

**FORENSIC MEDICAL REPORT: ACUTE (<72 HOURS)
CHILD/ADOLESCENT SEXUAL ABUSE EXAMINATION**

**STATE OF CALIFORNIA
GOVERNOR'S OFFICE of EMERGENCY SERVICES**

OES 930

Confidential Document

Patient Identification

A. GENERAL INFORMATION (print or type) Name of Medical Facility:

1. Name of patient		Patient ID number					
2. Address		City	County	State	Telephone		
3. Age	DOB	Gender M F	Ethnicity	Date/time of arrival		Date/time of discharge	
4. Name of : <input type="checkbox"/> Mother <input type="checkbox"/> Stepmother <input type="checkbox"/> Guardian		Address	City	County	State	Telephone W: H:	
5. Name of : <input type="checkbox"/> Father <input type="checkbox"/> Stepfather <input type="checkbox"/> Guardian		Address	City	County	State	Telephone W: H:	
6. Name(s) of Siblings		Gender M F	Age	DOB	Name(s) of Siblings		Gender M F
		M F					M F
		M F					M F

B. REPORTING AND AUTHORIZATION Jurisdiction (city county other):

1. Telephone report made to		Name	Agency	ID number	Telephone
Law Enforcement <input type="checkbox"/>		_____			
and/or		_____			
Child Protective Services <input type="checkbox"/>		_____			
2. Responding Personnel (to medical facility)		Name	Agency	ID number	Telephone
Law Enforcement <input type="checkbox"/>		_____			
and/or		_____			
Child Protective Services <input type="checkbox"/>		_____			
3. Assigned Investigator (if known)		Name	Agency	ID number	Telephone
Law Enforcement <input type="checkbox"/>		_____			
and/or		_____			
Child Protective Services <input type="checkbox"/>		_____			

4. Authorization for evidential exam requested by law enforcement or child protective services agency

I request a forensic medical examination for suspected sexual abuse at public expense.

Telephone Authorization Agency: Authorizing party: ID number: Date/time:	<input type="checkbox"/> Law enforcement officer ID number <input type="checkbox"/> Child Protective Services
Telephone Date Time Case number	_____ _____ _____ _____

C. CONSENT FOR EXAMINATION BY PATIENT/PARENT/GUARDIAN Note: Parental consent is not required for a suspected child sexual abuse examination if the child is in protective custody. Family Code Section 6927 permits minors (12 to 17 years of age) to consent to medical examination, treatment, and evidence collection for sexual assault without parental consent. See instructions regarding parental notification requirements for minors.

- I hereby consent to a forensic medical examination for evidence of sexual abuse. I understand that collection of evidence may include photographing injuries and that these photographs may include the anal-genital area (private parts). I further understand that medical providers are required to notify child protective authorities of known or suspected child abuse; and, if child abuse is found or suspected, this form and any evidence obtained will be released to a child protective agency.
- I have been informed that victims of crime are eligible to submit crime victim compensation claims to the State Victims of Crime (VOC) Restitution Fund for out-of-pocket medical expenses, psychological counseling, loss of wages, and job retraining/rehabilitation.
- I understand that data without patient identity may be collected from this report for health and forensic purposes and provided to health authorities and other qualified persons with a valid educational or scientific interest for demographic and/or epidemiological studies.

Signature _____ Patient Parent Guardian

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D. PATIENT HISTORY		
1. Record time or time frame of the incident(s)	Date(s)	Time or time frame
<input type="checkbox"/> Less than 72 hours		
<input type="checkbox"/> Multiple incidents over time		
2. Pertinent physical surroundings of abuse/assault:		

3. Record patient's name for:	4. Alleged perpetrator(s) name(s)	Age	Gender	Ethnicity	Patient Identification	
					Relationship to Patient	Relationship to Patient
Female genitalia					Known	Unknown
Male genitalia	#1.		M F			
Breasts	#2.		M F			
Anus	#3.		M F			

E. ACTS DESCRIBED BY HISTORIAN						
Name of historian	Relationship to patient	History obtained by:			Telephone	Agency <input type="checkbox"/> Not applicable
	No Yes Attempted Unsure N/A	Describe pain and/or bleeding and additional pertinent history:				

