

Sexual Assault Forensic/Medical Exam Documentation Revised 2021

This file contains the following forms:

- **Consent form** – 2 Pages – Maintained as part of the Medical Record
- **Medical History/ Initial Assessment form** – 6 Pages - Maintained as part of the Medical Record – **DO NOT COPY** or Forward to Law Enforcement of other disciplines
- **Forensic Examination form** – 12 Pages – Copy 1 to Law Enforcement, Copy 2 Inside the Kit Envelope

PLEASE PRINT LEGIBLY

**Sexual Assault Medical/Forensic Exam
Consent Form**

Patient Name

Date & Time

Case #

I, _____, freely consent to a forensic medical examination conducted by a medical professional in order to collect and preserve any potential evidence of the described assault. This procedure has been fully explained to me and I understand that I may refuse any portion of the examination at any time. If I decide to report, a copy of the forensic exam paperwork and any potential evidence obtained will be released to the law enforcement agency and the State Attorney's Office for the appropriate jurisdiction. Collection of other specimens and/or samples for laboratory analysis may be conducted per the events reported.

Patient Information

- I understand that healthcare facilities and their personnel must report certain crimes to law enforcement authorities in cases that a patient seeks medical care.
- I have been informed that Florida law provides that a victim of sexual offense shall not be charged for the costs of a forensic evidentiary exam.
- I understand that I do not need to report to law enforcement to receive this service. I understand that I have the option to have the examination performed and report at a later time if I choose to do so.
- I consent to the following (please initial by each item checked):

- _____ ☐ 1. Head to toes examination with visual inspection of injuries and possible areas of assault including the mouth, the genitalia and the rectum.
- _____ ☐ 2. Photographic documentation of any injuries including area of the mouth, genitalia, and anus.
- _____ ☐ 3. Photos will become part of the official record of this case and may be used for peer/chart review within the agency. Photos are only released to law enforcement and or state attorney's office with the consent of the patient and/or via a subpoena.
- _____ ☐ 4. Photos may be used for educational/training purposes. At no time will a name or any other identifying structure be associated with patient or the case.
- _____ ☐ 5. Collection of blood and urine for laboratory testing of possible drug facilitated assault.
- _____ ☐ 6. Administration of medication for prevention of infection and/or pregnancy.
- _____ ☐ 7. Provide first aid treatment to any superficial injuries.
- _____ ☐ 8. Provide information for follow-up testing for the diagnosis of HIV and sexually transmitted infections at the Health Department.
- _____ ☐ 9. Provide follow up communications from advocates and/or counselors.

**Sexual Assault Medical/Forensic Exam
Consent Form**

I consent to the above statements at this time **BUT** would like to have any potential evidence collected and held for _____ days until/if I decide to report to law enforcement.

At the end of that period:

Would you like to be contacted before the evidence kit is destroyed? ☐ Yes ☐ No

If Yes, then how? ☐ Letter _____

☐ Telephone _____

☐ Email _____

☐ Text _____

Can a message be left on an answering machine at the specified number? ☐ Yes ☐ No

Patient- Print Name

Patient- Signature

Date/Time

SANE/Forensic Examiner – Print Name

SANE/Forensic Examiner- Signature

Date/Time

Patient Name

DOB

Case #

Initials: _____

RAPE CRISIS CENTER / FACILITY NAME _____

DATE OF EXAM _____

DEMOGRAPHIC INFORMATION:

Gender: ☐ Male ☐ Female Preferred Pronoun ☐ She/Her ☐ He/Him ☐ They/Them

Transitioning: ☐ Male to Female ☐ Female to Male ☐ Other _____

Reported Race: ☐ White ☐ Black ☐ White/Hispanic ☐ Non-White Hispanic ☐ Other: _____

Preferred language: ☐ English ☐ Spanish ☐ Creole ☐ Sign Language ☐ Other _____

Does patient require impairment-related accommodations? ☐ No ☐ Yes, explain

Mandated Report? ☐ No ☐ *If yes, please indicate case number of report and name/ID of hotline staff*

