Options to prevent vomiting:

Source	Medicine	Brand	Dosage	Notes
Over the counter antiemetics	Meclizine Dimenhydrinate	Antivert® Dramamine®	25mg 25mg	30-60 minutes prior to the dose
Rectal suppository (by prescription)	Trimethobenzamide Promethazine	Tigan® Phenergan®	200mg 25mg	
Note: If vomiting occurs within two hours of taking a dose of the ECPs, the ECP dose should be repeated.				

- **Follow-up**
  - The menses following ECP treatment may be heavier or lighter than usual and may not occur at the expected time.
  - If no bleeding has occurred within three weeks, the patient must be evaluated and a repeat pregnancy test performed.
  - The patient must be advised not to have unprotected intercourse until after the menses has occurred, or the repeat pregnancy test is negative.

3. **Progestin only emergency contraception**
   - This method is similar to combination ECP therapy but uses only the progestin Levonorgestrel. Levonorgestrel alone is now FDA approved for emergency contraception.
   - It may be a good alternative for patients needing emergency contraception but who have relative contraindications to combined oral contraceptives.
   - As with the combination hormone method, the progestin only pills are started within 72 hours of exposure and given in two doses 12 hours apart.
   - The recommended regimen uses:

     Ovrette® (Levonorgestrel)
     Each dose: 20 yellow pills (total 0.75mg/dose)

     OR

     Plan B® (Levonorgestrel)
     Each dose: one pill (0.75mg/dose)

   - There is less nausea and vomiting with this method.
   - Follow-up is the same for the combination hormone method.

4. **Copper-T intrauterine device**
   - This method is not officially approved by the FDA for emergency contraception but has been well studied in clinical trials.
   - The method is highly effective (less than 1 % pregnancy rate).
   - The Copper-T will be effective if inserted within 5 days after exposure.
   - The contraindications, precautions, technique of insertion, complications and follow-up are the same as for an IUD used for routine contraception.
   - A special caution involves the insertion-related risk of pelvic inflammatory disease. Since the sexual assault victim is at greater risk for contracting a sexually transmitted disease from the assault, STD prophylaxis should be given one hour prior to insertion.
5. **Sample Discharge Instructions**

   Refer to **Appendix P** for Sample Discharge Instructions for Pregnancy and Sexually Transmitted Disease.

NORTH DAKOTA SEXUAL ASSAULT EVIDENCE COLLECTION PROTOCOL

OFFICE OF THE ATTORNEY GENERAL
WAYNE STENEHJEM

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Use of Colposcope/Medscope

Genital trauma is a good indication of recent forced sexual contact. To obtain photographic evidence of injuries, the use of a colposcope is necessary. Recent research indicates that injury to the posterior forichette, the point of greatest stress in forced penetration, is characterized by an acute mounting injury. This injury is indicative of sexual assault. Other trauma sites may include labia minora, hymen, or fossa naviularis.

The colposcope can have video or camera equipment easily attached and these test results can be used as forensic documentation. The non-invasive nature of this procedure makes it valuable for use with all victims, especially children and the elderly.

Pregnancy Concerns and Sexually Transmitted Infections

A major fear for sexual assault victims is becoming pregnant. The attending medical personnel should discuss this with the victim and explain her options for pregnancy prevention. Most medical treatment facilities offer pregnancy prevention or the "morning-after" pill. This is for women who are at risk to becoming pregnant within the first 72 hours after the assault and who have had a negative pregnancy test. This option should be offered to the victim along with information regarding the risk of pregnancy and effectiveness and side effects of treatment.

During the medical examination, attending medical personnel should be mindful of the possibility that the sexual assault may lead the victim to contract an STI.

Most clinicians recommend prophylactic treatment of STI's rather than performing cultures for the following reasons: performing cultures at the initial exam has not proven helpful to the prosecution of the perpetrator; positive cultures at the initial exam have been used against the victim in court to indicate sexual promiscuity; STI cultures are expensive and time consuming; and victims often do not return for follow-up testing and treatment.