Genital/vaginal contact/penetration by:						
Penis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Finger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Object (Describe)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Associated pain?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Associated bleeding?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Anal contact/penetration by:						
Penis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Finger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Object (Describe)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Associated pain?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Associated bleeding?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Oral copulation of genitals:						
Of patient by assailant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Of assailant by patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Oral copulation of anus:						
Of patient by assailant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Of assailant by patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anal/genital fondling:						
Of patient by assailant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Of assailant by patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Non-genital act(s)?	<input type="checkbox"/>	<input type="checkbox"/>				
If yes: <input type="checkbox"/> Fondling <input type="checkbox"/> Licking <input type="checkbox"/> Kissing <input type="checkbox"/> Suction Injury <input type="checkbox"/> Biting						
Other acts? (Describe)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Did ejaculation occur?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
If yes, note location(s):						
<input type="checkbox"/> Mouth <input type="checkbox"/> Vagina <input type="checkbox"/> Body surface <input type="checkbox"/> On bedding						
<input type="checkbox"/> Anus/Rectum <input type="checkbox"/> On clothing <input type="checkbox"/> Other						
Contraceptive or lubricant products? <input type="checkbox"/> No <input type="checkbox"/> Yes						
If yes, note type/brand: <input type="checkbox"/> Foam <input type="checkbox"/> Jelly <input type="checkbox"/> Lubricant <input type="checkbox"/> Condom						
Were force or threats used? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Force <input type="checkbox"/> Threats						
Were weapons used? <input type="checkbox"/> No <input type="checkbox"/> Yes						
If yes, describe: _____						
Were pictures/videotapes taken <input type="checkbox"/> or shown <input type="checkbox"/> ? <input type="checkbox"/> No <input type="checkbox"/> Yes						
If yes, note type(s): <input type="checkbox"/> Pictures <input type="checkbox"/> Videotapes						
Were drugs <input type="checkbox"/> or alcohol <input type="checkbox"/> used? <input type="checkbox"/> No <input type="checkbox"/> Yes*						
Loss of memory? <input type="checkbox"/> No <input type="checkbox"/> Yes*						
Lapse of consciousness? <input type="checkbox"/> No <input type="checkbox"/> Yes*						
Vomited after act(s)? <input type="checkbox"/> No <input type="checkbox"/> Yes						
Behavioral changes in patient? <input type="checkbox"/> No <input type="checkbox"/> Yes						

*Collection of toxicology samples is recommended according to local policy.

F. ACTS DESCRIBED BY PATIENT

1. Acts disclosed by patient to: Law Enforcement Officer

- Medical Examiner Multi-disciplinary Interview Team
 Social Worker Other:

	No	Yes	Attempted	Unsure	N/A
Genital/vaginal contact/penetration by:					
Penis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Finger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Object (Describe below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Associated pain?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Associated bleeding?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Anal contact/penetration by:					
Penis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Finger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Object (Describe below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Associated pain?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Associated bleeding?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Oral copulation of genitals:					
Of patient by assailant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Of assailant by patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oral copulation of anus:					
Of patient by assailant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Of assailant by patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anal/genital fondling:					
Of patient by assailant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Of assailant by patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Non-genital act(s)? <input type="checkbox"/>					
If yes: <input type="checkbox"/> Fondling <input type="checkbox"/> Licking <input type="checkbox"/> Kissing <input type="checkbox"/> Suction injury <input type="checkbox"/> Biting					
Other acts? (Describe below) <input type="checkbox"/>					
Did ejaculation occur? <input type="checkbox"/>					
If yes, note location(s):					
<input type="checkbox"/> Mouth <input type="checkbox"/> Vagina <input type="checkbox"/> Body surface <input type="checkbox"/> On bedding					
<input type="checkbox"/> Anus/Rectum <input type="checkbox"/> On clothing <input type="checkbox"/> Other					
Contraceptive or lubricant products? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>					
If yes, note type/brand: <input type="checkbox"/> Foam <input type="checkbox"/> Jelly <input type="checkbox"/> Lubricant <input type="checkbox"/> Condom					
Were force or threats used? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Force <input type="checkbox"/> Threats <input type="checkbox"/>					
Were weapons used? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>					
If yes, describe: _____					
Were pictures/videotapes taken <input type="checkbox"/> or shown <input type="checkbox"/> ? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>					
If yes, note type(s): <input type="checkbox"/> Pictures <input type="checkbox"/> Videotapes					
Were drugs <input type="checkbox"/> or alcohol <input type="checkbox"/> used? <input type="checkbox"/> No <input type="checkbox"/> Yes* <input type="checkbox"/>					
Loss of memory? <input type="checkbox"/> No <input type="checkbox"/> Yes* <input type="checkbox"/>					
Lapse of consciousness? <input type="checkbox"/> No <input type="checkbox"/> Yes* <input type="checkbox"/>					
Vomited after act(s)? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>					
Behavioral changes? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>					

*Collection of toxicology samples is recommended according to local policy.