GENERAL HEALTH HISTORY

Vital Signs: BP: _____/_____ P: _____ R: _____ T: _____

Height (stated): _____ Weight (stated): _____

Allergies: ☐ NKA ☐ Yes, describe allergen and response-

Latex Allergy: ☐ No ☐ Yes ☐ Unsure Dye Allergy: ☐ No ☐ Yes ☐ Unsure

Past Medical History (include pre-existing injuries): ☐ No history of health concerns reported

Past Surgical History: ☐ No surgical history reported ☐ Yes, describe

Current prescription and OTC medications: ☐ None ☐ Yes, list medication and date/time of last dose:

Patient Name

DOB

Case #

Initials: _____

Neurological/Coordination:

Level of Consciousness:

☐ Alert ☐ Somnolent but arousable ☐ Unconscious

Oriented to ☐ Person ☐ Place ☐ Time ☐ Situation

Gait: ☐ Steady ☐ Abnormal, describe _____

Cognition: ☐ No deficits noted ☐ Distracted ☐ Slow ☐ Confused

Mood / Affect: ☐ Tearful ☐ Distracted ☐ Slow ☐ Confused

☐ Avoids eye contact ☐ Fidgety ☐ Other _____

Glasgow Coma Score:

E: _____ V: _____ M: _____ Total: _____

Comments:

Best eye response (E)

Spontaneous opening - 4
Opens to command - 3
Opens to pain - 2
None - 1

Best verbal response (V)

Oriented- 5
Confused conversation but answers -4
Inappropriate responses-3
Incomprehensible speech - 2
None - 1

Best Motor response (M)

Obeys commands for movement- 6
Purposeful movement to painful stimulus-5
Withdraws from pain-4
Abnormal flexion, decorticate posture - 3
Extensor response, decerebrate posture- 2
None - 1

Reproductive Health – Circle Appropriate Stage

Female: Tanner Stage 1 (pre-pubertal no pubic hair - PH), Stage 2 (breast buds, minimal PH), Stage 3 (elevation of breast, dark coarse, curly PH), Stage 4 (areola forms, PH adult quality) Stage 5 (adult breast adult PH distribution)

Male: Tanner Stage 1 (pre-pubertal no pubic hair - PH), Stage 2 (enlargement of scrotum and testes), Stage 3 (enlargement of penis, further growth of testes), Stage 4 (increased size of penis, testes and scrotum larger, scrotum skin darker) Stage 5 (adult genitalia)

Gynecological History

Age of Menarche: _____ Last Menstrual Period: _____ Length: _____

Average number of days between periods: _____ ☐ Regular ☐ Irregular

Birth Control: ☐ None ☐ Yes, method: _____ For how long? _____

Hysterectomy?: ☐ No ☐ Yes Cervix removed? ☐ No ☐ Yes Cervix not removed? ☐ No ☐ Yes ☐ Unsure

Original Copy – Medical Records

DO NOT COPY/FORWARD MEDICAL RECORD TO LAW ENFORCEMENT OR OTHER DISCIPLINES

Patient Name

DOB

Case #

Obstetric History

Currently Pregnant? ☐ No ☐ Yes, EDC _____ ☐ Unsure

Pregnancy History: ☐ No History of pregnancy

of Pregnancies _____ # C-section: _____ #Vaginal Births: _____

Comments:

PRE-ASSAULT HISTORY

Are there any known medical conditions (bleeding or clotting Disorders, etc.) or current/recent physical injuries that may affect the interpretation of current findings? ☐ No ☐ Yes (describe)

Is there any history of anal or genital injuries, surgeries, diagnostic procedure, or medical treatment that may affect the interpretation of current physical findings? ☐ No ☐ Yes (describe)

Is there any history of anal or genital conditions(s) that may affect the interpretation of current physical findings? (e.g. UTI, constipation, ano-genital rashes, antibiotic use, etc.) ☐ No ☐ Yes (describe)

Did the patient experience ANAL or GENITAL pain and/or bleeding? ☐ Yes ☐ No ☐ Unsure

