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

All Originals – Medical Record

Patient Name
DOB
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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
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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_____

Comments:

Glasgow Coma Score:

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

Best eye response (E)	**Best verbal response (V)**	**Best Motor response (M)**
Spontaneous opening - 4	Oriented- 5	Obeys commands for movement- 6
Opens to command – 3	Confused conversation but answers -4	Purposeful movement to painful stimulus-5
Opens to pain – 2	Inappropriate responses-3	Withdraws from pain-4
None - 1	In comprehensible speech – 2	Abnormal flexion, decorticate posture - 3
	None – 1	Extensor response, de-cerebrate 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)	
☐ **N/A**	Before assault	Pain Scale:	Bleeding ☐ None ☐ Light ☐ Moderate ☐ Heavy
☐ **N/A**	During assault	Pain Scale:	Bleeding ☐ None ☐ Light ☐ Moderate ☐ Heavy
☐ **N/A**	After assault	Pain Scale:	Bleeding ☐ None ☐ Light ☐ Moderate ☐ Heavy
☐ **N/A**	Currently	Pain Scale:	Bleeding ☐ None ☐ Light ☐ Moderate ☐ Heavy

Describe location of pain / bleeding:

Before assault:_____

During assault:_____

After assault:_____

Currently: _____

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Patient Name
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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 #

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 ***one gram IM if ≥ 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** ☐ 28 day starter pack ☐ 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

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Patient Name
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Case #

DISCHARGE SUMMARY

_____ _____

Forensic Examiner- Print Name **Signature of Forensic Examiner**

Original Copy – Medical Records

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Patient Name_____

DOB_____

Case #_____

 ADULT / ADOLESCENT FORENSIC EXAMINATION

Exam Date: **Exam Time:**
By birth: ☐ **Female** ☐ **Male** **Race:** ☐ Black ☐ White ☐ White/Hispanic ☐ Hispanic ☐ Other:
Primary language: ☐ English ☐ Spanish ☐ Creole ☐ Other:
Patient's address: **City/State/Zip**
Phone # **Interpreter used?** ☐ No ☐ Yes, record name and/or ID#
Crisis Center / Agency: **CASE #**

Patient's Description of Assault, use quotations for direct quotes

Narrative continued on additional pages: ☐ Yes ☐ No

Initials _____Date_____

Patient Name_____

DOB_____

Case #_____

 ADULT / ADOLESCENT FORENSIC EXAMINATION

Has the patient had any consensual sexual relations in the last 5 days? ☐ No ☐ Yes		
Name of consensual partner(s): _____Buccal Swab Obtained? ☐ Yes ☐ No		
If consensual sexual relations in the last 5 days was it:		
Vaginal	☐ Yes ☐ No	If Yes, Date(s) & time(s)
Oral	☐ Yes ☐ No	If Yes, Date(s) & time(s)
Anal	☐ Yes ☐ No	If Yes, Date(s) & time(s)
Condom use?	☐ Yes ☐ No	If Yes, Date(s) & time(s)
Ejaculation?	☐ Yes ☐ 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	☐ Yes	☐ No	☐ Unsure	
Physical force: (hit, push, restrain, held down)	☐ Yes	☐ No	☐ Unsure	
Gagging	☐ Yes	☐ No	☐ Unsure	
Threats of Harm	☐ Yes	☐ No	☐ Unsure	
Binding or restraints	☐ Yes	☐ No	☐ Unsure	
Photos/video taken	☐ Yes	☐ No	☐ Unsure	
Other, describe	☐ Yes	☐ No	☐ Unsure	
Strangulation	☐ Yes	☐ No	☐ Unsure	Strangulation assessment done? ☐ Yes ☐ No

Initials _____Date_____

Patient Name_____

DOB_____

Case #_____

 ADULT / ADOLESCENT FORENSIC EXAMINATION

TOXICOLOGY: ALCOHOL AND DRUGS				
Voluntary/Involuntary ingestion of alcohol/drugs? Circle voluntary or involuntary	☐ Yes	☐ No	☐ Unsure	If, yes or unsure describe
Loss of memory?	☐ Yes	☐ No	☐ Unsure	
Loss of consciousness?	☐ Yes	☐ No	☐ Unsure	

