

OES 930
FORENSIC MEDICAL REPORT: ACUTE (<72 HOURS)
CHILD/ADOLESCENT SEXUAL ABUSE EXAMINATION

REQUIRED USE OF STANDARD STATE FORM:

Penal Code Section 13823.5(c) requires that every health care practitioner, who conducts a medical examination of a sexual assault or child sexual abuse victim for evidence of sexual assault or sexual abuse, must use a standard form to record findings. This form is intended to document forensic findings and, as such, is not a complete medical treatment record.

SUGGESTED USE OF THE STANDARD STATE FORMS: FOLLOW LOCAL POLICY.

OES 923	<ul style="list-style-type: none"> ▪ History of acute sexual assault (<72 hours) ▪ Examination of adults (age 18 and over) and adolescents (ages 12-17)
OES 925	<ul style="list-style-type: none"> ▪ History of nonacute sexual abuse (>72 hours) ▪ Examination of children and adolescents under age 18
OES 930	<ul style="list-style-type: none"> ▪ History of acute sexual abuse or assault (<72 hours) ▪ Examination of children under age 12
OES 930	<ul style="list-style-type: none"> ▪ History of chronic sexual abuse (incest) and recent incident (<72 hours) ▪ Examination of children and adolescents under age 18
OES 950	<ul style="list-style-type: none"> ▪ Examination of person(s) suspected of sexual assault or sexual abuse

Key terms for Sexual Assault or Sexual Abuse Exams	
Acute	Less than 72 hours have passed since the incident (<72 hours)
Nonacute	More than 72 hours have passed since the incident (>72 hours)
These terms are used to describe timeframes, not rigid standards. This is not to suggest that after 72 hours a complete exam should not be done. It is not unusual to detect injuries or possible trace and biological evidence after 72 hours.	

INSTRUCTIONS FOR OES 930

These instructions contain the recommended methods for meeting the minimum legal standards established by Penal Code Section 13823.11 for performing evidential examinations.

LIABILITY AND RELEASE OF INFORMATION:

This medical report is subject to the confidentiality requirements of the Child Abuse and Neglect Reporting Act (Pen. Code 11164 or privilege), the Medical Information Act (Civ. Code Sec. 56 et seq.), the Physician-Patient Privilege (Ev. Code Sec. 990), and the Official Information Privilege (Ev. Code Sec. 1040). It can only be released to those involved in the investigation and prosecution of the case: a law enforcement officer, district attorney, city attorney, crime laboratory, child protective services worker, a child abuse and neglect team member, county licensing agency, and coroner. Records may be released to the defense counsel only through discovery of documents in the possession of a prosecuting agency or after the appropriate court process (i.e., judicial review and a court order).

Complete this report in its entirety. Use N/A (not applicable) when appropriate to show that the examiner attended to the question.	Patient identification: This space is provided for hospitals and clinics using plastic plates for stamping identification information.
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A. GENERAL INFORMATION: Print or type the name of the facility where the examination was conducted.

1. Enter the patient's name and identification number (if applicable).
2. Enter the patient's address, city, county, state, and telephone number.
3. Enter the patient's age, date of birth (DOB), gender, and ethnicity; date/time of arrival; and date/time of discharge.
4. Enter the name of the mother, stepmother, or guardian and their address, city, county, state, and telephone numbers.
5. Enter the name of the father, stepfather, or guardian, and their address, city, county, state, and telephone numbers.
6. Enter the name(s) of siblings, gender, age, and date of birth.

B. REPORTING AND AUTHORIZATION: Indicate jurisdiction where the incident(s) occurred.

Penal Code Section 11166 requires all professional medical personnel to report suspected child abuse, defined by Penal Code Section 11165, immediately by telephone and to submit a written report (DOJ SS 8572) within 36 hours to the local law enforcement or child protective services agency.

1. Check the appropriate box to indicate whether a telephone report was made to a law enforcement and/or a child protective services agency. Identify the person who took the report by name, agency, identification number, and telephone number.
2. If the patient was accompanied by law enforcement or child protective services, enter the person's name and identifying information.
3. If known, identify the law enforcement and/or child protective services investigator assigned to this case.
4. Obtain the signature of a law enforcement and/or child protective services investigator to authorize payment for the evidential exam at public expense, the name of the agency, telephone number, date, time, and case number. If telephone authorization was obtained, enter the name of the authorizing party, identification number and the date and time in the Telephone Authorization box.
5. Medical facilities with contracts or memorandums of understanding may not require separate patient authorizations.

C. CONSENT FOR EXAMINATION BY PATIENT/PARENT/GUARDIAN

- Parental consent is not required for suspected sexual abuse examinations.
- Family Code Section 6927 permits minors (12 to 17 years of age) to consent to medical examination, treatment, and evidence collection related to a sexual assault without parental consent. Family Code Section 6928 requires health care professionals to attempt to contact the minor's parent or legal guardian, and to note in the minor's treatment record the date and time the attempted contact was made, including whether the attempt was successful or unsuccessful. This provision is not applicable when the health professional reasonably believes the parent(s) or guardian committed the sexual assault on the minor.