2. Describe pain and/or bleeding (using patient's exact words) and additional pertinent history from above.

Patient Identification

G. MEDICAL HISTORY (to be completed by medical personnel)

1. Name of person providing history	Relationship to patient				
2. Any recent (60 days) anal-genital injuries, surgeries, diagnostic procedures, or medical treatment that may affect the interpretation of physical findings?	No	Yes			
	<input type="checkbox"/>	<input type="checkbox"/>			
3. Any other pertinent medical conditions that may affect the interpretation of physical findings?	<input type="checkbox"/>	<input type="checkbox"/>			
4. Any pre-existing physical injuries?	<input type="checkbox"/>	<input type="checkbox"/>			
5. Any previous history of physical abuse and/or neglect?	<input type="checkbox"/>	<input type="checkbox"/>			
6. Any previous history of sexual abuse?	<input type="checkbox"/>	<input type="checkbox"/>			
7. Other intercourse? (For adolescents only)	<input type="checkbox"/>	<input type="checkbox"/>			
If yes,					
anal (within past 5 days)?	When _____	<input type="checkbox"/>	<input type="checkbox"/>		
vaginal (within past 5 days)?	When _____	<input type="checkbox"/>	<input type="checkbox"/>		
oral (within past 24 hours)?	When _____	<input type="checkbox"/>	<input type="checkbox"/>		
If yes, did ejaculation occur? <input type="checkbox"/>					
If yes, where? _____					
If yes, was a condom used? <input type="checkbox"/>					
8. Menstrual periods? If yes, age of menarche: _____	<input type="checkbox"/>	<input type="checkbox"/>			
Last menstrual period: _____					
9. Other symptoms disclosed	by patient:		by historian:		
	No	Yes	No	Yes	Unk
Abdominal/pelvic pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain on urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genital discomfort or pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genital itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genital discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genital bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rectal discomfort or pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rectal itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, describe onset, duration, and intensity:					

10. Post-assault hygiene activity	by patient:		by historian:		
	No	Yes	No	Yes	Unk
<input type="checkbox"/> Not applicable if over 72 hours					
Urinated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Defecated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genital or body wipes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, describe: _____					
Douched	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, with what? _____					
Removed/inserted <input type="checkbox"/> tampon <input type="checkbox"/> diaphragm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oral gargle/rinse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bath/shower/wash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brushed teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ate or drank	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Changed clothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, describe:					

H. GENERAL PHYSICAL EXAMINATION

Record all findings using diagrams, legend, and a consecutive numbering system.

1. BP	Pulse	Resp	Temp	Height	Weight	2. Date/time examination		
						Started	Completed	
3. Female Tanner Stage – Breast				1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
4. Describe general physical appearance.								
5. Describe general demeanor and relevant statements made during exam.								
6. Describe condition of clothing upon arrival.								
7. Collect outer and underclothing if indicated. <input type="checkbox"/> Not indicated						Patient Identification		
8. Conduct a physical examination. <input type="checkbox"/> Findings <input type="checkbox"/> No Findings General exam within normal limits: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, describe:								
9. Collect dried and moist secretions, stains, and foreign materials from the body. Scan the entire body with a Wood's Lamp. <input type="checkbox"/> Findings <input type="checkbox"/> No Findings								
10. Collect fingernail scrapings or cuttings according to local policy.								

