Sexual Assault Forensic/Medical Exam Documentation Revised 1/2025

This file contains the following forms:

- **Consent form** – 2 Pages – Maintained as part of the Medical Record
- **Medical History/ Initial Assessment form** – 7 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	Law Enforcement (LE) Case #

I, _____, freely consent to a forensic medical examination conducted by a medical professional 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 choose to report this crime, 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, and the sexual assault evidence kit will be submitted to a laboratory for testing as described in F.S. 943.326. Collection of other specimens and/or samples for laboratory analysis may be conducted per the events reported.

If I choose **not** to report this crime, the forensic exam paperwork will not be provided to any criminal justice agency and any potential evidence will not undergo testing. See additional information in the box on page 2 of the consent form.

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 medical-forensic 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 toe examination with visual inspection of injuries and possible areas of assault including the mouth, the genitalia and the anus.

☐ _____Swabbing of the body, including skin, mouth, genitalia, and the anus for any potential evidence that may be present.

☐ _____Photographic documentation of any injuries including area of the mouth, genitalia, and anus.

☐ _____Photos will become part of the official record of this case. 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, such as peer/chart review within the agency. At no time will a name or any other identifying structure be associated with the 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.

☐ _____Provide follow up communications from advocates and/or counselors.

☐ _____Shadowing of the examination by qualified examiner and / or victim advocate (if applicable).

Examiner Initials: _____ Date: _____

All Originals – Medical Record

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 s**exual 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

_____ _____

Legal Guardian/Parent- Print Name Legal Guardian/Parent - Signature

_____ _____

Date/Time Relationship to Patient

_____ _____

SANE/Forensic Examiner – Print Name SANE/Forensic Examiner- Signature

_____

Date/Time

All Originals – Medical Record

Patient Name

DOB

LE Case #

MEDICAL EXAM ORGANIZATION NAME_____

DATE OF EXAM _____

DEMOGRAPHIC INFORMATION:

Gender at birth: ☐ 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

Tetanus:

Is tetanus vaccine up to date?

☐ Yes ☐ No ☐ Unsure

Hepatits B Vaccine:

Has patient ever received Hepatitis B Vaccine?

☐ Yes ☐ No ☐ Unsure

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

_____

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

_____

Examiner Initials: _____

Original Copy – Medical Records

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

Patient Name

DOB

LE Case #

Reproductive Health – Document Appropriate Stage

Female Tanner Stage: _____

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: _____

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)

Pubic Hair Shaved? ☐ **Yes** ☐ **No**

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? _____

Gyn Surgical History:_____

Obstetric History

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

Pregnancy History: ☐ No History of pregnancy

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

Comments/Complications: _____

Medications

Current prescription and OTC Medications	**Date / Time of last dose**

Examiner Initials: _____

Original Copy – Medical Records

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Psychosocial

Suicide Risk Assessment (Columbia Protocol)

Always ask questions 1 and 2.	**YES**	**NO**
1. Have you wished you were dead or wished you could go to sleep and not wake up?	☐	☐
2. Have you actually had any thoughts about killing yourself? **If YES to 2, ask questions 3, 4, 5, and 6.** **If NO to 2, skip to question 6.**	☐	☐
3. Have you been thinking about how you might do this?	☐	☐
4. Have you had these thoughts and had some intention of acting on them?	☐	☐
5. Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?	☐	☐

Always ask question 6.	**YES**	**NO**
6. Have you done anything, started to do anything, or prepared to do anything to end your life? Examples: Took pills, tried to shoot yourself, cut yourself, tried to hang yourself, went to the roof but didn't jump, collected pills, obtained a gun, wrote a suicide note, etc. If yes, was this within the past 3 months?	☐	☐

If YES to 2 or 3, seek behavioral healthcare for further evaluation. If the answer to 4, 5, or 6 is YES, get immediate help: Call or text 988, call 911, or go to an emergency room. STAY WITH THEM until they can be evaluated.