D. PATIENT HISTORY

1. **Record the time or time frame of the incident(s) and date(s).**
 - For children, use familiar dates and time frames (holidays, birthdays, weekday or weekend, nighttime or daytime).
2. **Describe the pertinent physical surroundings that may have come in contact with the patient.**
 - During the physical examination, look for pattern injuries associated with the physical surroundings and/or trace evidence (e.g., grass, sand) transferred from the scene to the patient.
3. **Record the terms the patient uses for the female and male genitalia, breasts, and anus.**
4. **Record the identity of the alleged perpetrator(s) by name or nickname, approximate age, gender, ethnicity, relationship to the patient, and whether the perpetrator(s) are known or unknown to the patient.**
 - Use a numbering system to identify multiple perpetrators by name, if known, or a brief description such as the "big guy." This numbering system can be used to relate the perpetrator to the acts described by the historian and/or patient on pages 2 and 3.

E. ACTS DESCRIBED BY HISTORIAN

- **Record the acts described by the historian to the recorder of this form and additional pertinent history.**
- **For yes answers, ask if there was associated pain or bleeding and describe in the space provided.**

<ul style="list-style-type: none">• Genital/vaginal contact/penetration• Anal contact/penetration	Mark the appropriate box for each method of contact/penetration. Mark "attempted" if it is reasonably clear from the interview that the perpetrator(s) intended an act but was thwarted by the patient, an intervening occurrence, or was unable to accomplish the act. If either "attempted" or "unsure" is checked, provide a description in the adjacent space. If more than one perpetrator was involved, identify each one by number on the lines adjacent to the boxes. If an object was used, describe it.
<ul style="list-style-type: none">• Oral copulation of genitals• Oral copulation of anus	Mark the appropriate box. Mark "attempted" if it is reasonably clear, from the interview, that the perpetrator(s) intended an act but was thwarted by the patient, an intervening occurrence, or was unable to accomplish the act. If either "attempted" or "unsure" is checked, provide a description in the adjacent space. If more than one perpetrator was involved, identify each one by number on the lines adjacent to the boxes.
<ul style="list-style-type: none">• Anal-genital fondling	Mark the appropriate box. Mark "attempted" if it is reasonably clear, from the interview, that the perpetrator(s) intended an act but was thwarted by the patient, an intervening occurrence, or was unable to accomplish the act. If either "attempted" or "unsure" is checked, provide a description in the adjacent space. If more than one perpetrator was involved, identify each one by number on the lines adjacent to the boxes.
<ul style="list-style-type: none">• Non-genital acts	Mark the appropriate box. If yes, describe the act and note where it occurred on the adjacent line. Mark "attempted" if it is reasonably clear, from the interview, that the perpetrator(s) intended an act but was thwarted by the patient, an intervening occurrence, or was unable to accomplish the act. If either "attempted" or "unsure" is checked, provide a description in the adjacent space. If more than one perpetrator was involved, identify each one by number on the lines adjacent to the boxes. <ul style="list-style-type: none">• Note: Identify bites and alert law enforcement about their existence. Bites can provide very specific evidence and they fade very quickly. Bites should be swabbed for saliva, measured, and photographed. Contact a forensic odontologist or law enforcement to evaluate the need for impressions.• Note: The term suction injury means "hickey".
<ul style="list-style-type: none">• Other act(s)	If yes, describe.
<ul style="list-style-type: none">• Ejaculation	Mark the appropriate box. For body surfaces, note location(s) on the diagrams. For clothing, bedding, or other surface(s), describe in the space provided. If more than one perpetrator ejaculated, identify each one by number on the lines adjacent to the boxes. If "unsure" is checked, provide a description in the adjacent space.
<ul style="list-style-type: none">• Contraceptive or lubricant products	Note whether a contraceptive or a lubricant product was used. If yes, record the type or brand used, if known.
<ul style="list-style-type: none">• Force or threats	If yes, describe.
<ul style="list-style-type: none">• Weapons	If yes, describe.
<ul style="list-style-type: none">• Pictures or videotapes	If yes, describe.
<ul style="list-style-type: none">• Drugs or alcohol	Ask about the possibility of forced or coerced ingestion of alcohol or drugs. Mark the appropriate box. If yes: <ul style="list-style-type: none">• For blood alcohol analysis, collect 5cc of blood in a gray stoppered evacuated blood collection vial.• For ingestion of drugs, collect 100cc of urine in a clean container. It is important to collect the first available sample. Some drugs may be detected in urine up to 96 hours after ingestion.
<ul style="list-style-type: none">• Loss of memory• Lapse of consciousness	If the patient reports ingestion of drugs, describes symptoms, or shows signs of drug ingestion (e.g. lapse of consciousness, memory loss, abnormal vital signs, confusion, etc.) collection of toxicology samples is recommended according to local policy.
<ul style="list-style-type: none">• Vomited after act(s)	If yes, describe. Vomiting can also be a possible indicator of drug or alcohol ingestion.
<ul style="list-style-type: none">• Behavioral changes	If yes, describe.