Court-ordered Testing for Sexually Transmitted Infections

A court may order testing of any defendant charged with a sex offense (and any juvenile offender who is alleged to have committed certain crimes) to determine whether the defendant or alleged juvenile offender has any sexually transmitted disease. See Appendix I.

The court may order this testing only if the court receives a petition from the victim or from the prosecuting attorney with a written request from the victim. The suggested petition for use in North Dakota is attached as Appendix H.

THE SEXUAL ASSAULT EVIDENCE COLLECTION KIT

The following sections of the Protocol detail the evidence collection steps as each is set out in the Kit instruction sheet.

See Appendix A.

Forensic Evidence Collection and Care of the Sexual Assault Survivor: The SANE-SART Response

http://www.vaw.umn.edu/FinalDocuments/Commissioned_Docs/ForensicEvidence.pdf

By Linda E. Ledray, RN, Ph.D., LP, FAAN

Violence has a significant impact on the physical and psychosocial health of millions of Americans every year. It is essential that victims who present to emergency departments (ED) for even minor trauma be thoroughly evaluated. ED staff must be aware of the types of injuries most likely resulting from violence, and the victim must be asked about the cause of the trauma to determine if it is the result of violence and further evaluation is required (Sheridan: 1993). When violence, such as rape, is identified, further evaluation is usually necessary, including proper evidence collection maintaining chain-of-custody, crisis intervention, pregnancy and sexually transmitted infection (STI) risk evaluation, and preventive care.

It has been only in recent years that our health care facilities have begun to recognize their responsibility to have trained staff available to provide this specialized service for victims of sexual assault. Treating injuries alone is not sufficient. In 2000, Coney Island Hospital was fined $46,000 by state regulators after a rape victim came to the medical facility and a sexual assault evidentiary examination was not accurately performed. She was made to wait three hours before being examined and then potentially significant evidence, including her underwear and vaginal swabs, was lost. The Department of Health investigation also found that the hospital did not provide her with medication to prevent pregnancy and they failed to provide complete care. The authorities believed that had correct evidence collection and chain-of-custody (the signature record of everyone who had possession of then evidence) occurred, the evidence may have been useful to secure a conviction against the serial sex offender charged with her rape. As a result New York passed the Sexual Assault Reform Act requiring New York State medical facilities to develop specialized sexual assault examiner evidence collection programs in 2001 (Chivers: 2000).

It was as recently as 1992 that the guidelines of the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) first required emergency and ambulatory care facilities to have protocols on rape, sexual molestation and domestic abuse (Bobak: 1992). By 1997 they also required health care facilities to develop and train their staff to use criteria to identify possible victims of physical assault, rape or other sexual molestation, domestic abuse, and abuse or neglect of older adults and children (JCAHO: 1997). While JCAHO certainly does not require that specially trained forensic examiners (FE) or Sexual Assault Nurse Examiners (SANEs) be available to do the evaluation, these requirements do mean all medical facilities must identify and provide appropriate and complete services to victims of rape and abuse. These requirements have effectively set the

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follow-up visit (Ledray: 1991). In another study, only 15% returned. They were able to contact 47% of those who had not returned for follow-up and they found an additional 11% of these went elsewhere for medical follow-up, however, only 14% told the physician they saw for follow-up about the rape (Tintinali, Hoelzer & Michigan: 1985). Most clinicians recommend prophylactic treatment for STIs. Except in child sexual abuse cases, cultures taken need not be handled as evidence, because they are not used in court (Blair & Warner: 1992).

