

Sexual Assault Forensic/Medical Exam Documentation Revised 9/2024

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 or other disciplines
- **Forensic Examination form** – 11 Pages – Make 2 copies - Copy 1 to Law Enforcement, Copy 2 Inside the Kit Envelope
- **Chain of Custody form** - 1 page - Make 1 copy - Copy to Law Enforcement. DOES NOT need to be placed in kit.

**PLEASE COMPLETE ELECTRONICALLY OR PRINT
LEGIBLY**

**Start the kit tracking by entering the barcoded kit # at
<https://fl.track-kit.us/login>**

Give the tracking database access card to the victim/
patient.

Attach the extra barcode stickers to Pg-1 of the
Consent form, Pg-1 of the Medical History form
and Pg-1 of the Forensic Examination form.

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

Affix kit barcode sticker here

Patient Name	Date & Time	Case #
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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):

- _____ Head to toes examination with visual inspection of injuries and possible areas of assault including the mouth, the genitalia and the anus.
- _____ Photographic documentation of any injuries including area of the mouth, genitalia, and anus.
- _____ 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.
- _____ 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.
- _____ Collection of blood and urine for laboratory testing of possible drug facilitated assault.
- _____ Administration of medication for prevention of infection and/or pregnancy.
- _____ Provide first aid treatment to any superficial injuries.
- _____ Provide information for follow-up testing for the diagnosis of HIV and sexually transmitted infections at the Health Department.
- _____ Provide follow up communications from advocates and/or counselors.

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

SKIP SECTION BELOW WHEN REPORT HAS BEEN MADE TO LAW ENFORCEMENT

I consent to the above statements at this time **BUT** would **not** like to report to law enforcement. I understand that the **sexual assault evidence kit** will be held for 50 years, as indicated in F.S. 943.326, and that delaying the report could result in the statute of limitations expiring.

Other potential evidence collected will be held for _____months* until/if I decide to report to law enforcement.

For **other potential evidence** held, at the end of that period:

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

If Yes, then how? Letter _____

Telephone _____

Email _____

Text _____

Can a message be left at the specified number? Yes ☐ No ☐

*Timeframe determined by community service providers or law enforcement agency storing the other potential evidence.

Patient- Print Name

Patient- Signature

Date/Time

SANE/Forensic Examiner – Print Name

SANE/Forensic Examiner- Signature

Date/Time

Affix kit barcode sticker here

Patient Name

DOB

Case #

Page 1 of 6 ADULT / ADOLESCENT Medical History / Initial Assessment

Examiner 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:

Original Copy – Medical Records

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

Patient Name

DOB

Case #

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 – Select 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 Unsure

Original Copy – Medical Records

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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 PATIENT EXPERIENCE ANY PAIN OR BLEEDING?

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

Select the applicable action below:

Referred for nPEP: ☐ Yes ☐ No

Declined: ☐ Yes ☐ No

nPEP given: ☐ Yes ☐ No (if yes, be sure to complete the CDC 2021 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 po (e.g. Plan B, My Way)	_____am _____pm		
Yes No	Other:	_____am _____pm		

CDC 2021 RECOMMENDED STI MEDICATIONS

Given?	Medication	Time Given	Initials	Pharmacy: Name and time called in OR Indicate prescription given
Yes No	Gonorrhea: Ceftriaxone (Rocephin) 500mg* IM in a single dose *give 1 gm IM if >330 lbs; if >165 lbs counsel patient, may not be effective	_____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 - females only w/ a vaginal assault Flagyl (Metronidazole) 500 mg 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

Affix kit barcode sticker here

Patient Name_____

DOB_____

Case #_____

Page 1 of 11 **ADULT / ADOLESCENT FORENSIC EXAMINATION**

Examiner initial and date the bottom of each page where indicated.

