

**FORENSIC MEDICAL REPORT:  
SEXUAL ASSAULT SUSPECT EXAMINATION**

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

**OES 950**

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 (W) (H)
3. Age	DOB	Gender M F	Ethnicity	Date/time of arrival	Date/time of discharge

**B. AUTHORIZATION Jurisdiction ( city county other):**

1. Name of Law Enforcement Officer	Agency	ID Number	Telephone
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2. I request a forensic medical examination for suspected sexual assault at public expense.

_____	_____	_____	_____
Law enforcement officer signature	Date	Time	Case number

**C. MEDICAL HISTORY**

1. Any recent (60 days) anal-genital injuries, surgeries, diagnostic procedures, or medical treatment that may affect the interpretation of current physical findings?  No  Yes  
If yes, describe: \_\_\_\_\_

2. Any other pertinent medical condition(s) that may affect the interpretation of current physical findings?  No  Yes  
If yes, describe: \_\_\_\_\_

3. Any pre-existing physical injuries?  No  Yes  
If yes, describe: \_\_\_\_\_

**D. RECENT HYGIENE INFORMATION Not applicable if over 72 hours**

	No	Yes		No	Yes
Urinated	<input type="checkbox"/>	<input type="checkbox"/>	Bath/shower/wash	<input type="checkbox"/>	<input type="checkbox"/>
Defecated	<input type="checkbox"/>	<input type="checkbox"/>	Brushed teeth	<input type="checkbox"/>	<input type="checkbox"/>
Genital or body wipes	<input type="checkbox"/>	<input type="checkbox"/>	Ate or drank	<input type="checkbox"/>	<input type="checkbox"/>
If yes, describe: _____			Changed clothing	<input type="checkbox"/>	<input type="checkbox"/>
Oral gargle/rinse	<input type="checkbox"/>	<input type="checkbox"/>	If yes, describe: _____		

**E. GENERAL PHYSICAL EXAMINATION**

1. Blood Pressure	Pulse	Respiration	Temperature	2. Date/Time of Examination	
				Started	Completed
3. Height	Weight	Hair color	Eye color	<input type="checkbox"/> Right-handed <input type="checkbox"/> Left-handed	

4. Describe general physical appearance

5. Describe general demeanor

6. Describe condition of clothing upon arrival.

7. Collect outer and under clothing, if indicated.  Not indicated

**DISTRIBUTION OF OES 950**

Original - Law Enforcement

Copy within evidence kit - Crime Lab

Copy - Medical Facility Records

**E. GENERAL PHYSICAL EXAMINATION**

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

- 8. Conduct a physical examination. Record scars, tattoos, skin lesions, and distinguishing physical features.  Findings  No Findings
- 9. Collect dried and moist secretions, stains, and foreign materials from the body. Scan the entire body with a Wood's Lamp.  Findings  No Findings
- 10. Collect fingernail scrapings or cuttings according to local policy.
- 11. Collect chest hair reference samples according to local policy.