Human Trafficking Screening (Rapid Appraisal for Trafficking)

	YES	**NO**
1. It is not uncommon for people to stay in work situations that are risky or even dangerous, simply because they have no other options. Have you ever worked, or done other things, in a place that made you feel scared or unsafe?	☐	☐
2. In thinking back over your past experience, have you ever been tricked or forced into doing any kind of work that you did not want to do?	☐	☐
3. Sometimes people are prevented from leaving an unfair or unsafe work situation by their employers. Have you ever been afraid to leave or quit a work situation due to fears of violence or threats of harm to yourself or your family?	☐	☐
4. Have you ever received anything in exchange for sex (for example, a place to stay, gifts, or food)?	☐	☐

If YES to any of the four questions, there is a potential need for further evaluation regarding human trafficking concerns based on your agency policies.

Patient Name
DOB
LE Case #

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

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)

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

DID PATIENT EXPERIENCE ANY PAIN OR BLEEDING?

		1 (least) & 10 (worst)	BLEEDING
☐ **N/A**	Before assault	Pain Scale:	☐ None ☐ Light ☐ Moderate ☐ Heavy
☐ **N/A**	During assault	Pain Scale:	☐ None ☐ Light ☐ Moderate ☐ Heavy
☐ **N/A**	After assault	Pain Scale:	☐ None ☐ Light ☐ Moderate ☐ Heavy
☐ **N/A**	Currently	Pain Scale:	☐ None ☐ Light ☐ Moderate ☐ Heavy

Describe location of pain / bleeding (include description of bleeding – clots, amount/size, comparison):

Before assault:_____

During assault:_____

After assault:_____

Currently: _____

Examiner Initials: _____

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Patient Name

DOB

LE 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 _____

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

Pregnancy Test:

☐ **Positive** ☐ **Negative** ☐ **Not Done**

Comments: _____

nPEP:

Risk assessment discussed? ☐ Yes ☐ No

Comments:

Select the applicable action below:

nPEP given:	☐ Yes	☐ No
Referred for nPEP:	☐ Yes	☐ No
Declined:	☐ Yes	☐ No
Not indicated:	☐ Yes	☐ No

Original Copy – Medical Records

Examiner Initials: _____

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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) if patient >165 lbs counsel, may not be effective.	_____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.	_____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** ☐ 28 day starter ☐ pack 3 to 4 day starter pack			
☐ Yes ☐ No	OTHER:	_____am _____pm		
☐ Yes ☐ No	OTHER:	_____am _____pm		
☐ Yes ☐ No	OTHER:	_____am _____pm		

Examiner Initials: _____

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Patient Name
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Referrals made? ☐ Yes ☐ No (If yes, please describe below)
STI Follow up? ☐ **Yes** ☐ **No** (If yes, please describe)

DISCHARGE SUMMARY:
ADDITIONAL NURSES NOTES:

Forensic Examiner- Print Name

Signature of Forensic Examiner

Original Copy – Medical Records

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Affix kit barcode sticker here

Patient Name
D OB
LE Case #

Exam Date:	**Exam Time:**	**Medical Exam Agency Name**:
Gender at 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#	
CRCC (Advocacy agency):		

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

Narrative continued on additional pages: ☐ Yes ☐ No

Examiner Initials: _____

Patient Name
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Has the patient had any consensual sexual relations in the last 5 days? ☐ No ☐ Yes			
Name of consensual partner(s): _____ **Partner's Buccal Swab Obtained?** ☐ Yes ☐ No			
If consensual sexual relations in the last 5 days was it:			Consensual Partner Gender at Birth: ☐ M ☐ F
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