Drug Facilitated Sexual Assault Kit completed? ☐ N/A ☐ Yes, both blood and urine ☐ Blood only ☐ Urine only

If urine only explain or if blood only explain: _____

IF neither blood or urine collected, explain: ☐ N/A ☐ Declined ☐ > 120 hours ☐ Other_____

***DFSA 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	☐ Yes	☐ No	☐ Unsure	☐ Penetration Reported	☐ N/A	
Finger	☐ Yes	☐ No	☐ Unsure	☐ Penetration Reported	☐ N/A	
Mouth/Tongue	☐ Yes	☐ No	☐ Unsure	☐ Penetration Reported	☐ N/A	
Object (describe in comment box)	☐ Yes	☐ No	☐ Unsure	☐ Penetration Reported	☐ N/A	
Other	☐ Yes	☐ No	☐ Unsure	☐ Penetration Reported	☐ N/A	

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

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

Initials _____Date_____

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

Did Ejaculation Occur?	☐ **N/A**			
Mouth	☐ Yes	☐ No	☐ Unsure	Comments (i.e. **how many times and where**)
Body surface	☐ Yes	☐ No	☐ Unsure	
On bedding	☐ Yes	☐ No	☐ Unsure	
On clothing	☐ Yes	☐ No	☐ Unsure	
Other	☐ Yes	☐ No	☐ Unsure	

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

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

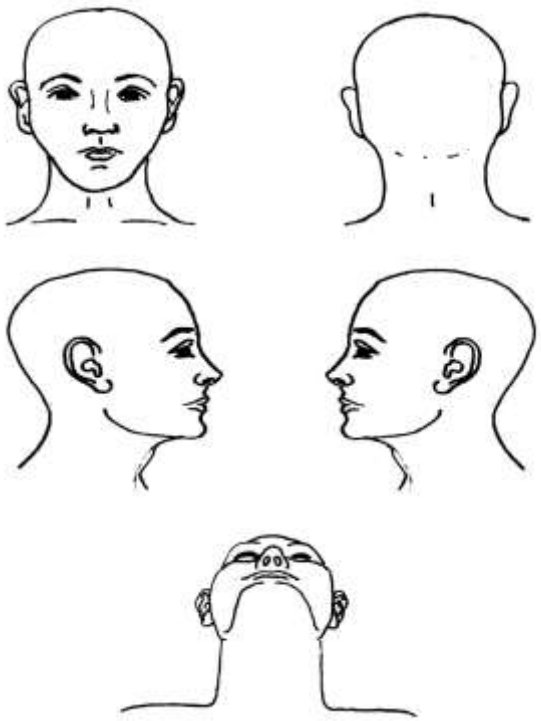
Patient Name_____

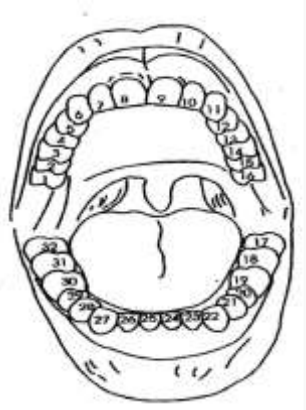
DOB_____

Case #_____

 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	☐ Yes	☐ No		Brushed teeth	☐ Yes	☐ No	
Bowel movement	☐ Yes	☐ No		Rinsed mouth	☐ Yes	☐ No	
Showered	☐ Yes	☐ No		Ate or drank	☐ Yes	☐ No	
Washed off/ wiped off	☐ Yes	☐ No		Vomited	☐ Yes	☐ No	
Changed clothing	☐ Yes	☐ No		Douched	☐ Yes	☐ No	
Changed underwear	☐ Yes	☐ No		Changed pad/tampon	☐ Yes	☐ 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	