F. ACTS DESCRIBED BY PATIENT

Interview Methods

- Determine and use terms familiar to the patient.
- Allow the patient to describe the incident(s) to the extent possible.
- Follow-up questions may be necessary to ensure that all items are covered.
- Avoid asking questions that may be leading or suggestive.
- Gather as much information as possible from law enforcement officers and social workers to avoid redundant interviewing.

1. Record the acts disclosed by the patient and to whom.

Each act may lead to evidence of a chargeable crime. Any penetration, however slight, of a genital or anal opening by an object or body part constitutes an act. Oral copulation only requires contact.

- For yes answers, ask if there was associated pain or bleeding. Sometimes patients report no pain, but say "tickled".
- Use quotation marks to quote relevant statements. Example: "He put his private in my pee pee".
- Document if statement(s) made by the patient were spontaneous (i.e., not in response to a question or comment).
- Patient statements not heard directly by the recorder may be included, e.g., the child told the teacher that "he put his private in my pee pee".
- Under non-genital acts, the term suction injury means "hickey".
- Lubricant: describe by name, color, odor, flavor, and container description (if known or disclosed).
- Condom or other forms of covering: describe type or brand used (if known).
- If the patient experienced a lapse of consciousness, collection of toxicology samples as specified by local policy may be indicated.

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

G. MEDICAL HISTORY

1. Record the name of the person providing the medical history and the relationship to the patient.
2. Any recent (past 60 days) anal-genital injuries, surgeries, diagnostic procedures, or medical treatment that may affect the interpretation of physical findings?
 - This information is requested to avoid confusing pre-existing lesions with injuries or findings related to the alleged abuse.
3. Any other pertinent medical conditions that may affect the interpretation of physical findings?
4. Any pre-existing physical injuries?
5. Any previous history of physical abuse and/or neglect?
6. Any previous history of sexual abuse?
7. For adolescents, ask whether the patient has had other anal or vaginal intercourse.

The information is needed by the medical examiner to interpret the genital findings. The information is also required by the crime laboratory to properly interpret the findings. **Do not record any other information regarding sexual history on this form**

- If yes, ask whether the other intercourse occurred within the past 5 days. If yes, ask when.
 - If yes, ask whether the patient has had other oral copulation within the past 24 hours. If yes, ask when.
 - If yes, ask whether ejaculation occurred. If yes, ask where. If yes, ask whether a condom was used.
8. Record whether menstrual periods have started, the age of menarche, and the date of the last menstrual period.
 9. Record other symptoms described by patient and/or historian.
 - Describe onset, duration, and intensity of symptoms.
 - Use the "other" category to include enuresis, encopresis, etc.
 10. Record post-assault hygiene activity, if the incident occurred within 72 hours of examination.
 - This information is relevant because it can affect the interpretation of findings.
 - If the patient has bathed, showered, or douched, the examiner should still collect samples from the appropriate body areas to attempt to preserve any biological or trace evidence.
 - Ask the patient if tissues, wipes, or clothing were used to cleanse the mouth, genitals, and/or body. If yes, collect these items, if available. Air dry, package, label, and seal. If not available, notify law enforcement so these items may be collected.

H. GENERAL PHYSICAL EXAMINATION: COLLECT AND PRESERVE EVIDENCE. RECORD FINDINGS.

1. **Record vital signs.** Take blood pressure, if indicated by clinician judgment. Height and weight are optional.
2. **Record the date and time the examination was started and completed.**
3. **For females, record Breast Tanner Stage by checking the appropriate box.**

Breast Tanner Stages	Genital Tanner Stages
1. Preadolescent	1. No or fine vellus (peach fuzz) hair
2. Breast and papilla elevated as small mound: areolar diameter increased	2. Sparse, long straight pigmented hair
3. Breast and areola enlarged, no contour separation	3. Increased density, dark coarse curly hair
4. Areola and papilla form secondary mound	4. Abundant hair, sparing medial thighs
5. Mature: nipple projections, areola part of general breast contour	5. Abundant hair, spreading to medial thighs

4. **Describe the patient's general physical appearance.**
5. **Describe the patient's general demeanor and any relevant spontaneous statements made during the exam.**
 - Describe behaviors such as crying, fearfulness, willingness or ability to cooperate, responsiveness, ability to give history, etc. The issue of non-cooperativeness can cause exam delays and impair the examiner's ability to collect evidence. Avoid the use of vague, subjective, or judgmental descriptors.
 - Documenting helps the examiner recall the patient's behavior and response during the examination for future reference.
6. **Describe the condition of clothing upon arrival (rips, tears, presence of foreign materials).**
7. **Collect outer and under clothing worn during or immediately after the incident.**
 - Coordinate with the law enforcement officer regarding clothing to be collected.
 - Wear gloves while collecting clothing.
 - Have patient disrobe on two sheets of paper placed one on top of the other on the floor. Have patient remove shoes before stepping on the paper. Shoes may be collected, if indicated, and packaged separately.
 - Package each garment in an individual paper bag, label, and seal.
 - Carefully fold the top sheet of paper into a bundle, label, and seal. Discard the bottom sheet. Place this large bundle and all individually bagged garments into a large paper bag(s) with a chain of custody form, label, and seal.
 - Wet stains or other wet evidence require special handling. Consult local policy.
 - Give special focus to items that are close to the genital structures or otherwise have the highest potential to contain seminal fluid according to the assault history. According to local policy, these items may be placed in the evidence kit.
8. **Conduct a physical examination. Record all findings and whether the general exam was within normal limits.**