Since the early 1980's HIV has been a concern for rape survivors even though the actual risk still appears to be low. The US Center for Disease Control and Prevention estimates that the risk is 1 in 500 nationally (CDC: 1999). In a study of 412 Midwest rape victims with vaginal or rectal penetration, tested for HIV in the ED, at three months post-rape, and again at six months post-rape, not one became positive for HIV. The study also found, however, that even if the survivor did not ask about HIV in the ED, within two weeks it was a concern of theirs or their sexual partner. While the researchers did not recommend routine HIV testing, based on the recommendations of the study population, they recommend that even if the survivor does not raise the issue of HIV or AIDS in the ED, the SANE or forensic examiner should, in a matter of fact manner, provide them with information about their risk, testing and safe sex options. This will allow them to make decisions based on facts, not fear (Ledray: 1993). How to best deal with the issue of HIV is complicated and controversial (Blair & Warner: 1992). Because the rates of infection vary from state to state, so does the actual risk of infection. As the antiviral agents that are used after possible exposure are toxic and have side effects that will likely make the victim very nauseated and these prophylactic agents are still of uncertain efficacy, it is not generally recommended (ACEP: 1999; Hampton: 1995).

Pregnancy. While the risk of pregnancy from a rape is the same as the risk of pregnancy from a one time sexual encounter, 2% to 4% (Yuzpe, Smith, Rademaker: 1982), pregnancy is a concern of most sexual assault victims and must be addressed at the time of the initial examination even if the treating medical personnel or the medical facility does not support termination of an existing pregnancy. The National Conference of Catholic Bishops has agreed that, "A female who has been raped should be able to defend herself against a potential conception from the sexual assault. If, after appropriate testing, there is no evidence that conception has occurred already, she may be treated with medication that would prevent ovulation, or fertilization."(p. 16, National Conference of Catholic Bishops). The importance of offering complete care to sexual assault victims, which includes care to prevent pregnancy when the victim wants this care, was further strengthened by the fine against the New York City hospital, which did not ensure that a victim received a full birth-control prescription to prevent pregnancy (Chivers, 2000).

Most programs offer pregnancy prevention care for the women at risk of becoming pregnant, if they are seen within 72 hours of the rape, and have a negative pregnancy test in the ED. Sometimes referred to as "the morning-after pill," oral contraceptives such as Ovral, or Lovral are used for emergency contraception (ACOG: 1996). The Yuzpe regimen using a combined oral contraceptive is currently the most common emergency contraceptive (Yuzpe Rademaker: 1982). This will reduce the risk of pregnancy by 60% to 90%.

However, more recently, clinicians have begun to use a newly available progestin only contraceptive, Levonorgestrel 0.75 mg. (Plan B). Plan B is slightly, but non-significantly, more effective in reducing the risk of pregnancy. When started within 72 hours of unprotected intercourse, 85% of pregnancies were prevented in one study, compared to 57% using the Yuzpe regimen (Task Force on Post Ovulatory Methods of Fertility Regulation: 1998). The effectiveness of both methods decreases as the time between the assault and the first dose increases. When given within the first 24 hours Plan B reduced

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the risk of pregnancy by 95%, but only by 61% when given between 48 and 72 hours after unprotected intercourse. The significant difference was in the only side effect, nausea and vomiting, which was significantly reduced with the use of Plan B to 23.1%, from 50% with the Yuzpe method (Task Force on Postovulatory methods of Fertility Regulation: 1998).

Crisis intervention and counseling. One of the basic components of the evidentiary exam is crisis intervention, mental health assessment and referral for follow-up counseling. While this will be the primary role of the rape crisis center advocate when one is present, the SANE or forensic examiner is also responsible to provide crisis intervention and ensure follow up counseling services are available (Speck & Aiken: 1995; Ledray, Faugno & Speck: 2001).

When domestic violence is suspected or substantial drug or alcohol abuse appears to be an issue, it is important to have a protocol in place for screening and/or referral. Many medical facilities have domestic violence victim advocates available who can be called to the hospital, similar to rape crisis center advocates. If available, these services should be utilized. It is also important to be aware of the availability of shelters for victims of domestic violence who may need a safe place to go after the evidentiary exam.