Exam Date:	Exam Time:	Collecting Agency Name:
By birth: <input type="checkbox"/> Female <input type="checkbox"/> Male Race: <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> White/Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Other:		
Primary language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Creole <input type="checkbox"/> Other:		
Patient's address:		City/State/Zip
Phone #	Interpreter used? <input type="checkbox"/> No <input type="checkbox"/> Yes, record name and/or ID#	
CRCC (Advocacy agency):		

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

Narrative continued on additional pages: ☐ Yes ☐ No

Examiner's Name:
(Please Print)

Initials _____ Date _____

Original Copy – Medical Chart

Copy 2 – Law Enforcement

Copy 3 - Inside Crime Lab Envelope

Patient Name _____
 DOB _____
 Case # _____

Page 2 of 11 **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): _____		Cons. Part. Buccal Obtained? <input type="checkbox"/> Yes <input type="checkbox"/> No
If consensual sexual relations in the last 5 days was it:		Consensual Partner Gender at Birth: M F
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 11 **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 the assailant(s) put any of the below body parts or objects 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 the assailant(s) touch patient's penis with any of the below body parts or objects?

For MALE Patient: Did the assailant(s) touch patient's penis with any of the below body parts or objects?						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 the assailant(s) put any of the below body parts or objects in or on patient's anus?

Did the assailant(s) put any of the below body parts or objects 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_____

Patient Name_____

DOB_____

Case #_____

Page 4 of 11 ADULT / ADOLESCENT FORENSIC EXAMINATION

Did the assailant(s) put any of the below body parts or objects 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						

Was ejaculation observed?	<input type="checkbox"/> N/A			Comments (i.e. how many times and where)
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 _____

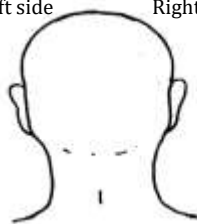
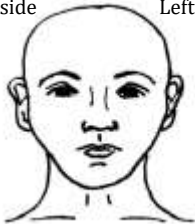
DOB _____

Case # _____

Page 5 of 11 **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:			

Right side Left side Left side Right side



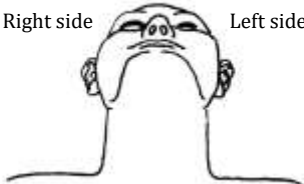
Right side

Left side



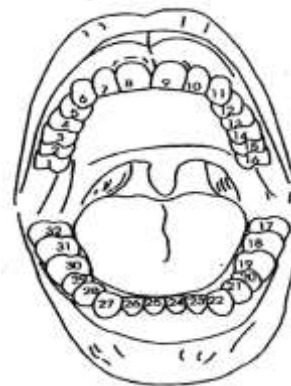
Right side

Left side



Right side

Left side

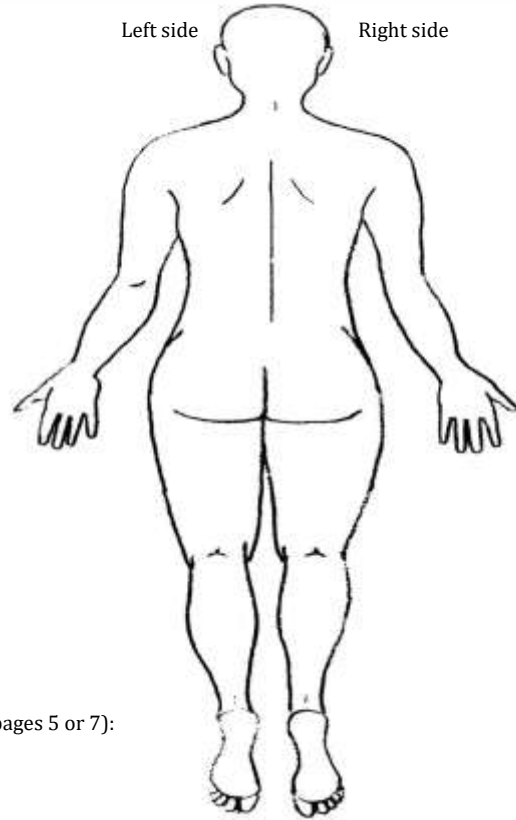
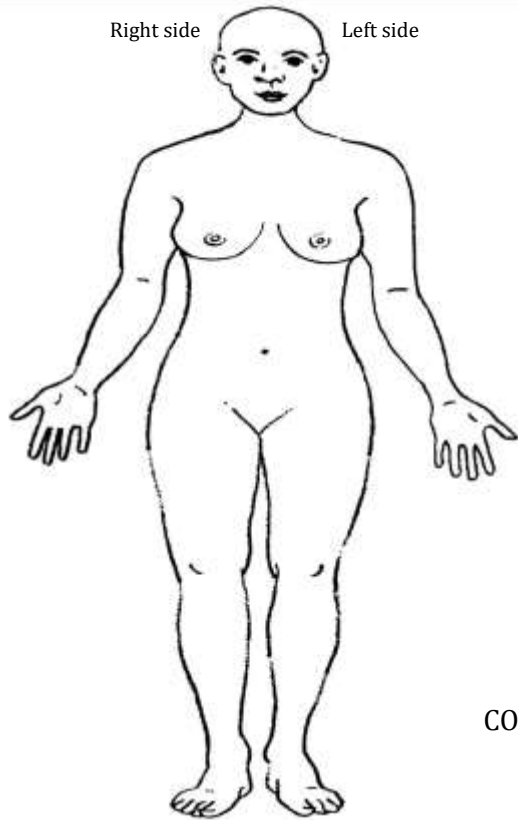