Patient Identification

Diagram A

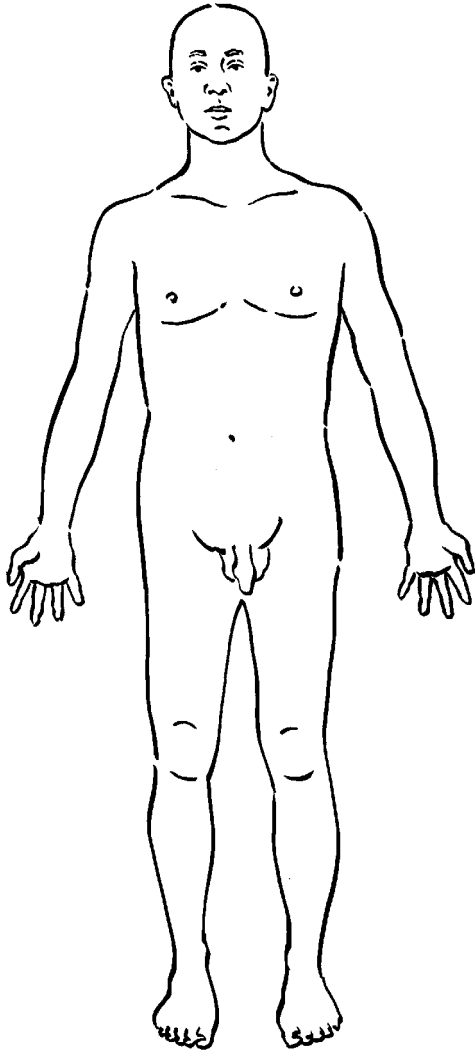
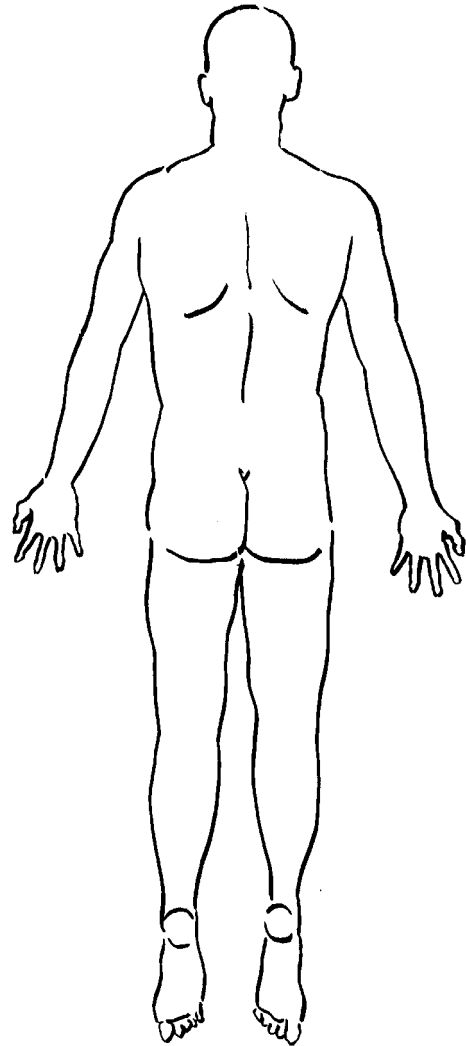


Diagram B



**LEGEND: Types of Findings**

<b>AB</b> Abrasion	<b>DE</b> Debris	<b>F/H</b> Fiber/hair	<b>OF</b> Other Foreign Materials	<b>SC</b> Scars	<b>TA</b> Tattoos
<b>BI</b> Bite	<b>DF</b> Deformity	<b>IN</b> Induration	(describe)	<b>SHX</b> Sample Per History	<b>TB</b> Toluidine Blue⊕
<b>BP</b> Body Piercing	<b>DS</b> Dry Secretion	<b>IW</b> Incised Wound	<b>OI</b> Other Injury (describe)	<b>SI</b> Suction Injury	<b>TE</b> Tenderness
<b>BU</b> Burn	<b>EC</b> Ecchymosis (bruise)	<b>LA</b> Laceration	<b>PE</b> Petechiae	<b>SW</b> Swelling	<b>V/S</b> Vegetation/Soil
<b>CS</b> Control Swab	<b>ER</b> Erythema (redness)	<b>MS</b> Moist Secretion	<b>PS</b> Potential Saliva		<b>WL</b> Wood's Lamp⊕

Locator #	Type	Description	Locator #	Type	Description

**RECORD ALL CLOTHING AND SPECIMENS COLLECTED ON PAGE 5**

**F. 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. Collect dried and moist secretions, stains, and foreign materials from face, head, hair, scalp, and neck.     Findings     No Findings
3. Examine the oral cavity for injury and foreign materials (if indicated by assault history). Collect foreign materials.  
Exam done:     Not applicable     Yes     Findings     No Findings
4. Collect 2 swabs from the oral cavity up to 12 hours post assault and prepare one dry mount slide from one of the swabs.
5. Collect head and facial hair reference samples according to local policy.