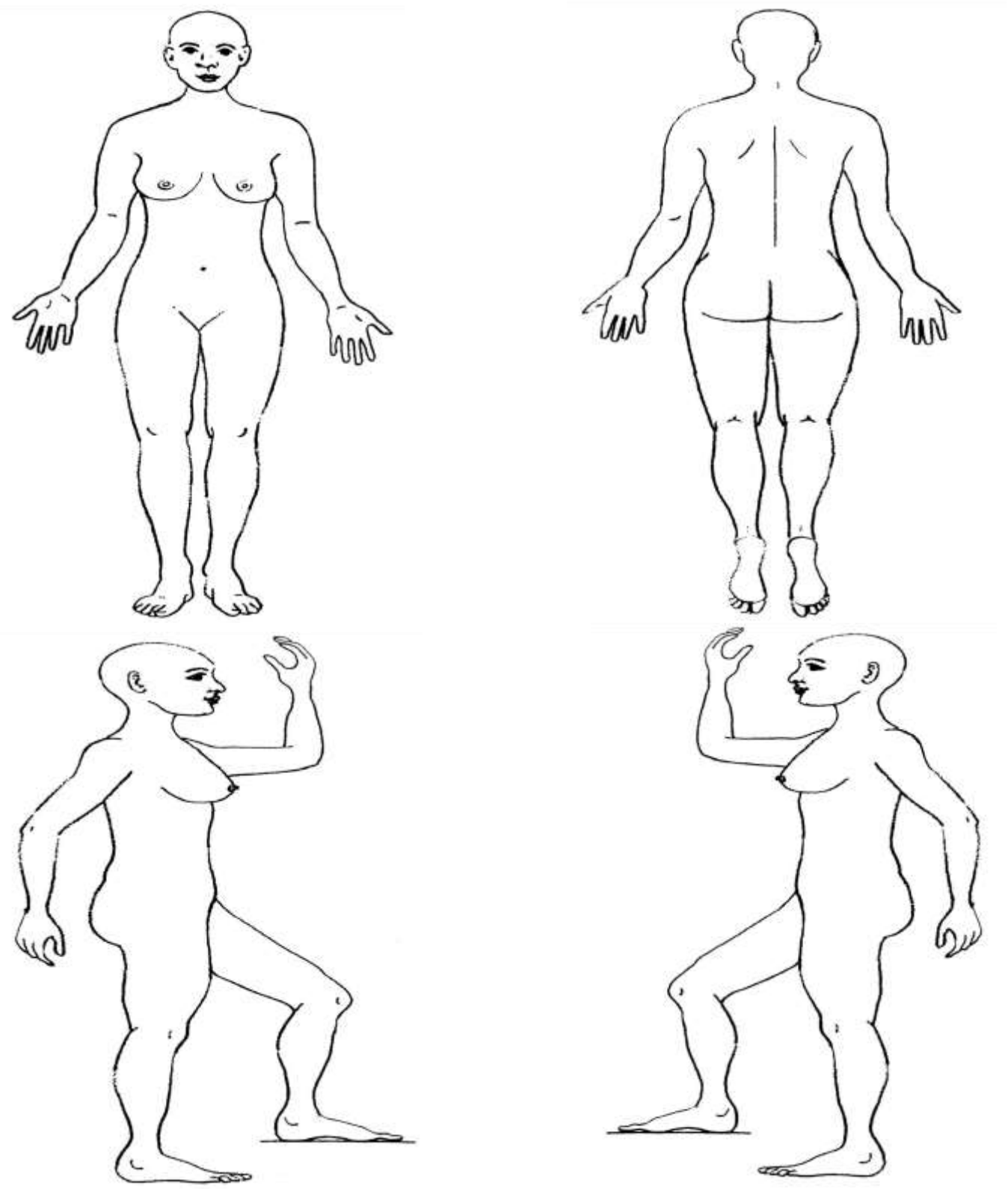
Initials _____Date_____

Patient Name_____

DOB_____

Case #_____

Adult/Adolescent Body Diagram



Initials _____Date_____

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 ADULT / ADOLESCENT FORENSIC EXAMINATION

LEGEND: Types of Findings			
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BI Bite	**ER** Erythema (redness)	**OF** Other Foreign Materials (describe)	**SW** Swelling
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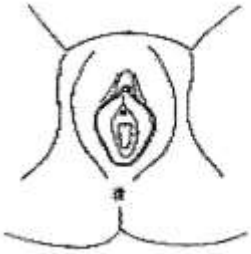