		1 (least) & 10 (worst)	
<input type="checkbox"/> N/A	Before assault	Pain Scale:	Bleeding <input type="checkbox"/> None <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy
<input type="checkbox"/> N/A	During assault	Pain Scale:	Bleeding <input type="checkbox"/> None <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy
<input type="checkbox"/> N/A	After assault	Pain Scale:	Bleeding <input type="checkbox"/> None <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy
<input type="checkbox"/> N/A	Currently	Pain Scale:	Bleeding <input type="checkbox"/> None <input type="checkbox"/> Light <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy

Describe location of pain / bleeding:

Before assault: _____

During assault: _____

After assault: _____

Currently: _____

Patient Name

DOB

Case #

Psychosocial

Suicidal Ideations: ☐ No ☐ Yes (If yes, when and document actions / referrals)

History of Self-harm: ☐ No ☐ Yes (If yes, when and document actions / referrals)

History of substance use: ☐ No ☐ Yes (If yes, when and document actions / referrals)

Does the patient have a safe place to go upon discharge? ☐ No ☐ Yes

Is there someone that can stay with patient upon D/C? ☐ No ☐ Yes

Tetanus:

Is tetanus vaccine up to date? ☐ Yes ☐ No ☐ Unsure

Hepatitis B Vaccine

Has patient ever received Hepatitis B Vaccine? ☐ Yes ☐ No ☐ Unsure

nPEP:

Risk assessment discussed? ☐ Yes ☐ No

Circle the applicable action below:

Referred for nPEP: ☐ Yes ☐ No

Declined: ☐ Yes ☐ No

nPEP given: ☐ Yes ☐ No (if yes, be sure to complete the CDC 2015 Recommended STI Medications on next page)

Was pregnancy test positive? ☐ Yes ☐ No (if yes, state where referred to)

Patient Name

DOB

Case #

Initials: _____

EMERGENCY CONTRACEPTION

Given?	Medication	Time Given	Initials	Pharmacy: Name and time called in OR Indicate prescription given
Yes No	Levonorgestrel 1.5 mg orally x1 dose (e.g. Plan B, My Way)	_____am _____pm		
Yes No	Other	_____am _____pm		

CDC 2021 RECOMMENDED STI MEDICATIONS

Given?	Medication CIRCLE THE MED GIVEN	Time Given	Initials	Pharmacy: Name and time called in OR Indicate prescription given
Yes No	Gonorrhea: Ceftriaxone (Rocephin) 500mg* IM in a single dose *1 gram if \geq 330 lbs	_____am _____pm		
Yes No	Chlamydia: Doxycycline 100 mg orally 2x a day for 7 days (do not give if pregnant)	_____am _____pm		
Yes No	Trichomonas Flagyl (Metronidazole) 500 mg orally 2x a day for 7 days	_____am _____pm		
Yes No	nPEP <input type="checkbox"/> 28 day starter pack <input type="checkbox"/> 3 to 4 day start			
Yes No	OTHER:	_____am _____pm		

Referrals made? ☐ Yes ☐ No (If yes, please describe below)

STI Follow up? ☐ Yes ☐ No (If yes, please describe)

Original Copy – Medical Records

DO NOT COPY/FORWARD MEDICAL RECORD TO LAW ENFORCEMENT OR OTHER DISCIPLINES

Case #

[illegible]

Signature of Forensic Examiner

DO NOT COPY/FORWARD MEDICAL RECORD TO LAW ENFORCEMENT OR OTHER DISCIPLINES

Case # _____

Patient Name_____
DOB_____
Case #_____

Page 2 of 12 **ADULT / ADOLESCENT FORENSIC EXAMINATION**

Has the patient had any consensual sexual relations in the last 5 days? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Name of consensual partner(s): _____ Buccal Swab Obtained? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If consensual sexual relations in the last 5 days was it:		
Vaginal	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Date(s) & time(s)
Oral	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Date(s) & time(s)
Anal	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Date(s) & time(s)
Condom use?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Date(s) & time(s)
Ejaculation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, location(s):

ASSAULT HISTORY

Date/Time of assault(s):

Location of Assault: (inside, outside, vehicle, workplace, etc.):

ASSAILANT INFORMATION

of Assailants: _____

Name(s) of Assailant	Gender	Age	Race/Ethnicity	Relationship to Victim
1.				
2.				
3.				