Diagram A

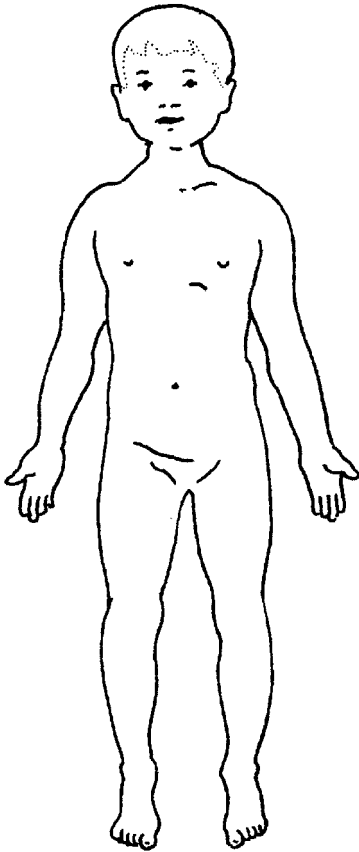
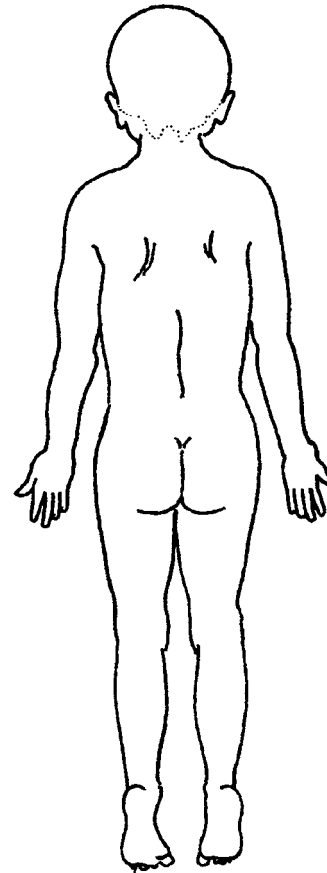


Diagram B



LEGEND: Types of Findings

AB Abrasion	CS Control Swab	DS Dry Secretion	HC Hymenal Cleft	OI Other Injury (describe)	PE Petechiae	SW Swelling
AHT Absent Hymenal Tissue	CV Congenital Variation	EC Ecchymosis (bruise)	IN Induration	OSC Other Skin Condition	PGW Possible Genital Wart	TB Toluidine Blue⊕
AL Anal Laxity	DE Debris	ER Erythema (redness)	IW Incised Wound	OT Other	PS Potential Saliva	TE Tenderness
BI Bite	DF Deformity	FB Foreign Body	LA Laceration	PW Perianal Wart	SH Submucosal Hemorrhage	V/S Vegetation/Soil
BU Burn	DI Discharge	F/H Fiber/Hair	MS Moist Secretion	OF Other Foreign Materials (describe)	SHX Sample Per History	VL Vesicular Lesion
		GT Granulation Tissue			SI Suction Injury	WL Wood's Lamp⊕

Locator #	Type	Description	Locator #	Type	Description

RECORD ALL CLOTHING AND SPECIMENS COLLECTED ON PAGE 8

I. HEAD, NECK, AND ORAL EXAMINATION

Record all findings using diagrams, legend, and a consecutive numbering system.

1. Examine the face, head, hair, scalp, and neck for injury and foreign materials.
 Findings No Findings
2. Exam method:
 Direct visualization Colposcope Other magnification
3. Collect dried and moist secretions, stains, and foreign materials from the face, head, hair, scalp, and neck.
 Findings No Findings
4. Examine the oral cavity for injury and foreign materials. Collect foreign materials.
 Findings No Findings
5. Collect 2 swabs from the oral cavity up to 12 hours post assault and prepare one dry mount slide from one of the swabs.
6. Collect head hair reference samples according to local policy.

