

ZIMBABWE NATIONAL GUIDELINES ON THE CLINICAL CARE AND MANAGEMENT OF SURVIVORS OF

SEXUAL VIOLENCE: MEDICAL EXAMINATION CONSENT FORM FOR CHILDREN AND OTHER

VULNERABLE SURVIVORS

To be completed by the Healthcare Professional (HCP)

Consent must be gained from parent(s) or other(s) with responsibility for the child and from the child where appropriate. On occasions, consent may be gained by a court order.

I give permission for:

- | | | |
|--|------------|-----------|
| • Medical examination to be done and recorded in writing | Yes | No |
| • Collection of specimens for forensic tests | Yes | No |
| • Collection of samples for medical tests | Yes | No |
| • Photo-documentation of examination | Yes | No |

Photo-documentation of the examination may be used to support clinical evidence of injury and may need to be shared with another healthcare professional involved in any court proceedings, or may be used for diagnosis and for teaching and training other healthcare professionals.

I give permission for photo-documentation to be used:

- | | | |
|---|------------|-----------|
| • To support clinical evidence in court proceedings | Yes | No |
| • For teaching/training purposes | Yes | No |

I have been advised that I may strike out any of the above before I sign. It is routine practice to share information with other agencies and possibly law enforcement agencies as part of child protection and safeguarding procedures. It is routine that the medical records including pictures are peer reviewed by other healthcare professionals as part of quality assurance.

I give consent for the uses of anonymised data from the medical examination to be used for audit, research and clinical governance.

I understand that the information recorded during this examination is for the purposes of providing evidence and may be required by the court.

I understand that a referral to Social Welfare Services will be made. Referral to other healthcare/support services may be made.

Clients Consent

Signed (client):	Date:
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Parent/Carer/Professional with parental responsibility (if under 18 years of age, or other vulnerability factors)

Signed (Appropriate Adult)	Date:
Name	Relationship:

Interpreter Required

No Yes (interpreter please sign below)

Name:	Specify language:
Signed (Interpreter):	Date:

HCP's Declaration that the nature of the examination has been explained

Healthcare Professional's Name	Signature	Date
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