Continued fear and anxiety resulting from the rape can significantly affect the survivor's life, including her work, school and relationships with others, far into the future (Ledray: 1999). The psychological impact and treatment needs of the survivor have been addressed extensively in the psychological literature, review of which is beyond the bounds of this summary. Dr. Burgess summarized and labeled the psychological impact Rape Trauma Syndrome (Burgess & Holmstrom: 1974). Self-help books such as **Recovering From Rape** (Ledray: 1994), are available for the large majority of rape survivors who do not return for counseling.

Non-genital injuries. Physical injuries are probably the best proof of force and need to be photographed, described on drawings, and documented in writing on the exam report (Ledray: 1992). Photographs are not meant to take the place of good charting (Pasqualone: 1996). Specific consent to photograph is necessary, but may be included as a standard part of the exam consent. Two sets of pictures should always be taken. One set always remains with the chart. The second set should be given to the police with the other sexual assault evidence, and will usually be the pictures used in court. When pictures are taken, the first picture should always be of the survivor's face and others should follow in a systematic order, such as head to toe, or front to back. They should be taken first without a scale to show nothing is being hidden, then with a scale to document size. While a coin such as a quarter is sufficient, a gray photographic scale will also assist with color determination.

Each picture should include a label with the survivor's name and/or case number in the picture. On the back of every Polaroid the SANE should print the date, time, client number and/or name, and the examiner's name and title. It is recommended that photographic documentation of injuries be completed using a 35mm camera with a standard 50mm lens and 100-200 speed (ASA) color film. A disadvantage of 35mm pictures is that they must be sent out for developing and often are not available to the police when they investigate, or to the prosecutor deciding to charge the case. Polaroid pictures have the advantage of being available to the police during their initial investigation, but they have the disadvantage of poorer quality, especially for close ups. Polaroid film is also very expensive (Sheridan: 1993). Some experts recommend taking both Polaroid pictures (for use in the initial investigation and the charging decision making process) and 35mm pictures (that can be developed and used if the case goes to court) (Ledray: 1999).

While some examiners have been historically hesitant to take pictures of victims' breasts and genitals, improperly documented injuries with pictures may result in liability for failure to document (Pasqualone: 1996). The

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Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient

American College of Emergency Physicians®

Medical treatment

Consider offering the following interventions depending on the circumstances:

1. Antibiotic prophylaxis for sexually transmitted diseases (Modules–Sexually Transmitted Disease in Adult and Child Patients Who Have Been Sexually Assaulted/Abused; and Pediatric/Adolescent Patient).
2. Hepatitis B immunization is indicated if the patient has not been previously immunized (Modules–Sexually Transmitted Disease in Adult and Child Patients Who Have Been Sexually Assaulted/Abused; and Pediatric/Adolescent Patient).
3. HIV prophylaxis based on risk assessment of exposure (Module–Human Immunodeficiency Virus)
4. Pregnancy prevention (Module–Emergency Pregnancy Prophylaxis).

Coordination of Care

1. The patient should be given referrals to local resources for follow-up counseling and advocate services (Module–State Sexual Assault Coalitions).
2. The patient should be referred for follow-up examinations in 2 weeks, 3 months, and 6 months for evaluation of pregnancy and sexually transmitted diseases (Module–Sexually Transmitted Disease in Adult and Child Patients Who Have Been Sexually Assaulted/Abused).
3. Provide written documentation to the patient of tests performed, treatment received, follow-up appointments, community resources, and what to expect in terms of test results and the legal process.

Minimum Core Content

At a minimum, health care professionals practicing in the area of sexual assault should receive instruction on the following topics, especially as they relate to specific local, legal, clinical, and follow-up issues:

- Multidisciplinary Team Concept

- Dynamics of Sexual Assault
  - Myths and realities
  - Rape Trauma Syndrome, Post-traumatic Stress Disorder (PTSD)

- Sexual Assault Forensic Examination
  - Communication skills
  - History
  - Physical assessment
  - Detailed genital examination
  - Physical evidence collection
  - Forensic photography
  - Documentation

- Criminal Justice System

Source: Curriculum excerpts based on the "Sexual Assault Nurse Examiner Education Guidelines" of the International Association of Forensic Nurses. (Complete curriculum outline on adult and children available from the IAFN on request.)