Did patient inflict injury upon assailant(s) during assault? ☐ No ☐ Yes ☐ Unsure

*If yes, describe injuries, location(s) on assailant's body & mechanism of injury. Collect swab samples under fingernails. If unsure describe reason:

Methods of control used by assailant(s)				If yes or unsure describe:
Use of weapons	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	
Physical force: (hit, push, restrain, held down)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	
Gagging	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	
Threats of Harm	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	
Binding or restraints	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	
Photos/video taken	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	
Other, describe	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	
Strangulation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	Strangulation assessment done? <input type="checkbox"/> Yes <input type="checkbox"/> No

Patient Name_____

DOB_____

Case #_____

Page 3 of 12 **ADULT / ADOLESCENT FORENSIC EXAMINATION****TOXICOLOGY: ALCOHOL AND DRUGS**

Voluntary/Involuntary ingestion of alcohol/drugs? Circle voluntary or involuntary	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	If, yes or unsure describe
Loss of memory?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	
Loss of consciousness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	
Drug Facilitated Sexual Assault Kit completed? <input type="checkbox"/> N/A <input type="checkbox"/> Yes, both blood and urine <input type="checkbox"/> Blood only <input type="checkbox"/> Urine only				
If urine only explain or if blood only explain: _____				
IF neither blood or urine collected, explain: <input type="checkbox"/> N/A <input type="checkbox"/> Declined <input type="checkbox"/> > 120 hours <input type="checkbox"/> Other_____				
*DFS kit is a separate item of evidence Expiration date of kit:				

ASSAULT DESCRIPTION:

DID ASSAILANT(S) PUT ANY OF THE BELOW IN OR ON PATIENT'S VAGINA?						Comment
Penis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> N/A	
Finger	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> N/A	
Mouth/Tongue	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> N/A	
Object (describe in comment box)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> N/A	
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> N/A	

FOR MALE PATIENT: DID ASSAILANT(S) TOUCH PATIENT'S PENIS WITH ANY OF THE BELOW?

FOR MALE PATIENT: DID ASSAILANT(S) TOUCH PATIENT'S PENIS WITH ANY OF THE BELOW?						Comment
Penis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> N/A	
Finger	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> N/A	
Mouth/Tongue	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> N/A	
Object (describe in comment box)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> N/A	
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> N/A	

DID ASSAILANT(S) PUT ANY OF THE BELOW IN OR ON PATIENT'S ANUS?

DID ASSAILANT(S) PUT ANY OF THE BELOW IN OR ON PATIENT'S ANUS?						Comment
Penis / Vagina circle	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> N/A	
Finger	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> N/A	
Mouth/Tongue	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> N/A	
Object	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> N/A	
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> N/A	

Initials_____Date_____

Original Copy – Medical Chart

Copy 2 – Law Enforcement

Copy 3 - Inside Crime Lab Envelope

Patient Name_____

DOB_____

Case #_____

Page 4 of 12 **ADULT / ADOLESCENT FORENSIC EXAMINATION**

DID ASSAILANT(S) PUT ANY OF THE BELOW IN OR ON PATIENT'S MOUTH?						Comments
Penis / Vagina CIRCLE	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> N/A	
Finger	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> N/A	
Anus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> N/A	
Vagina	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> N/A	
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> N/A	
Was the patient forced to put his/her mouth on assailant's penis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure Was the patient forced to put his/her mouth on assailant's anus? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure						

Did Ejaculation Occur?	<input type="checkbox"/> N/A			Comments (i.e. how many times and where)
Mouth	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	
Body surface	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	
On bedding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	
On clothing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	

Non-Genital Acts: Did assailant(s) use his/her mouth to do the following:				If yes, where on the body?
Licking	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	
Kissing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	
Suction injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	
Bite(s)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	
Other acts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	