Patient Identification

Diagram C

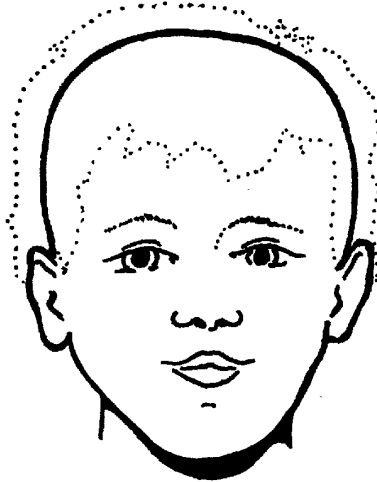


Diagram D

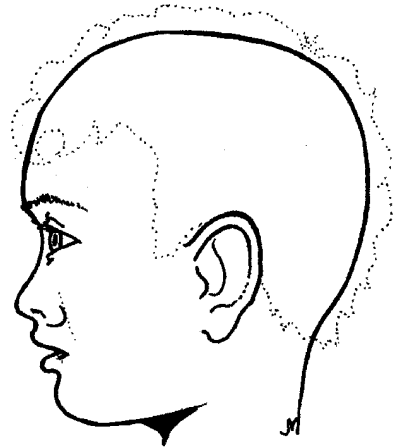


Diagram E

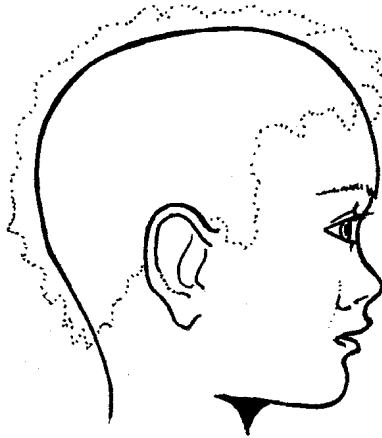
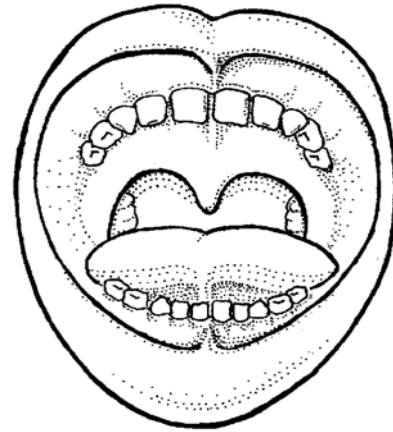


Diagram F



LEGEND: Types of Findings

AB Abrasion	CS Control Swab	DS Dry Secretion	HC Hymenal Cleft	OI Other Injury (describe)	PE Petechiae	SW Swelling
AHT Absent Hymenal Tissue	CV Congenital Variation	EC Ecchymosis (bruise)	IN Induration	OSC Other Skin Condition	PGW Possible Genital Wart	TB Toluidine Blue⊕
AL Anal Laxity	DE Debris	ER Erythema (redness)	IW Incised Wound	OT Other	PS Potential Saliva	TE Tenderness
BI Bite	DF Deformity	FB Foreign Body	LA Laceration	PW Perianal Wart	SH Submucosal Hemorrhage	V/S Vegetation/Soil
BU Burn	DI Discharge	F/H Fiber/Hair	MS Moist Secretion	OF Other Foreign Materials (describe)	SHX Sample Per History	VL Vesicular Lesion
		GT Granulation Tissue			SI Suction Injury	WL Wood's Lamp⊕

Locator #	Type	Description	Locator #	Type	Description

RECORD ALL SPECIMENS COLLECTED ON PAGE 8

J. GENITAL EXAMINATION - FEMALES

Record all findings using diagrams, legend, and a consecutive numbering system.

- Examine the inner thighs, external genitalia, and perineal area.
- Exam method: Direct visualization Colposcope Other magnification
 Exam positions/methods: Separation Traction Knee Chest
 Supine
 Prone
 Saline/Water Moistened swab Toluidine Blue Dye
 Catheter Other:

- Genital Tanner Stage 1 2 3 4 5
- Examine the genital structures. Check the ABN box(es) if there are abuse/assault related findings and describe.

WNL ABN Describe:

Inner thighs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Inguinal adenopathy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Labia majora	<input type="checkbox"/>	<input type="checkbox"/>	_____
Labia minora	<input type="checkbox"/>	<input type="checkbox"/>	_____
Clitoral hood	<input type="checkbox"/>	<input type="checkbox"/>	_____
Perineum	<input type="checkbox"/>	<input type="checkbox"/>	_____
Periurethral tissue/urethral meatus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Perihymenal tissue (vestibule)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hymen <input type="checkbox"/> Supine <input type="checkbox"/> Prone	<input type="checkbox"/>	<input type="checkbox"/>	_____
Record morphology:			
<input type="checkbox"/> Annular			_____
<input type="checkbox"/> Crescentic			_____
<input type="checkbox"/> Imperforate			_____
<input type="checkbox"/> Septate			_____
Fossa navicularis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Posterior fourchette	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vagina (pubertal adolescents)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cervix (pubertal adolescents)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Discharge <input type="checkbox"/> No <input type="checkbox"/> Yes			
If yes, describe: _____			