Examiner Initials: _____

Patient Name
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TOXICOLOGY: ALCOHOL AND DRUGS				
Voluntary/Involuntary ingestion of alcohol/drugs? _ ☐ Voluntary ☐ Involuntary	☐ Yes	☐ No	☐ 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 the assailant(s) put any of the below body parts or objects in or on patient's genitals?						Comment
Penis	☐ Yes	☐ No	☐ Unsure	☐ Penetration Reported	☐ N/A	
Vagina	☐ 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 the assailant(s) put any of the below body parts or objects in or on patient's anus?						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	☐ Yes	☐ No	☐ Unsure	☐ Penetration Reported	☐ N/A	
Other	☐ Yes	☐ No	☐ Unsure	☐ Penetration Reported	☐ N/A	
Did the assailant(s) put any of the below body parts or objects in or on patient's mouth?						Comment
Penis	☐ Yes	☐ No	☐ Unsure	☐ Penetration Reported	☐ N/A	
Vagina	☐ Yes	☐ No	☐ Unsure	☐ Penetration Reported	☐ N/A	
Finger	☐ Yes	☐ No	☐ Unsure	☐ Penetration Reported	☐ N/A	
Anus	☐ Yes	☐ No	☐ Unsure	☐ Penetration Reported	☐ N/A	
Other	☐ Yes	☐ No	☐ Unsure	☐ Penetration Reported	☐ N/A	

Examiner Initials: _____

Patient Name
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Was ejaculation observed?	☐ **N/A**			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				If yes describe (lubrication, lotion, oil, saliva, etc.)
Lubricant or spermicide used	☐ Yes	☐ No	☐ Unsure	
Condom used	☐ Yes	☐ No	☐ Unsure	
Location of condom if known	☐ Yes	☐ No	☐ N/A	

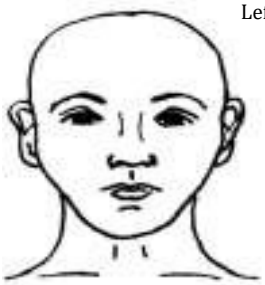
POST ASSAULT ACTIVITY							
Since assault has patient:			**If yes, please note number of times**	**Since assault has patient:**			**If yes, please note number of times**
Urinated	☐ Yes	☐ No		Brushed teeth	☐ Yes	☐ No	
Bowel movement	☐ Yes	☐ No		Rinsed mouth	☐ Yes	☐ No	
Showered	☐ Yes	☐ No		Ate or drank	☐ 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:			