Physical Findings: A physical finding includes observable or palpable tissue injuries, physiologic changes, or foreign materials (e.g. grass, sand, stains, dried or moist secretions, or positive fluorescence). If none of the above are present, mark "No Findings".

- Be observant for erythema (redness), abrasions, bruises, swelling, lacerations, fractures, bites, and burns.
- Note areas of tenderness or induration.

DOCUMENTATION OF INJURIES AND FINDINGS USING DIAGRAMS AND LEGEND

- Record size and appearance of injuries and other findings using the diagrams, the legend, and a consecutive numbering system.
- Bruises: describe shape, size, and color.
- Use the legend to list and describe the injury/finding drawn on the diagram. Show the diagram letter followed by the finding number. Use the abbreviations in the legend to describe the type of finding. Example: A-1, EC 2x3cm red/purple indicates that the first finding on Diagram A is an ecchymosis (bruise) that is red/purple in color and 2x3 centimeters in size. See example below.

Locator #	Type	Description
A-1	EC	2x3 cm red/purple
A-2	DS	Dried secretion
A-3	CS	Control swab

- **Photograph injuries and other findings according to local policy.**
 - **Use proper forensic photographic techniques.**
 - Use an appropriate light source and a scale near the finding.
 - Note: The plane of the film must be parallel to the plane of the finding.
9. **Collect dried and moist secretions, stains (including semen, bloodstains, saliva from bites, suction injury [hickey], licking, and kissing), and foreign materials from the body.**
 - **Scan** the entire body with a Wood's Lamp (long wavelength ultraviolet light) or other alternate light source. Note fluorescent area(s) on the diagrams and record in legend as WL⊕.
 - **Swab moist secretions** with a dry swab to avoid dilution. Label and air dry before packaging.
 - **Swab dried stains and/or Wood's Lamp positive area(s)** with a swab (or multiple swabs for large stains) moistened with sterile, deionized, or distilled water. Label and air dry the evidence swab(s) before packaging. Make a control swab by swabbing an unstained area adjacent to the stain (when possible). Label, air dry, and package the control swab separately from the evidence sample.
 - **Collect** foreign materials such as fibers, sand, hair, grass, soil, and vegetation. Place in bindles and/or envelopes as appropriate for each location on the body. Label and seal.
 - **Record** all findings on the diagrams and the legend as shown above.
 - Use the legend locator number to label evidence collection envelopes.
 - Record the locations of swab collection sites and control swabs.
 10. **Collect fingernail scrapings or cuttings according to local policy.**
 - Use clean toothpicks or manicure sticks to collect scrapings from under the fingernails. Place scrapings from **each** hand into separate containers or bindles, then place into envelopes. Label (indicating right or left hand) and seal; **OR**,
 - Use a clean fingernail cutter or scissors to cut the fingernails, and place the cuttings from **each** hand into separate containers or bindles.

Package and label as above.

I. HEAD, NECK, AND ORAL EXAMINATION

1. Examine the face, head, hair, scalp, and neck for injury and foreign materials.

- Give special focus to the lips, perioral region, and nares in the examination.
- Record injuries and other findings using the diagrams and legend.
- Photograph injuries and other findings according to local policy. A colposcope may be used.

2. Record examination method used.

3. Collect dried and moist secretions, stains and foreign materials from the face, head, hair, scalp, and neck.

- **Swab moist secretions** with a dry swab to avoid dilution. Label and air dry before packaging.
- **Swab dried stains and/or Wood's Lamp positive area(s)** with a swab (or multiple swabs for large stains) moistened with sterile, deionized, or distilled water. Label and air dry the evidence swab(s) before packaging. Make a control swab by swabbing an unstained area adjacent to the stain (when possible). Label, air dry, and package the control swab separately from the evidence sample.
- **Collect** foreign materials such as fibers, sand, hair, grass, soil, and vegetation. Place in bindles and/or envelopes as appropriate for each location on the body. Label and seal.
- **Cut** matted head or facial hairs (for males) bearing crusted material and place in a bindle. Package, label, and seal.
- **Record** all findings on the diagrams and legend.
 - Use the legend locator number to label evidence collection envelopes.
 - Record the locations of swab collection sites and control swabs.