- No Findings
- Collect dried and moist secretions, stains, and foreign materials. Scan the area with a Wood's Lamp. Findings No Findings
 - Collect swabs and prepare slides.
 - Prepubertal female
 - Collect at least 2 vulvar and 2 vestibular swabs.
 - Pubertal female
 - Collect 4 swabs from the vaginal pool.
 - Prepare one wet mount and one dry mount slide.
 - Collect 2 cervical swabs (if over 48 hours post assault).
 - Collect pubic hair combing or brushing. Not applicable
 - Collect pubic hair reference samples according to local policy. Not applicable

LEGEND: Types of Findings

AB Abrasion	DF Deformity	LA Laceration	SH Submucosal Hemorrhage
AHT Absent Hymenal Tissue	DI Discharge	MS Moist Secretion	SHX Sample Per History
AL Anal Laxity	DS Dry Secretion	OF Other Foreign Materials (describe)	SI Suction Injury
BI Bite	ER Erythema (redness)	OI Other Injury (describe)	SW Swelling
BU Burn	FB Foreign Body	OSC Other Skin Condition	TB Toluidine Blue ⁺
CS Control Swab	F/H Fiber/hair	OT Other	TE Tenderness
CV Congenital Variation	GT Granulation Tissue	PW Perianal Wart	V/S Vegetation/Soil
DE Debris	HC Hymenal Cleft	PE Petechiae	VL Vesicular Lesion
	IN Induration	PGW Possible Genital Wart	WL Wood's Lamp ⁺
	IW Incised Wound	PS Potential Saliva	

Locator #	Type	Description

Patient Identification

Diagram the position that best illustrates your findings.

Diagram G Genitalia - Supine

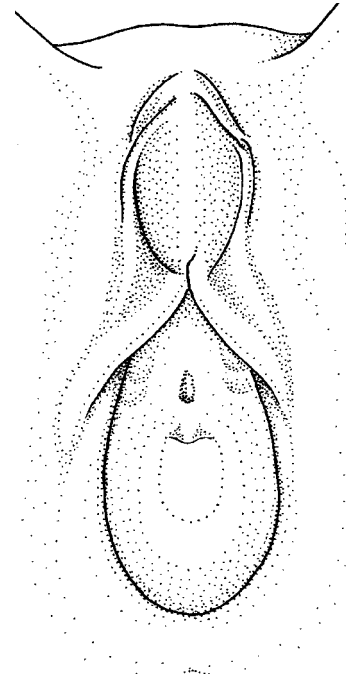
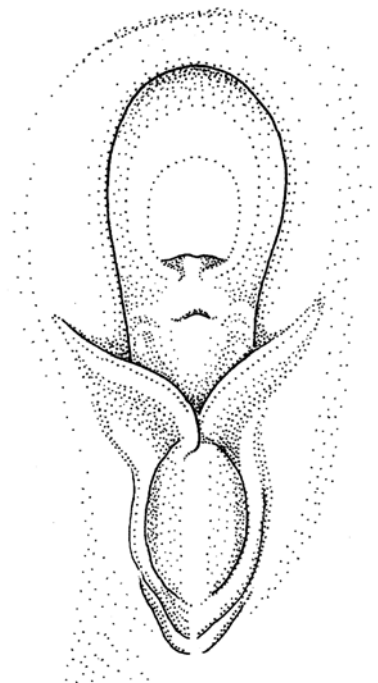


Diagram H Genitalia - Knee-Chest



RECORD ALL SPECIMENS COLLECTED ON PAGE 8

K. GENITAL EXAMINATION – MALES

Record all findings using diagrams, legend, and a consecutive numbering system.

- Examine the inner thighs, external genitalia, and perineal area.
- Exam method: Direct visualization Colposcope Other magnification
Exam positions/methods:
 Supine Prone Moistened swab
 Toluidine Blue Dye Other: _____
- Genital Tanner Stage 1 2 3 4 5
- Circumcised: No Yes
- Check the ABN box(es) if there are abuse/assault related findings and describe.