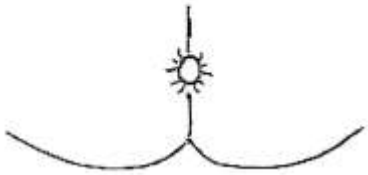

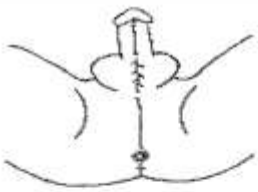

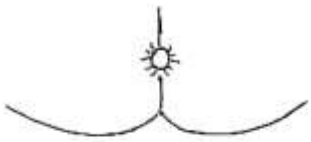

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Patient Name_____

DOB_____

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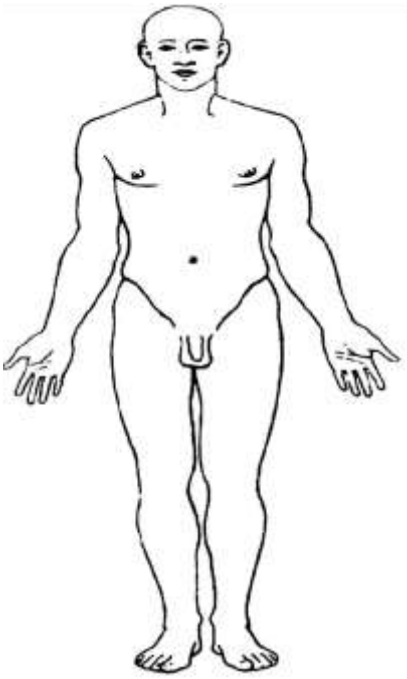
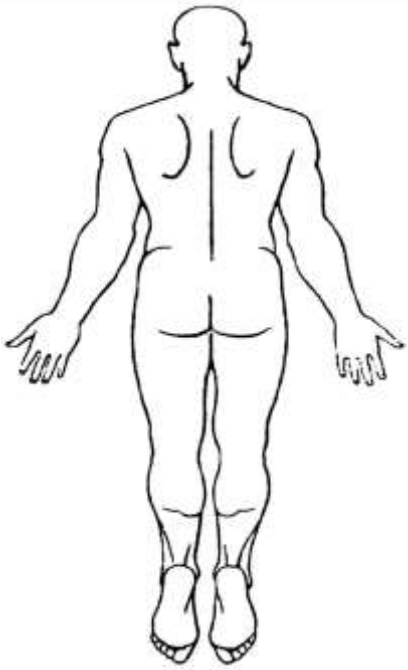
 ADULT / ADOLESCENT FORENSIC EXAMINATION





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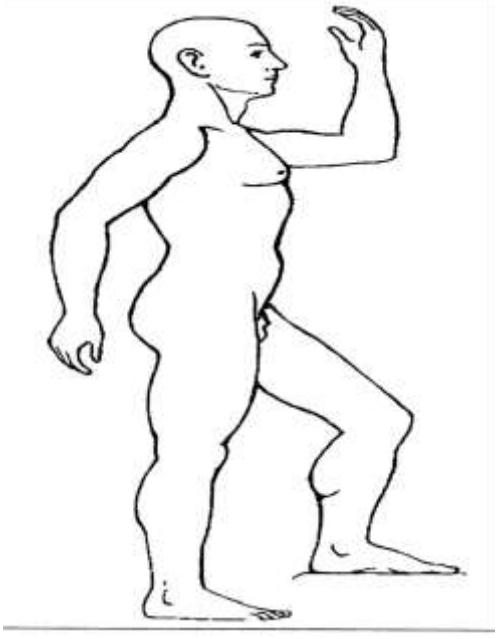
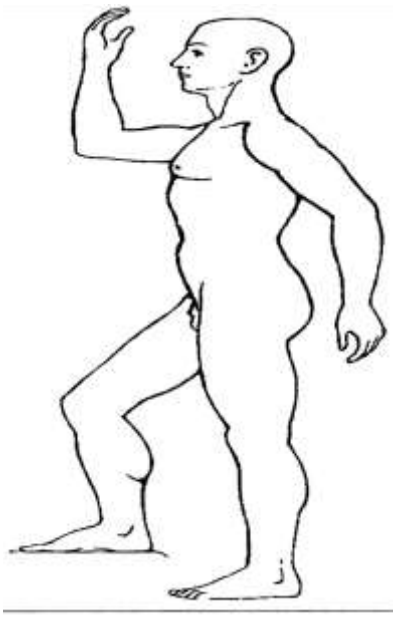
COMMENTS:





Initials _____Date_____

Patient Name_____

DOB_____

Case #_____

 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.	☐ **time of assault** ☐ **after assault**	☐ Yes ☐ No	
2.	☐ **time of assault** ☐ **after assault**	☐ Yes ☐ No	
3.	☐ **time of assault** ☐ **after assault**	☐ Yes ☐ No	
4.	☐ **time of assault** ☐ **after assault**	☐ Yes ☐ No	
5.	☐ **time of assault** ☐ **after assault**	☐ Yes ☐ No	
6.	☐ **time of assault** ☐ **after assault**	☐ Yes ☐ No	
7.	☐ **time of assault** ☐ **after assault**	☐ Yes ☐ No	
8.	☐ **time of assault** ☐ **after assault**	☐ Yes ☐ No	
9.	☐ **time of assault** ☐ **after assault**	☐ Yes ☐ No	
10.	☐ **time of assault** ☐ **after assault**	☐ Yes ☐ No	

Initials _____Date_____

Patient Name_____

DOB_____

Case #_____

 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)	☐ Yes	☐ No	
Buccal Swab (2 dry swabs)	☐ Yes	☐ 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	☐ Yes	☐ 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.	☐ Yes	☐ No	
Pubic Hair Combings w/comb or If no hair = Mons pubis (2 lightly moistened swabs)	☐ Yes	☐ No	
External Genitalia (Vaginal Vestibule to include: labia minora, clitoris, hymen, fossa navicularis and posterior fourchette) (2 lightly moistened swabs)	☐ Yes	☐ 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)	☐ Yes	☐ No	
Penis and scrotum (shaft, glans, under the foreskin & around the corona), and scrotum) (2 lightly moistened swabs) Avoid the urethra.	☐ Yes	☐ No	
Peri-Anal/Anal Swabs (2 lightly moistened swabs)	☐ Yes	☐ No	
Rectal Swabs (2 lightly moistened swabs)	☐ Yes	☐ No	
Other (2 swabs)	☐ Yes	☐ No	
Other (2 swabs)	☐ Yes	☐ No	
Other (2 swabs)	☐ Yes	☐ No	
EVIDENTIARY SWABS COLLECTED – IF MORE SWABS OBTAINED, EXPLAIN:			

Initials _____Date_____

Patient Name_____

DOB_____

Case #_____

 ADULT / ADOLESCENT FORENSIC EXAMINATION

PHOTOS TAKEN? ☐ **Yes** ☐ **No** **Total number of photos taken: _____**

Camera Type: _____

Injury #	**Photo #**	**Location of Injury/Photo**	**Description of Injury/Photo**
N/A	1	N/A	Label /Case Identification Card / patient photo

Photo documentation continued on additional pages: ☐ Yes ☐ No

Initials _____Date_____

Patient Name_____

DOB_____

Case #_____

Evidence Item Received:	**Yes**	**No**	**Comments** *N/I = not indicated
S/A kit			
DFSA kit			
Photographs:			
CD			
Other:			
Clothing:			
Shirt/top			
Pants/shorts			
Underwear			
Bra			
Jacket/coat			
Shoes			
Other:			
Other:			

TRANSFER OF EVIDENCE/CHAIN OF CUSTODY FORM

On _____ at _____ am/pm,
(date) (time)

_____ of the _____,
(police officer/detective) (agency name)

assumed custody of the following items of evidence:

Damp/ Wet Item (description): _____

_____ I verify that the status of the above item was provided to me.
(initial)

Received From: _____
(Examiner's printed name)

Date/Time: _____Signature:_____

Received By: _____
(LEO printed name)

Date/Time:_____Signature:_____

Initials _____Date_____