- Anatomy and physiology as it relates to sexual assault/abuse
  1. Normal male and female genital structures, from birth to reproductive age to the aged adult
  2. Effect of hormones on the genital structures
  3. Effects of the human sexual response cycle on the body
  4. Anatomic sequelae of nonconsenting sexual acts plus associated physical trauma
  5. Medical conditions, anomalies, or pathology that may influence the physical examination

- Psychological aspects of sexual assault

- Medicolegal forensic examination
  1. Patient assessment/patient history
  2. Evidence collection: physical examination/enhanced visualization/evidence collection kits/preservation of evidence

- The role of the forensic examiner in the criminal justice system

- Medical management of sexually transmitted diseases, HIV, and pregnancy

- Referral services available for the victim

Source: Curriculum based on the "Sexual Assault Nurse Examiner Development and Operations Guide" of the US Department of Justice, Office on Womens Health (Module–SANE Development & Operation Guide).

Emergency Pregnancy Prophylaxis

The following are tables to aid in prescribing prophylaxis medications. Specific information about this practice may be found within the patient "Informed Consent[1] Form" on the next page. The clinician should ensure they are familiar with this form and the relative contraindications for the various types of pregnancy prevention. Some clinicians have found it helpful to provide the patient with an antiemetic before giving oral pregnancy prevention medications. The second table provides potential options for this practice. **This information is for information only and should not serve as the sole source for prescribing information or clinical decision making.**

Table 1

Brand	Pills per Dose[2]	Ethinyl Estradiol per Dose (μg)	Levonorgestrel per Dose (mg)
Preven Kit[3]	2 blue pills	100	0.50
Ovral	2 white pills	100	0.50
Alesse	5 pink pills	100	0.50
Nordette	4 light-orange pills	120	0.60
Levlen	4 light-orange pills	120	0.60
Lo/Ovral	4 white pills	120	0.60
Triphasil	4 yellow pills	120	0.50
Tri-Levlen	4 yellow pills	120	0.50
Ovrette	20 yellow pills	0	0.75

Table 2

Medication[4]	Dose[5]	Repeat Dosing if Required
Metoclopramide	10 mg	6 h
Meclizine	25 to 50 mg	24 h
Diphenhydramine	25 to 50 mg	4 to 6 h
Trimethobenzamide	200-mg suppository	6 to 8 h
Promethazine	25-mg suppository	8 to 12 h
Dramamine	25 to 50 mg	6 to 8 h

[1] If using an "off-label" drug, informed consent may be protective in cases where rare but possible side effects occur such as bleeding, pulmonary embolism, or continued pregnancy despite "prophylaxis." Informed consent ensures proper patient education has occurred and ensures that her values and ethics are taken into account in what may be a very emotionally charged decision. An informed decision is always better than a misinformed one.

[2] First dose should be given within 72 hours of alleged event. Second dose should be taken 12 hours after the first dose. If an antiemetic is being used, it should be given 1 hour before the oral emergency pregnancy prevention tablets.

[3] Although commonly used "off-label," none of the above, with the exception of Preven, are FDA approved for postcoital pregnancy prophylaxis.

[4] Other medications may be equally effective.

[5] Dose may need to be altered based on patient age, weight, or concurrent medications.

Source: Adapted from Trussell J, Koenig J, Ellertson C, et al: Preventing unintended pregnancy: The cost-effectiveness of three methods of emergency contraception. *Am J Public Health* 1997;87(6):932-937.

Name _____ Age _____
Address _____
Medical Record # _____ Telephone # _____

This form is being given to you to provide information on postcoital pregnancy prevention. Your signature below indicates your understanding of the material contained in this form, that you have received a copy of this form, and that you have had the opportunity to discuss the issues contained within this form with the clinician. After reading through this information and discussing it with the clinician, it is recommended that you take some time to consider your options. Should you decide to use the postsexual intercourse pregnancy prevention pills or an IUD, you should contact your primary care physician, your gynecologist, or Planned Parenthood at once. Should you be unable to do so or if you need further referral, it can be obtained free of charge 24 hours per day via the emergency contraception hotline at *1-888-NOT-2LATE*.