Patient Identification

Diagram C

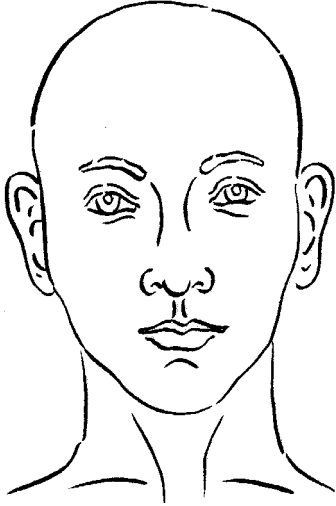


Diagram D

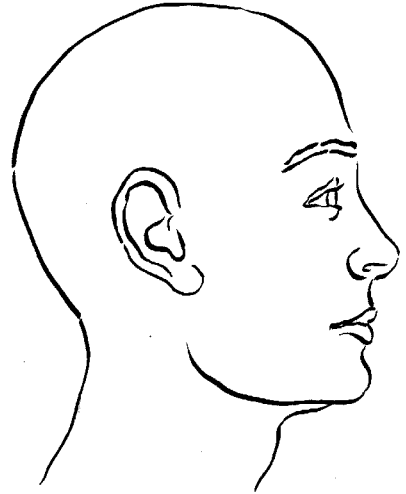


Diagram E

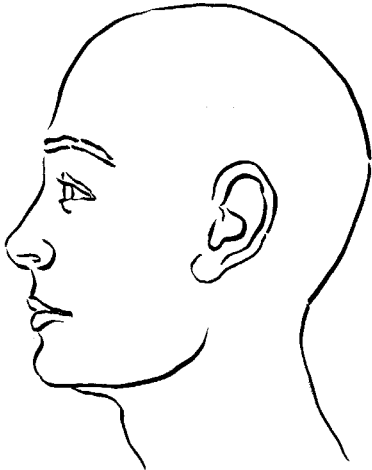


Diagram F



**LEGEND: Types of Findings**

AB Abrasion	DE Debris	F/H Fiber/hair	OF Other Foreign Materials (describe)	SC Scars	TA Tattoos
BI Bite	DF Deformity	IN Induration	OI Other Injury (describe)	SHX Sample Per History	TB Toluidine Blue®
BP Body Piercing	DS Dry Secretion	IW Incised Wound	PE Petechiae	SI Suction Injury	TE Tenderness
BU Burn	EC Ecchymosis (bruise)	LA Laceration	PS Potential Saliva	SW Swelling	V/S Vegetation/Soil
CS Control Swab	ER Erythema (redness)	MS Moist Secretion			WL Wood's Lamp®

Locator #	Type	Description	Locator #	Type	Description

**RECORD ALL SPECIMENS COLLECTED ON PAGE 5**

**G. GENITAL EXAMINATION**

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

1. Examine the inner thighs, external genitalia, and perineal area. Check the box(es) if there are assault related findings:

- No Findings
- Inner thighs       Glans penis       Scrotum
- Perineum           Penile shaft       Testes
- Foreskin           Urethral meatus

2. Circumcised

- No       Yes

3. Collect dried and moist secretions, stains, and foreign materials. Scan the area with a Wood's Lamp.       Findings       No Findings

4. Collect pubic hair combing or brushing.

5. Collect pubic hair reference samples according to local policy.

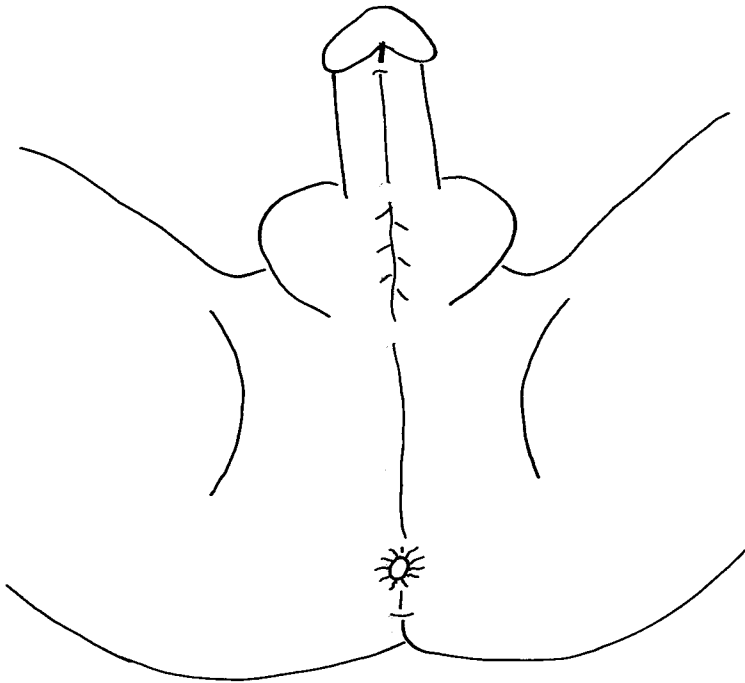
6. Collect 2 penile swabs, if indicated by assault history.       N/A

7. Collect 2 scrotal swabs, if indicated by assault history.       N/A

8. Record other findings per history.       No       Yes

If yes, describe:

Diagram G



**Patient Identification**

Diagram H

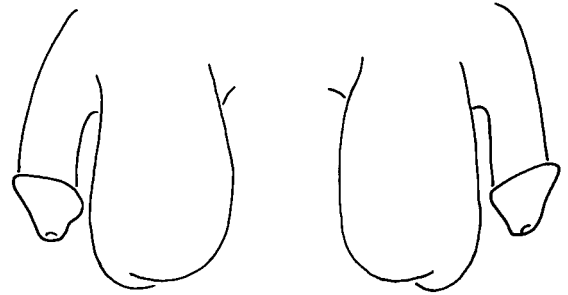


Diagram I

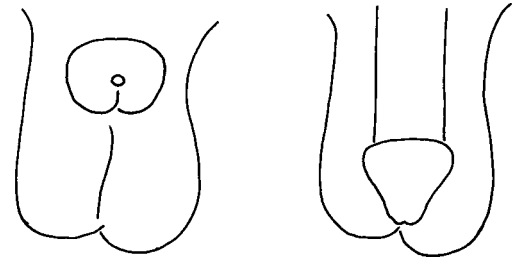
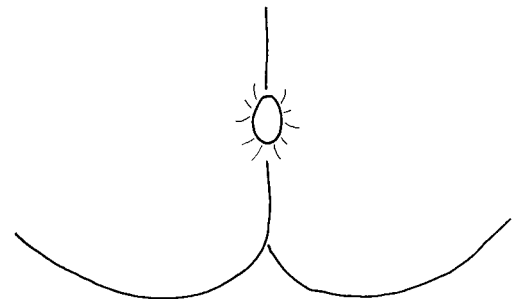


Diagram J



**LEGEND: Types of Findings**

<b>AB</b> Abrasion	<b>ER</b> Erythema (redness)	<b>PE</b> Petechiae	<b>V/S</b> Vegetation/Soil
<b>BI</b> Bite	<b>F/H</b> Fiber/Hair	<b>PS</b> Potential Saliva	
<b>WL</b> Wood's Lamp <sup>⊕</sup>			
<b>BP</b> Body Piercing	<b>IN</b> Induration	<b>SC</b> Scars	
<b>BU</b> Burn	<b>IW</b> Incised Wound	<b>SHX</b> Sample Per History	
<b>CS</b> Control Swab	<b>LA</b> Laceration	<b>SI</b> Suction Injury	
<b>DE</b> Debris	<b>MS</b> Moist Secretion	<b>SW</b> Swelling	
<b>DF</b> Deformity	<b>OF</b> Other Foreign Materials (describe)	<b>TA</b> Tattoos	
<b>DS</b> Dry Secretion	<b>OI</b> Other Injury (describe)	<b>TB</b> Toluidine Blue <sup>⊕</sup>	
<b>EC</b> Ecchymosis (bruise)		<b>TE</b> Tenderness	

Locator #	Type	Description

**H. EVIDENCE COLLECTED AND SUBMITTED TO CRIME LAB**

<b>1. Clothing placed in evidence kit</b>	<b>Other clothing placed in bags</b>

Patient Identification

**L. RECORD EXAM METHODS**

	No	Yes
Direct visualization only	<input type="checkbox"/>	<input type="checkbox"/>
Colposcopy	<input type="checkbox"/>	<input type="checkbox"/>
Other magnifier	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

If yes, describe:

\_\_\_\_\_

**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 <sup>⊕</sup> 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"/>	_____
Other types	<input type="checkbox"/>	<input type="checkbox"/>	_____

If yes, describe:

**M. RECORD EXAM FINDINGS**

Physical Findings       No Physical Findings

**N. SUMMARIZE FINDINGS**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**3. Oral/genital samples**

	# Swabs	# Slides	Time collected	Collected by:
Oral				
Penile				
Scrotal				

**I. TOXICOLOGY SAMPLES**

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

**O. PRINT NAMES OF PERSONNEL INVOLVED**

History taken by: \_\_\_\_\_ Telephone \_\_\_\_\_

Exam performed by: \_\_\_\_\_

Specimens labeled and sealed by: \_\_\_\_\_

Assisted by:  N/A

Signature of examiner: \_\_\_\_\_ License No. \_\_\_\_\_

**J. REFERENCE SAMPLES**

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

**P. EVIDENCE DISTRIBUTION GIVEN TO:**

Clothing (item(s) not placed in evidence kit)

Evidence kit

Reference blood samples

Toxicology samples

**K. PHOTO DOCUMENTATION METHODS**

	No	Yes	Colposcope/35mm	Macrolens/35mm	Colposcope/ Videocamera	Other optics
<b>Body</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Genitals</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Photographed by: \_\_\_\_\_

**Q. SIGNATURE OF OFFICER RECEIVING**

Signature: \_\_\_\_\_

Print name and ID#: \_\_\_\_\_

Agency: \_\_\_\_\_

Date: \_\_\_\_\_ Phone: \_\_\_\_\_