COMMENTS:

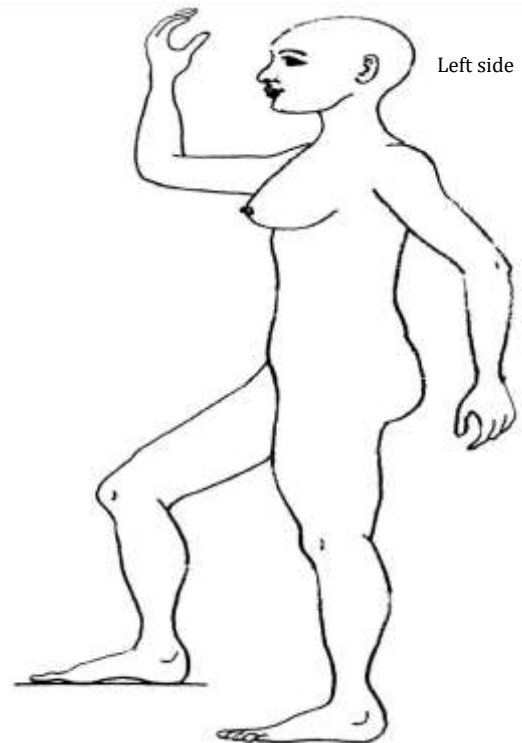
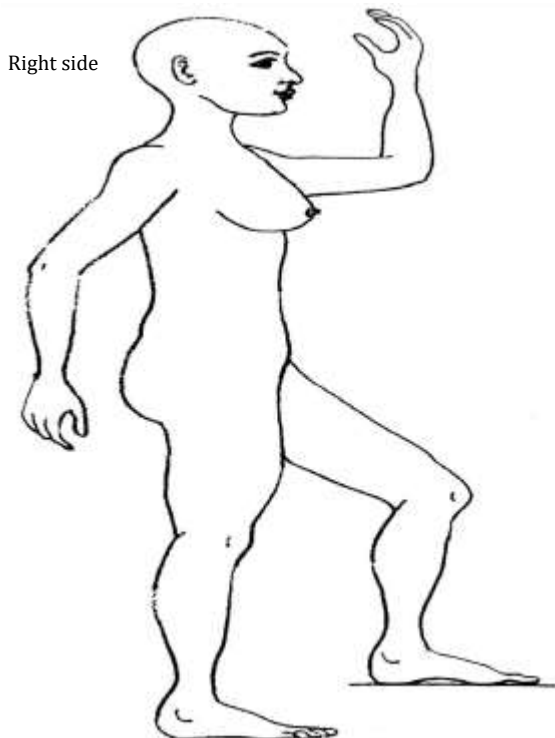
LEGEND: Types of Findings			
AB Abrasion Occurred	EC Ecchymosis (bruise)	MS Moist Secretion	SO Suction
BI Bite	ER Erythema (redness)	OF Other Foreign Materials (describe)	SW Swelling
BU Burn	F/H Fiber/Hair		TB Toluidine Blue⊕
CS Control Swab	FB Foreign Body	OI Other Injury (describe)	TE Tenderness
DE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