Contraceptive or lubricant products used:				
Lubricant or spermicide used	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	If yes describe (lubrication, lotion, oil, saliva, etc.)
Condom used	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	
Location of condom if known	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	

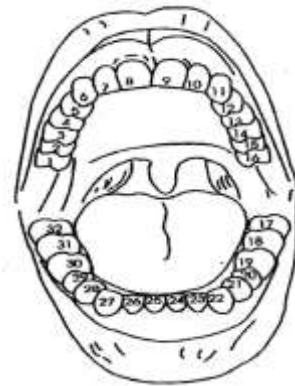
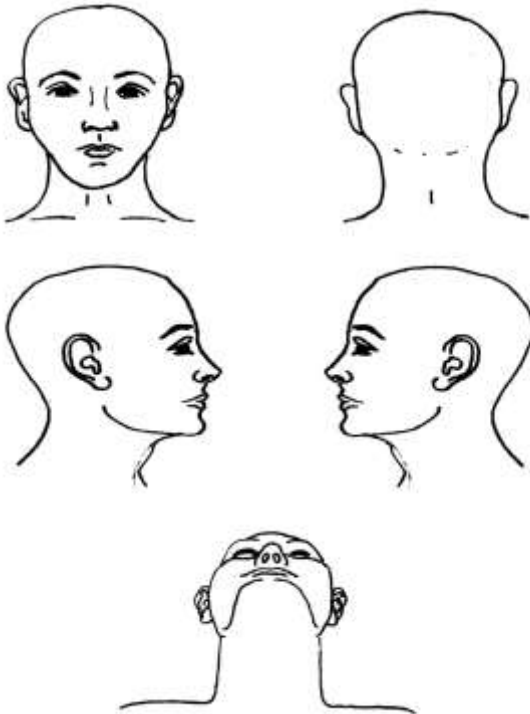
Patient Name _____