4. Examine the oral cavity for injury and foreign materials.

- Give special focus to frenulums, buccal surfaces, gums, and soft palate.
- Record injuries, foreign materials, and other findings using the diagrams and legend.
- Photograph injuries and other findings according to local policy. A colposcope may be used.
- Collect foreign materials found in the oral cavity, e.g. hair. Package, label, and seal.

5. Collect 2 swabs from the oral cavity for seminal fluid up to 12 hours post assault and prepare one dry mount slide from one of the swabs.

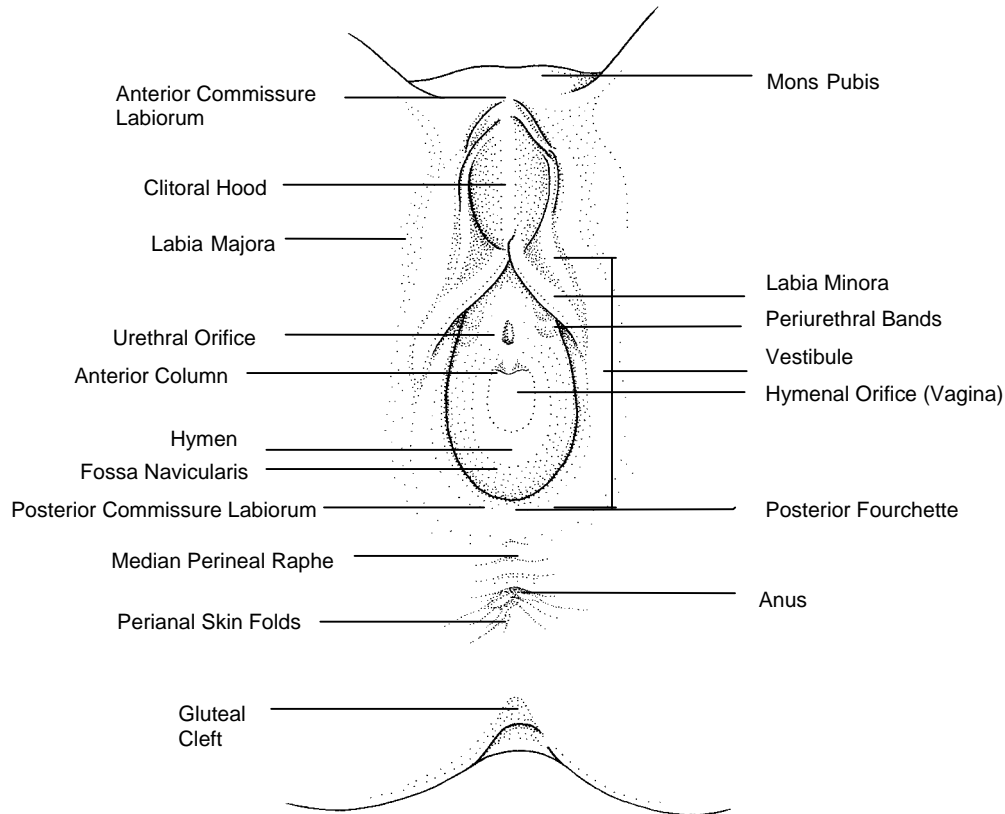
- Swab the gum to the tonsillar fossae, the upper first and second molars, behind the incisors, and the fold of the cheek (buccal space).
- Label and air dry swabs and slide. Code the swab to enable the crime laboratory to determine which swab was used to make the slide. Package, label, and seal.

6. Collect head hair reference samples according to local policy.

- According to local policy, pull (or have patient pull) 20-30 hairs representative of variations in length and color from different areas of the head; **OR**, cut the hairs close to the skin. Package, label, and seal.

FEMALE GENITALIA WITH LABELS: SUPINE VIEW

Diagrams of female and male genitalia with definitions are provided in Appendix N of the Protocol.



J. GENITAL EXAMINATION - FEMALES

Advisory: Record observations, take colposcopic photographs, and collect swabs before using the visualization enhancement Toluidine Blue Dye.

1. Examine the inner thighs, external genitalia, and perineal area for injury, foreign materials, and other findings.

- Use a colposcope, if available, or employ other means of magnification.
- Record size and appearance of injuries, foreign materials, and other findings using the diagrams, the legend, and a consecutive numbering system. Note swelling and areas of tenderness and induration. Describe genital findings as the face of a clock with the top of a genital diagram being 12 o'clock and the bottom of a genital diagram being 6 o'clock.
- Photograph injuries and other findings according to local policy.