	WNL	ABN	Describe:
Inner thighs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Inguinal adenopathy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Perineum	<input type="checkbox"/>	<input type="checkbox"/>	_____
Foreskin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glans Penis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Penile shaft	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urethral meatus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Scrotum	<input type="checkbox"/>	<input type="checkbox"/>	_____
Testes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Discharge <input type="checkbox"/> No <input type="checkbox"/> Yes			If yes, describe: _____
No Findings <input type="checkbox"/>			
- Collect dried and moist secretions, stains, and foreign materials. Scan the area with a Wood's Lamp. Findings No Findings
- Collect pubic hair combing or brushing. Not applicable
- Collect pubic hair reference samples according to local policy. Not applicable
- Collect 2 penile swabs, if indicated by assault history. Not applicable
- Collect 2 scrotal swabs, if indicated by assault history. Not applicable

L. FEMALE/MALE ANAL AND RECTAL EXAMINATION

- Examine the buttocks, perianal skin, and anal folds for injury, foreign materials, and other findings.
- Record exam positions, methods, observations:

	Observation	Observation with traction
Supine	<input type="checkbox"/>	<input type="checkbox"/>
Supine knee chest	<input type="checkbox"/>	<input type="checkbox"/>
Prone knee chest	<input type="checkbox"/>	<input type="checkbox"/>
Lateral recumbent	<input type="checkbox"/>	<input type="checkbox"/>

 Exam methods: Moistened swab Toluidine blue dye Anoscopy Other: _____
- Check the ABN box(es) if there are abuse/assault related findings and describe any abnormal or unusual findings.

<input type="checkbox"/> No Findings	WNL	ABN	Describe:
Buttocks	<input type="checkbox"/>	<input type="checkbox"/>	_____
Perianal skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anal verge/folds/rugae	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rectum	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anal dilation <input type="checkbox"/> No <input type="checkbox"/> Yes			If yes: <input type="checkbox"/> Immediate <input type="checkbox"/> Delayed
Stool present in rectal ampulla <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined			
- Collect dried and moist secretions, stains, and foreign materials. Findings No Findings
- Collect 2 anal and/or rectal swabs and prepare one dry mount slide.
- Rectal bleeding: No Yes If yes, describe: _____

LEGEND: Types of Findings

AB Abrasion	DF Deformity	LA Laceration	SH Submucosal Hemorrhage
AHT Absent Hymenal Tissue	DI Discharge	MS Moist Secretion	SHX Sample Per History
AL Anal Laxity	DS Dry Secretion	OF Other Foreign Materials (describe)	SI Suction Injury
BI Bite	EC Ecchymosis (bruise)	OI Other Injury (describe)	SW Swelling
BU Burn	ER Erythema (redness)	OSC Other Skin Condition	TB Toluidine Blue⊕
CS Control Swab	FB Foreign Body	OT Other	TE Tenderness
CV Congenital Variation	F/H Fiber/hair	PW Perianal Wart	V/S Vegetation/Soil
DE Debris	GT Granulation Tissue	PE Petechiae	VL Vesicular Lesion
	HC Hymenal Cleft	PGW Possible Genital Wart	WL Wood's Lamp⊕
	IN Induration	PS Potential Saliva	
	IW Incised Wound		

Locator #	Type	Description

RECORD ALL SPECIMENS COLLECTED ON PAGE 8

Patient Identification

Diagram I - Penis

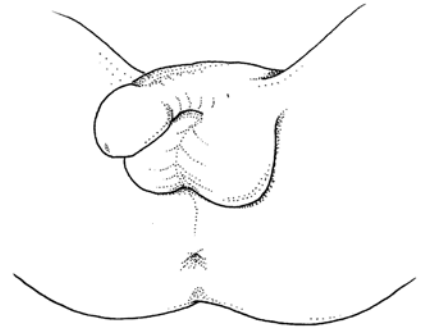


Diagram J - Penis

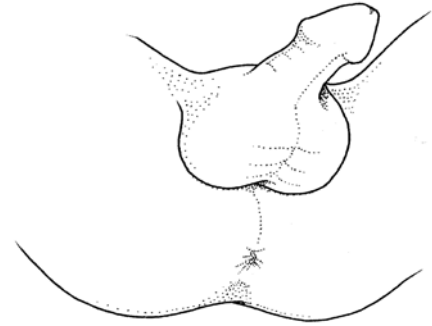


Diagram K - Anus Supine

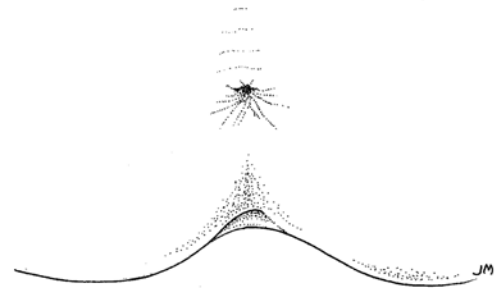
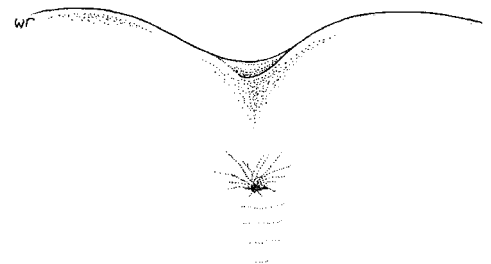