DOB _____

Case # _____

Page 5 of 12 **ADULT / ADOLESCENT FORENSIC EXAMINATION**

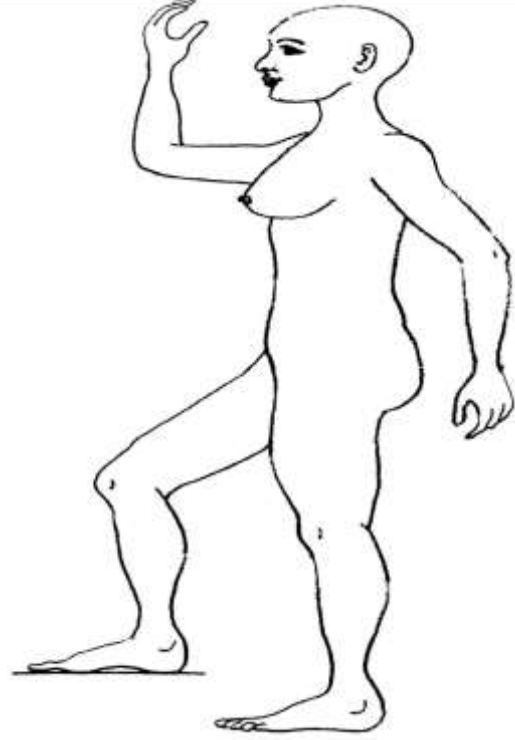
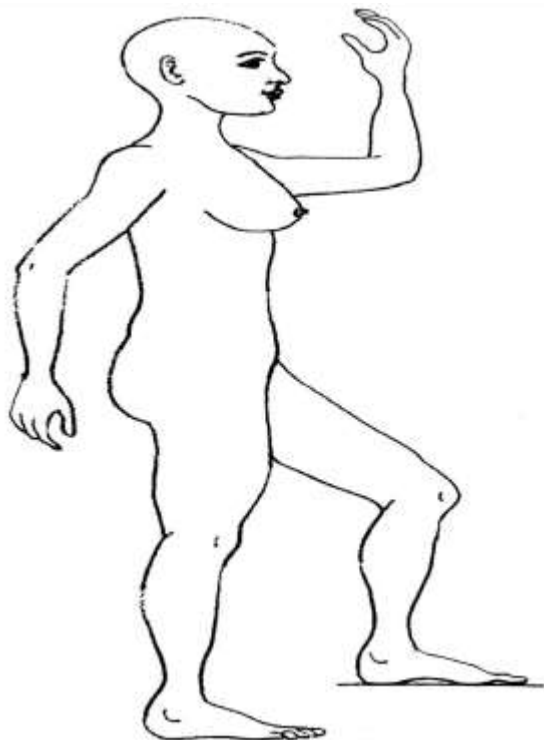
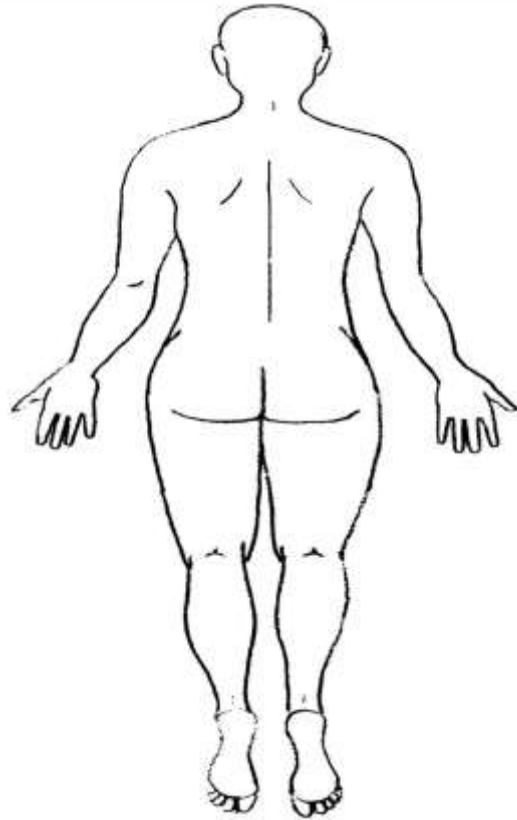
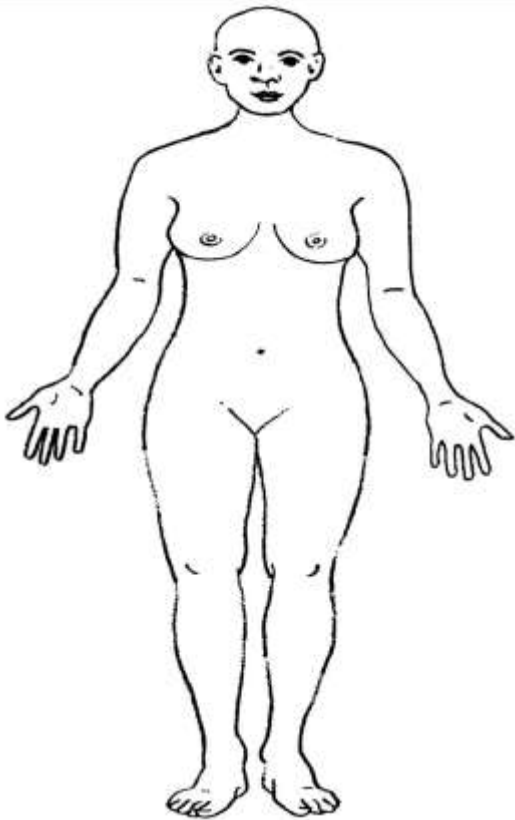
POST ASSAULT ACTIVITY							
Since assault has patient:			If yes, please note number of times	Since assault has patient:			If yes, please note number of times
Urinated	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Brushed teeth	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Bowel movement	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Rinsed mouth	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Showered	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Ate or drank	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Washed off/ wiped off	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Vomited	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Changed clothing	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Douched	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Changed underwear	<input type="checkbox"/> Yes	<input type="checkbox"/> No		Changed pad/tampon	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Other:				Other:			