2. Record examination positions and methods used.

Knee chest:	Prone: child rests on knees with upper chest on the examination table in a lordotic (swayback) posture Supine: child rests on back with flexed knees brought to chest	Saline/water: used to float/separate the hymenal tissue that may be rolled or overlapping upon itself
Traction:	labia majora are grasped between the thumbs and index fingers and gently pulled toward the examiner	Moistened swab: used to reposition hymenal tissue Always use a moistened swab to reduce discomfort
Separation:	labia majora are gently separated in a lateral and downward direction exposing the structures within the vestibule	Speculum exams: Never done on prepubertal females

3. Record Genital Tanner Stage by checking the appropriate box. Descriptions are provided on page 4.

4. Examine the genital structures. Check the ABN box(es) if there are abuse/assault related findings.

- **Diagram the position that best illustrates your findings.**

Record morphology of the hymen:	Terms relating to the hymen:
annular: circumferential	estrogenized: influenced by estrogen, hymen takes on thickened, redundant, pale appearance
crescentic: attachments at about the 11 and 1 o'clock positions without tissue being present between the two attachments	fimbriate/denticular: multiple projections and indentations along edge
imperforate: no opening	narrow/wide rim: viewed in the coronal plane-from edge of hymen to muscular portion(attachment) of the vaginal opening
septate: bisected by a band of hymenal tissue creating two or more orifices	membrane thickness: relative amount of tissue between internal and external surfaces of the hymenal membrane

5. Collect dried and moist secretions, stains, foreign materials, and foreign bodies.

- **Scan** the area with a Wood's Lamp (long wavelength ultraviolet light) or other alternate light source. Note fluorescent area(s) on the diagrams and record in legend as WL⊕.
- **Swab moist secretions** with a dry swab to avoid dilution. Label and air dry before packaging.
- **Swab dried stains and/or Wood's Lamp positive areas** with a swab (or multiple swabs for large stains) moistened with sterile, deionized, or distilled water. Label and air dry the evidence swab(s) before packaging. Make a control swab by swabbing an unstained area adjacent to the stain (when possible). Label, air dry, and package the control swab separately from the evidence sample.
- **Collect** foreign materials such as fibers, sand, hair, grass, soil, vegetation. Place in bindles and/or envelopes as appropriate for each location on the body. Label and seal.
- Allow foreign bodies to air dry for at least one hour. If any item is still wet, package and label as "wet evidence". Consult local policy.
- **Cut** matted pubic hairs bearing crusted material and place in a bindle. Package, label, and seal.
- **Record** all findings on the diagrams and legend.
 - Use the legend locator number to label evidence collection envelopes.
 - Record the locations of swab collection sites and control swabs.

Swab collection: Collection of intra-vaginal swabs is rarely done on prepubertal girls. If the hymenal diameter is not large enough to insert a swab without touching the edge of the hymen, then vaginal swabbing should NOT be done. If vaginal swabs are not collected, vulvar and vestibular swabs must be collected in all cases.

6. Collect swabs and prepare slides.

Prepubertal female(s): vulvar and vestibular swabs
<ul style="list-style-type: none"> • Collect at least 2 vulvar and 2 vestibular swabs. • Hold the swabs together as a unit, rotate them as a unit to ensure uniform sampling. Allow adequate time for saturation of the swabs.
Pubertal female(s): vaginal swabs
<ul style="list-style-type: none"> • Collect (ideally) 4 swabs from the adolescent's vaginal pool. • Hold the swabs together as a unit and insert them into the vaginal pool at the same time. Rotate the swabs as a unit in the vaginal vault to ensure uniform sampling. Allow for adequate time for saturation of the swabs. Separate the swabs before drying. • Prepare a wet mount slide from one swab using normal saline or a buffered nutrient medium. Examine immediately for motile or non-motile sperm. A phase contrast or other optically staining microscope facilitates this exam. Label the swab and the slide as "wet mount". Air dry the slide with cover slip in place. Package, label, and seal. • Prepare one dry mount slide from one of the other swabs. Package, label, and seal. • Code the swab(s) used to make the wet mount and dry mount slides to enable the crime laboratory to determine which swab was used to make each slide. Air dry all swabs and slides. • Note: aspirates or washings may be collected of the detection of spermatozoa. Consult local policy.
Pubertal female(s): cervical swabs
<ul style="list-style-type: none"> • If 48 hours or more post assault, collect 2 cervical swabs only if a speculum can be used without causing trauma. Label the swabs so it is clear that these are cervical, not vaginal swabs. Air dry, package, label, and seal.

7. Collect pubic hair combing or brushing, if applicable.

- Place a paper sheet under the patient's buttocks. Comb the pubic hair downward to remove any loose hairs or foreign materials. Collect and fold the paper with the comb or brush inside. Package, label, and seal.

8. Collect pubic hair reference samples according to local policy. See page 8.

K. GENITAL EXAMINATION - MALES

Advisory: Record observations, take colposcopic photographs, and collect swabs before using the visualization enhancement Toluidine Blue Dye.