Diagram L - Anus Prone



M. EVIDENCE COLLECTED AND SUBMITTED TO CRIME LAB

1. Clothing placed in evidence kit	Other clothing placed in bags

2. Foreign materials collected

	No	Yes	Collected by:
Swabs/suspected blood	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dried secretions	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fiber/loose hairs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vegetation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Soil/debris	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swabs/suspected semen	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swabs/suspected saliva	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swabs/Wood's Lamp+ area(s)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Control swabs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fingernail scrapings/cuttings	<input type="checkbox"/>	<input type="checkbox"/>	_____
Matted hair cuttings	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pubic hair combings/brushings	<input type="checkbox"/>	<input type="checkbox"/>	_____
Intravaginal foreign body	<input type="checkbox"/>	<input type="checkbox"/>	_____
Describe: _____			
Other types	<input type="checkbox"/>	<input type="checkbox"/>	_____
If yes, describe:			

3. Oral/genital/anal/rectal samples

	# Swabs	# Slides	Time collected	Collected by:
Oral				
Vulvar				
Vestibular				
Vaginal				
Cervical				
Anal				
Rectal				
Penile				
Scrotal				
Aspirate/washings (optional)	<input type="checkbox"/> No	<input type="checkbox"/> Yes		

4. Vaginal wet mount slide

	No	Yes	Time	Examiner:
Slide prepared				
Motile sperm observed				
Non-motile sperm observed				

N. TOXICOLOGY SAMPLES

	No	Yes	Time	Collected by:
Blood alcohol/toxicology (gray top tube)				
Urine toxicology				

O. REFERENCE SAMPLES

	No	Yes	Collected by:
Blood (lavender top tube)			
Blood (yellow top tube)			
Blood Card (optional)			
Buccal swabs (optional)			
Saliva swabs			
Head hair			
Pubic Hair			

P. PHOTO DOCUMENTATION METHODS

	No	Yes	Colposcope/ 35mm	Macrolens/ 35mm	Colposcope/ Videocamera	Other Optics
Body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genitals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Photographed by:						

Patient Identification

Q. FINDINGS AND INTERPRETATION

1. Anal-Genital Findings

Normal anal-genital exam
 Abnormal anal-genital exam
 Indeterminate anal-genital exam

2. Assessment of Anal-Genital Findings

Consistent with history
 Inconsistent with history
 Limited/Insufficient history

3. Interpretation of Anal-Genital Findings

Normal exam: can neither confirm nor negate sexual abuse
 Non specific: may be caused by sexual abuse or other mechanisms
 Sexual abuse is highly suspected
 Definite evidence of sexual abuse and/or sexual contact

4. Need further consultation/investigation

5. Lab results or photo review pending (may alter assessment)

6. Additional comments regarding findings, interpretations, and recommendations:

R. MEDICAL LAB TESTS PERFORMED

STD Cultures	GC	Chlamydia	Other	Describe	Collected by:
Oral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Vestibular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Vaginal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Cervical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Rectal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Penile	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Wet mount	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Serology Syphilis	<input type="checkbox"/>	HIV <input type="checkbox"/>	Hepatitis <input type="checkbox"/>	_____	_____
Pregnancy test	Blood <input type="checkbox"/>	Urine <input type="checkbox"/>	_____	_____	_____
Other test(s)				_____	_____

S. PRINT NAMES OF PERSONNEL INVOLVED

History taken by: _____	Telephone _____
Exam performed by: _____	
Specimens labeled and sealed by: _____	
Assisted by: <input type="checkbox"/> N/A	
Signature of examiner _____	License No. _____

T. EVIDENCE DISTRIBUTION

	GIVEN TO:
Clothing (item(s) not placed in evidence kit)	_____
Evidence Kit	_____
Reference blood samples	_____
Toxicology samples	_____

U. SIGNATURE OF OFFICER RECEIVING EVIDENCE

Signature: _____

Print name and ID#: _____

Agency: _____

Date: _____ Telephone: _____