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

Patient Name_____
DOB_____
Case #_____

Adult/Adolescent Body Diagram



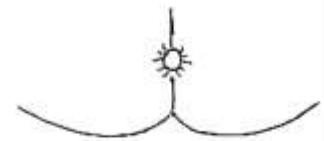
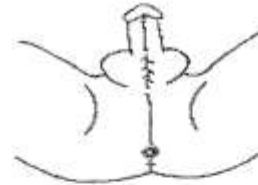
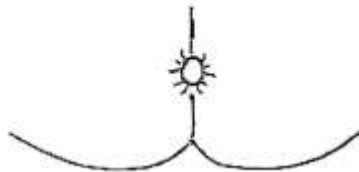
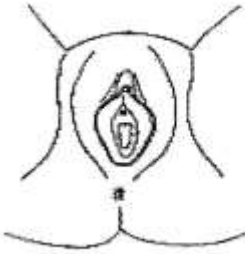
Patient Name _____

DOB _____

Case # _____

Page 7 of 12 **ADULT / ADOLESCENT FORENSIC EXAMINATION**

LEGEND: Types of Findings			
AB Abrasion	EC Ecchymosis (bruise)	MS Moist Secretion	SO Suction occurred
BI Bite	ER Erythema (redness)	OF Other Foreign	SW Swelling
BU Burn	F/H Fiber/Hair	Materials (describe)	TB Toluidine Blue⊕
CS Control Swab	FB Foreign Body	OI Other Injury (describe)	TE Tenderness
DE Debris	IN Induration	PE Petechiae	V/S Vegetation/Soil
DF Deformity	IW Incised Wound	PS Potential Saliva	WL Wood's Lamp⊕
DS Dry Secretion	LA Laceration	SHX Sample Per History	



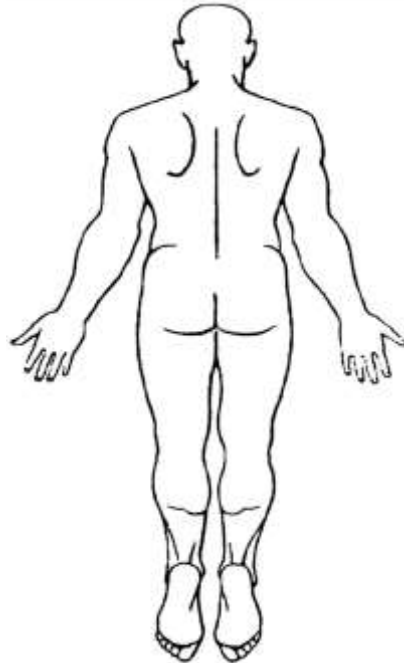
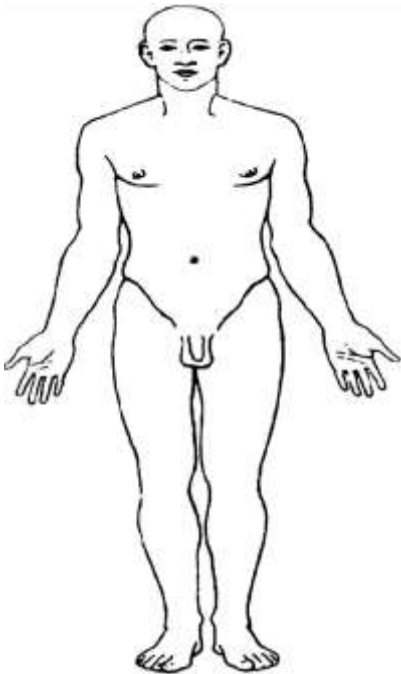
Initials _____ Date _____

Patient Name_____

DOB_____

Case #_____

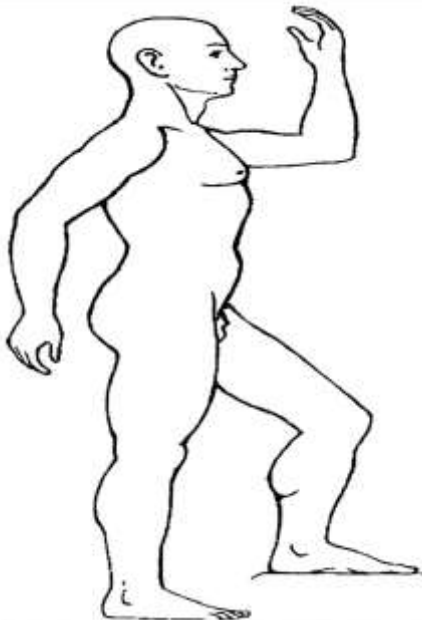
Page 8 of 12 **ADULT / ADOLESCENT FORENSIC EXAMINATION**