1. **Examine the inner thighs, external genitalia, and perineal area for injury, foreign materials, and other findings.**
 - Use a colposcope, if available, or employ other means of magnification.
 - Record size and appearance of injuries, foreign materials, and other findings using the diagrams, the legend, and a consecutive numbering system. Note swelling and areas of tenderness and induration.
 - Photograph injuries and other findings according to local policy.
2. **Record examination positions/methods used.**
3. **Record Genital Tanner stage by checking the appropriate box. Descriptions are provided on page 4.**
4. **Record whether circumcised or not.**
5. **Check the ABN box(es) if there are abuse/assault related findings.**
6. **Collect dried and moist secretions, stains, and foreign materials.**
 - **Scan** the area with a Wood's Lamp (long wavelength ultraviolet light) or other alternate light source. Note fluorescent area(s) on the diagrams and record in legend as WL⊕.
 - **Swab moist secretions** with a dry swab to avoid dilution. Label and air dry before packaging.
 - **Swab dried stains and Wood's Lamp positive areas** with a swab (or multiple swabs for large stains) moistened with sterile, deionized, or distilled water. Label and air dry the evidence swab(s) before packaging. Make a control swab by swabbing an unstained area adjacent to the stain (when possible). Label, air dry, and package separately from the evidence sample.
 - **Collect** foreign materials such as fibers, sand, hair, grass, soil, and vegetation. Place in bindles and/or envelopes as appropriate for each location on the body. Label and seal.
 - **Cut** matted pubic hairs bearing crusted material and place in a bindle. Package, label, and seal.
 - **Record** all findings on the diagrams and legend.
 - Use the legend locator number to label evidence collection envelopes.
 - Record the locations of swab collection sites and control swabs.
7. **Collect pubic hair combing or brushing, if applicable.**
 - Place a paper sheet under the patient's buttocks. Comb the pubic hair downward to remove any loose hairs or foreign materials. Collect and fold the paper under the buttocks with the comb or brush inside. Package, label, and seal.
8. **Collect pubic hair reference samples according to local policy.**
 - According to local policy, pull (or have patient pull) 20-30 hairs representative of variations in length and color from different areas of the pubic region; **OR**, cut the hairs close to the skin. Package, label and seal.
9. **Collect 2 penile swabs, if indicated by the assault history, e.g., if the suspect orally copulated the male victim.**
 - Hold the swabs together as a unit and swab the glans, shaft, and base of the penis with a rotating motion to ensure uniform sampling. Avoid swabbing the urethral meatus. Use swabs moistened with sterile, deionized, or distilled water for these swabbings. Air dry, package, label, and seal.
10. **Collect 2 scrotal swabs, if indicated by the assault history, e.g., if the suspect orally copulated the victim.**
 - Hold the swabs together as a unit and swab the scrotum in a rotating motion, focusing on the area that is in closest proximity to the penis. Use swabs moistened with sterile, deionized, or distilled water. Air dry, package, label, and seal.

L. FEMALE/MALE ANAL AND RECTAL EXAMINATION

1. **Examine the buttocks, perianal skin, and the anal folds for injury, foreign materials, and other findings.**
 - Use a colposcope, if available, or employ other means of magnification.
 - Photograph injuries and other findings according to local policy.
2. **Record examination positions, methods, and observations.**
 - Examination position options: supine, prone, or lateral recumbent (lying on side with hips and knees flexed).
 - Use lateral traction on the buttocks or the knee-chest position with lateral traction on the buttocks to conduct the examination.
 - Indicate if anal dilation is immediate or delayed. If anus dilates, record if stool is present in the rectal ampulla.
3. **Check the ABN box(es) if there are abuse/assault related findings. Record findings using the legend and diagrams.**
4. **Collect dried and moist secretions, stains, and foreign materials. Foreign materials may include lubricants.**

Collect samples and record findings using the techniques described under #6 above.
5. **Collect 2 anal and/or rectal swabs and prepare one dry mount slide.**
 - To avoid contaminating anal/rectal swabs, clean the perianal area thoroughly. This should be done after the female vaginal samples, external secretions, and foreign materials have been collected.
 - Label and air dry the swabs and slide. Code the swab to enable the crime laboratory to determine which swab was used to make the slide. Package, label, and seal.
6. **If rectal injury is suspected or if there is any sign of rectal bleeding, use lateral traction on the buttocks or the knee-chest position with lateral traction on the buttocks to conduct the examination.**
 - Check the box if there is rectal bleeding and describe findings.
 - If an anoscopic examination is medically indicated, document under examination methods. Sedation or anesthesia is recommended for the prepubertal child.

All swabs and slides must be air dried prior to packaging (Penal Code Section 13823.11). Air dry in a stream of cool air for 60 minutes. Only place samples from one patient at a time in the swab drying box. Wipe or spray the swab drying box with 10% bleach before each use.

Labeling requirements: Swabs, slides, bindles, and small containers must be individually labeled with the patient's name and sample source. Code swabs and slides to show which slides were prepared from which swabs. Containers for these individual items must be labeled with the name of the patient, date of collection, description of the evidence including location from which it was taken, signature or initials of the person who collected the evidence. Include the legend locator number, if the legend was used to document the location from which the evidence was collected. Package containers in a Sexual Assault Evidence Collection Kit and record the chain of custody.