Patient Name	_____
DOB	_____
Case #	_____

Adult/Adolescent Body Diagram



COMMENTS (see legend pages 5 or 7):



Patient Name _____

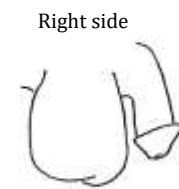
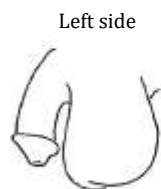
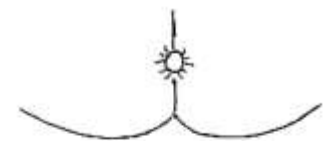
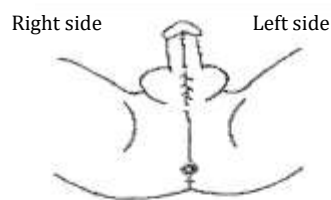
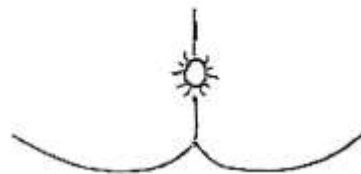
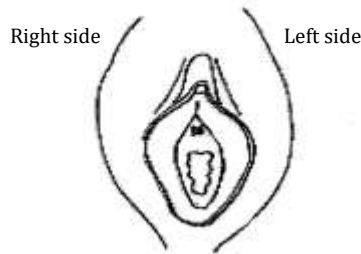
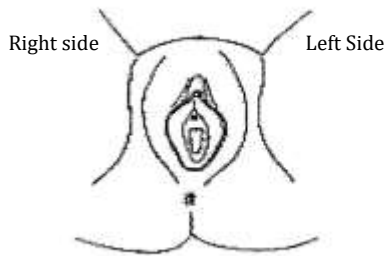
DOB _____

Case # _____

Page 7 of 11 **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:



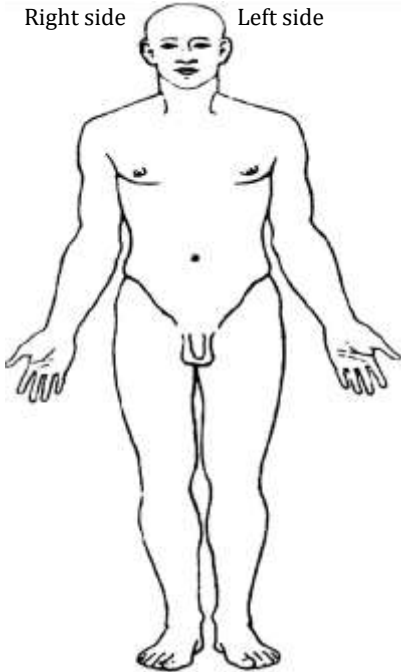
Patient Name_____

DOB_____

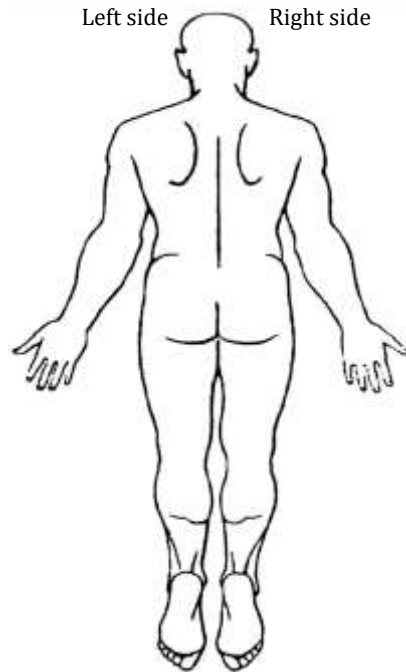
Case #_____

Page 8 of 11 **ADULT / ADOLESCENT FORENSIC EXAMINATION**

Right side Left side



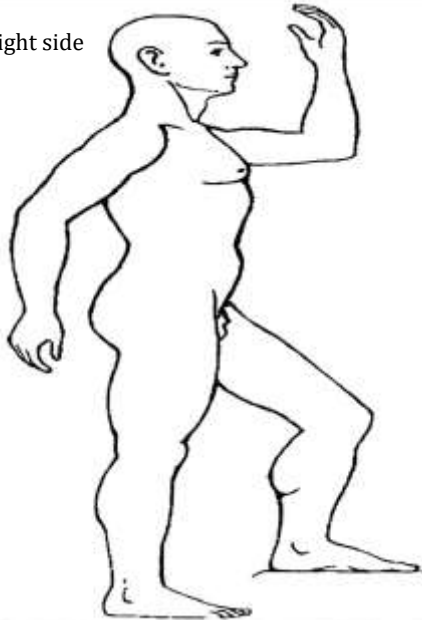
Left side Right side



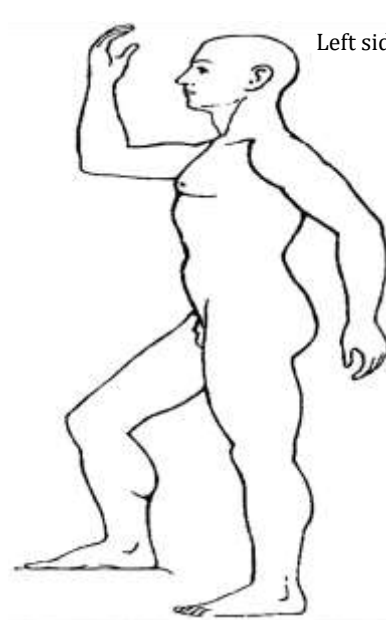
COMMENTS:

LEGEND: Types of Findings			
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DS Dry Secretion	LA Laceration	SHX Sample Per History	

Right side



Left side



Case # _____

Copy 3 - Inside Crime Lab Envelope

Patient Name_____
DOB_____
Case #_____

CLOTHING COLLECTED

Item, e.g. shirt, pants, etc.	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	Yes No	
2.	<input type="checkbox"/> time of assault <input type="checkbox"/> after assault	Yes No	
3.	<input type="checkbox"/> time of assault <input type="checkbox"/> after assault	Yes No	
4.	<input type="checkbox"/> time of assault <input type="checkbox"/> after assault	Yes No	
5.	<input type="checkbox"/> time of assault <input type="checkbox"/> after assault	Yes No	
6.	<input type="checkbox"/> time of assault <input type="checkbox"/> after assault	Yes No	
7.	<input type="checkbox"/> time of assault <input type="checkbox"/> after assault	Yes No	
8.	<input type="checkbox"/> time of assault <input type="checkbox"/> after assault	Yes No	
9.	<input type="checkbox"/> time of assault <input type="checkbox"/> after assault	Yes No	
10.	<input type="checkbox"/> time of assault <input type="checkbox"/> after assault	Yes No	

Patient Name_____
DOB_____
Case #_____

SWABS/SAMPLES 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 SAMPLES COLLECTED – IF MORE SWABS OBTAINED, EXPLAIN IN NOTES	Swabs collected? Select one	# of Swabs collected	NOTES
Oral Swabs (oral assault) (2 dry swabs). After obtained, patient to rinse out mouth; wait 10-15 minutes before obtaining Buccal Swab	Yes No		
Buccal Swab (2 dry swabs) ALWAYS COLLECT	Yes No		
Palms of 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		
Fingernails (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 Combing w/comb or If no hair, swab the 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 – left and right vaginal walls (2 dry swabs)	Yes No		
Internal Genitalia – Cervical, vaginal vault, posterior fornix, cervix/cervical os / if no cervix then swab vaginal cuff (2 dry swabs)	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:			

Patient Name_____

DOB_____

Case #_____

TRANSFER OF EVIDENCE/CHAIN OF CUSTODY FORM

Evidence Item(s) Received:	Yes	No	Comments:	Indicate if Wet/Damp
SAE kit				
DFSA kit				
Photographs:				
CD				
Other:				
Clothing:				
Shirt/top				
Pants/shorts				
Underwear				
Bra				
Jacket/coat				
Shoes				
Other:				
Other:				

Evidence Collected By (print):_____

Date/Time:_____ Signature:_____

Evidence Received From:_____
(Printed name)

Date/Time:_____ Signature:_____

Received By: _____
(LEO printed name)

Date/Time:_____ Signature:_____