Instructions to Patient:

Please initial if you understand and agree with the statement. DO NOT SIGN the form until the clinician is with you and can witness your signature.

Informed Consent

____ I understand that ECPs (emergency contraceptive pills) contain a combination of hormones that act to prevent pregnancy, as defined by the American College of Obstetricians and Gynecologists. These pills are to be taken after unprotected vaginal sex (sex without birth control). They are to be used as an emergency treatment only and not as a routine method of contraception.

____ I understand that ECPs may or may not actually prevent conception, the combining of egg with sperm.

____ I understand that Pennsylvania law states that life begins at conception.

____ I understand that the American College of Obstetricians and Gynecologists defines pregnancy as beginning after the implantation of the human embryo into the tissue of the uterus. This definition is controversial as many believe life begins at conception, the combining of the egg with the sperm (see above).

____ I understand that ECPs may work by preventing or delaying the release of an egg from the ovary, preventing the combining of the egg and sperm, or causing changes in the lining of the uterus or womb that prevent the implantation of a human embryo. I understand that if the zygote is already implanted into the uterus, these medications will not stop the pregnancy.

____ I understand that ECPs are regular birth control pills taken differently.

____ I understand that the US Food and Drug Administration has recently approved birth control pills for this use and has stated that they are safe and relatively effective for emergency contraception.

____ I understand that the medication should be started as soon as convenient after unprotected sex and should be started within 3 days (72 hours) of that sex. Should the 72-hour window not be met, an IUD may be placed with similar results up to 5 days (120 hours) after sex. Neither of these options should be chosen without informed consent and serious consideration of how the individual's belief system fits with the proposed mechanism with which these medications work.

____ I understand that ECPs are effective if used within 72 hours in about 75% of the cases. Effectively, this lowers the risk of pregnancy from about 8 per 100 to about 2 per 100.

____ I understand that should the pregnancy continue despite the use of these medications, there is no data to suggest they could have any adverse effects on the unborn child.

____ I understand that some reactions to the medication may include:

- Nausea and vomiting
- Fatigue
- Dizziness
- Breast tenderness
- Early or late menstrual period

____ I understand that I should see my primary care physician or do a home pregnancy test if my period has not started within 3 weeks after taking the medications.

____ I understand that emergency contraceptive pills may not prevent an ectopic pregnancy in the tubes or abdomen, a potentially serious condition. Therefore, should I develop abdominal pain in the first few months after taking the medication, I should see my primary care physician immediately.

____ I understand that I should use condoms, spermicides, and/or a diaphragm or continue taking certain birth control pills to prevent pregnancy if I have sex before my next period. After that, I can use any regular method of contraception.

____ I understand that if I see a physician for any reason before I get my period, I should tell him or her that I have taken ECPs.

____ I understand that ECPs will not protect me from or treat sexually transmitted diseases and that I should see a physician for diagnosis and treatment if I am concerned about this.

____ I understand that a clinician is available to answer any questions I may have.

____ No guarantee or assurance has been made to me as to the results that may be obtained if I use ECPs. I have given a complete and accurate history to those taking care of me.

____ I will follow the guidelines set forth above.

____ I understand that I assume all risk and responsibility for pregnancy should it occur.

_____ _____

SIGNATURE OF PATIENT *Date*

I witnessed the fact that the patient received the above-mentioned information and said she read and understood the same.

_____ _____

SIGNATURE OF WITNESS *Date*

_____ _____

SIGNATURE OF PHYSICIAN/NURSE PRACTITIONER *Date*

Source: **Adapted from Planned Parenthood of Western Washington. Morning After Treatment Consent form, June 1996.**