M. RECORD ALL EVIDENCE COLLECTED AND SUBMITTED TO THE CRIME LABORATORY

1. Record all items of clothing collected.
2. Record all foreign materials collected and the name of the person who collected them.
Note: An intravaginal foreign body may include a tampon, diaphragm, condom, etc. Consult the local crime laboratory for packaging recommendations for foreign bodies.
3. Record information about the oral/genital/rectal samples:
Record the number of swabs and slides collected, the time collected, and the person who took the samples.
4. Record information about the vaginal wet mount slide:
Record whether the wet mount slide was prepared and whether or not motile or non-motile sperm were observed. Record the time the slide was prepared, observed, the person who prepared it, and the person who examined it.

N. TOXICOLOGY SAMPLES

- Collect samples for blood alcohol/toxicology at the discretion of the examiner and/or law enforcement officer in accordance with local policy.
- Cleanse the arm with a non-alcoholic solution and collect 5cc of blood in a gray stoppered evacuated vial. Label vial and envelope and seal.
- Up to 96 hours after suspected ingestion of drugs, collect a urine specimen (100cc) in a clean container. It is important to collect the first available sample.

O. REFERENCE SAMPLES: Policies pertaining to whether reference samples are collected at the time of the exam or later vary by jurisdiction. If collected at the time of the exam, ALWAYS collect after the evidence samples. For those jurisdictions not performing conventional serology, a buccal swab can be taken in place of the blood reference sample. Consult your local crime laboratory.

Blood:

Collect blood sample in lavender and/or yellow stoppered evacuated vials as specified by local policy. A blood card is an option in some jurisdictions. Label vial(s) and envelope(s) and seal.

Buccal (inner cheek) swabs:

Collect as a DNA reference sample. Rub two swabs gently but firmly along the inside of the cheek in a rotating motion to ensure even sampling. Air dry, package, label, and seal.

Saliva:

Note: If a saliva reference sample is required by the local crime laboratory, collect it whether or not an oral assault occurred. Collect sample by placing two swabs in the mouth and allowing them to saturate. Air dry, package, label and seal.

Head hair:

According to local policy, pull (or have patient pull) 20-30 hairs representative of variations in length and color from different areas of the scalp; OR, cut the hairs close to the skin. Package, label, and seal.

Pubic hair from pubertal males and females:

According to local policy, pull (or have patient pull) 20-30 hairs representative of variations in length and color from different areas of the pubic region; OR, cut the hairs close to the skin. Package, label, and seal.

P. RECORD PHOTO DOCUMENTATION METHODS

Document photographic methods used and areas which were photographed. Documentation must clearly link the patient's identity to the specific photographs of injuries and/or findings. For example, include a picture of the patient identification on the roll or use a databack camera which can be programmed with the patient's identification number.

Q. RECORD FINDINGS AND INTERPRETATION

- Findings and interpretations are based on both the patient history available at the time and the medical examination.
- A normal exam does not indicate that sexual abuse did not occur.
- A medical exam is only one part of a complete investigation.

1. Anal-Genital Findings

- Normal anal-genital exam
- Abnormal anal-genital exam
- Indeterminate anal-genital exam (Example: erythema)

2. Assessment of Anal-Genital Findings

- Check the box to indicate whether the findings are consistent or inconsistent with the history given, or whether history was limited or insufficient.

3. Interpretation of Anal-Genital Findings

- Normal exam: can neither confirm nor negate sexual abuse

Examples:	Normal findings and variations of normal
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- Nonspecific: may be caused by sexual abuse or other mechanisms

Examples:	<ul style="list-style-type: none">• labia minora contusion• erythema (redness) of the anogenital tissues
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- Sexual abuse is highly suspected

Examples:	<ul style="list-style-type: none">• condyloma acuminata on a 9 year old without history of prior condylomata• vestibular injuries with no labial trauma
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- Definite evidence of sexual abuse and/or sexual contact

Examples:	<ul style="list-style-type: none">• nonperinatal culture proven <i>Neisseria gonorrhoeae</i>• sperm• pregnancy• bleeding hymenal tear/laceration with a history of recent sexual assault
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4. Need further consultation/investigation

Examples:	<ul style="list-style-type: none">• examiner may not have seen this type of finding before• no history to account for examiner's findings larger than "normal" hymenal diameter
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5. Check if lab results or photo review are pending.

6. Record additional comments regarding findings, interpretations, and recommendations; or, use to describe variations of normal congenital abnormalities.

R. RECORD MEDICAL LAB TESTS PERFORMED

- Consider abuse history, patient's medical history, and exam findings to determine tests needed.
- Perform medical lab tests after collection of forensic material.
- Pregnancy testing should be considered for all females Tanner Stage 3 and above, irrespective of menarche.
- Additional tests performed depend upon clinical assessment (i.e. urinalysis, biopsy, cultures, viral titers, etc.).

S. PRINT NAMES OF PERSONNEL INVOLVED. OBTAIN SIGNATURE AND LICENSE NUMBER OF EXAMINER.

T. EVIDENCE DISTRIBUTION: List to whom the evidence was given.

U. OBTAIN SIGNATURE OF OFFICER RECEIVING EVIDENCE.