LEGEND: Types of Findings

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

COMMENTS:



Patient Name_____

DOB_____

Case #_____

Page 9 of 12 ADULT / ADOLESCENT FORENSIC EXAMINATION

CLOTHING COLLECTED

Item	When was the item worn?	Is the clothing / item wet?	Description (color, size, brand, condition, location of stains, etc.). Photo-document any relevant abnormalities.
1.	<input type="checkbox"/> time of assault <input type="checkbox"/> after assault	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2.	<input type="checkbox"/> time of assault <input type="checkbox"/> after assault	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3.	<input type="checkbox"/> time of assault <input type="checkbox"/> after assault	<input type="checkbox"/> Yes <input type="checkbox"/> No	
4.	<input type="checkbox"/> time of assault <input type="checkbox"/> after assault	<input type="checkbox"/> Yes <input type="checkbox"/> No	
5.	<input type="checkbox"/> time of assault <input type="checkbox"/> after assault	<input type="checkbox"/> Yes <input type="checkbox"/> No	
6.	<input type="checkbox"/> time of assault <input type="checkbox"/> after assault	<input type="checkbox"/> Yes <input type="checkbox"/> No	
7.	<input type="checkbox"/> time of assault <input type="checkbox"/> after assault	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8.	<input type="checkbox"/> time of assault <input type="checkbox"/> after assault	<input type="checkbox"/> Yes <input type="checkbox"/> No	
9.	<input type="checkbox"/> time of assault <input type="checkbox"/> after assault	<input type="checkbox"/> Yes <input type="checkbox"/> No	
10.	<input type="checkbox"/> time of assault <input type="checkbox"/> after assault	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Patient Name_____
DOB_____
Case #_____

Page 10 of 12 **ADULT / ADOLESCENT FORENSIC EXAMINATION**

SWABS COLLECTED

Number of swabs indicated below is the minimum number requested. If additional swabs are collected, note how many swabs taken in the notes section.

EVIDENTIARY SWABS COLLECTED – IF MORE SWABS OBTAINED, EXPLAIN IN NOTES			NOTES
Oral Swabs (oral assault) (2 dry swabs)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Buccal Swab (2 dry swabs)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Hands (1 swab per hand) Swab the entire palmar surface of each hand separately, and then package and label each envelope separately as left palm or right palm	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Fingernail Swabs (1 swab per hand) Swab the underside of the fingernails with a lightly moistened swab, unless the victim's history (scratching) indicates that nail clippings would yield additional DNA.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Pubic Hair Combing w/comb or If no hair = Mons pubis (2 lightly moistened swabs)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
External Genitalia (Vaginal Vestibule to include: labia minora, clitoris, hymen, fossa navicularis and posterior fourchette) (2 lightly moistened swabs)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Internal Genitalia – Vaginal & Cervical (Vaginal Vault Swabs, including posterior fornix, cervix/cervical os / if no cervix then vaginal cuff (2 dry swabs Vaginal, 2 dry swabs Cervical))	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Penis and scrotum (shaft, glans, under the foreskin & around the corona), and scrotum) (2 lightly moistened swabs) Avoid the urethra.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Peri-Anal/Anal Swabs (2 lightly moistened swabs)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Rectal Swabs (2 lightly moistened swabs)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Other (2 swabs)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Other (2 swabs)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Other (2 swabs)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
EVIDENTIARY SWABS COLLECTED – IF MORE SWABS OBTAINED, EXPLAIN:			

Case # _____

Camera Type: _____

[illegible]

Copy 3 - Inside Crime Lab Envelope

Case # _____