Examiner Initials: _____

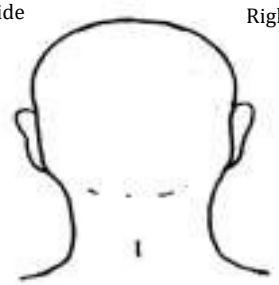
Patient Name
DOB
Case #

Facial/Mouth Diagram

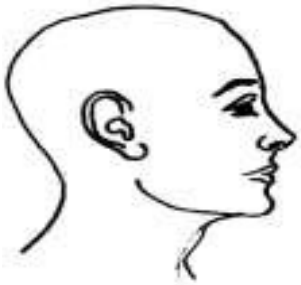
Right Side Left Side



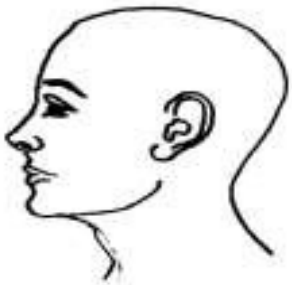
Left Side Right Side



Right Side

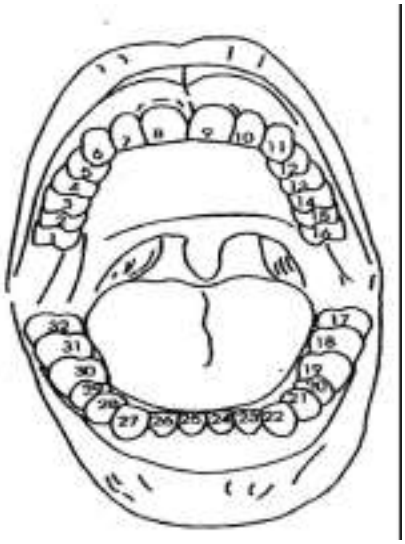


Left Side



Right Side Left Side

Right Side



Left side

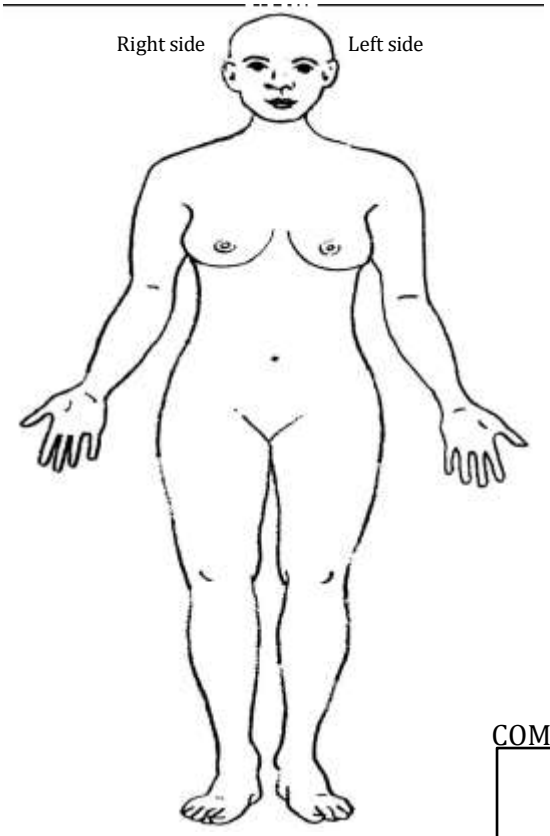
LEGEND: Types of Findings							
AB	Abrasion	**EC**	Ecchymosis	**MS**	Moist Secretion	**SO**	Suction occurred
BI	Bite	**ER**	Erythema (redness)	**OF**	Other Foreign Materials (describe)	**SW**	Swelling
BU	Burn	**F/H**	Fiber/Hair	**OI**	Other Injury (describe)	**TB**	Toluidine Blue⊕
BR	Bruise	**FB**	Foreign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

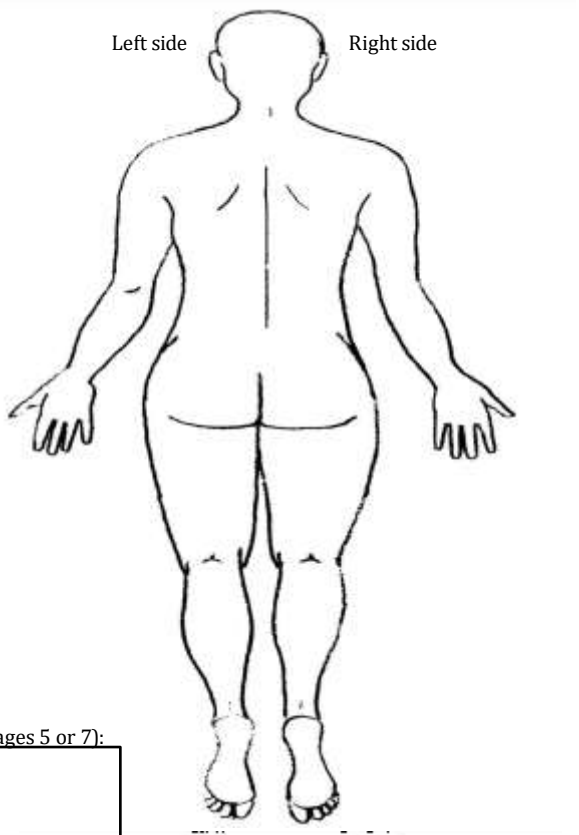
COMMENTS:

Examiner Initials: _____

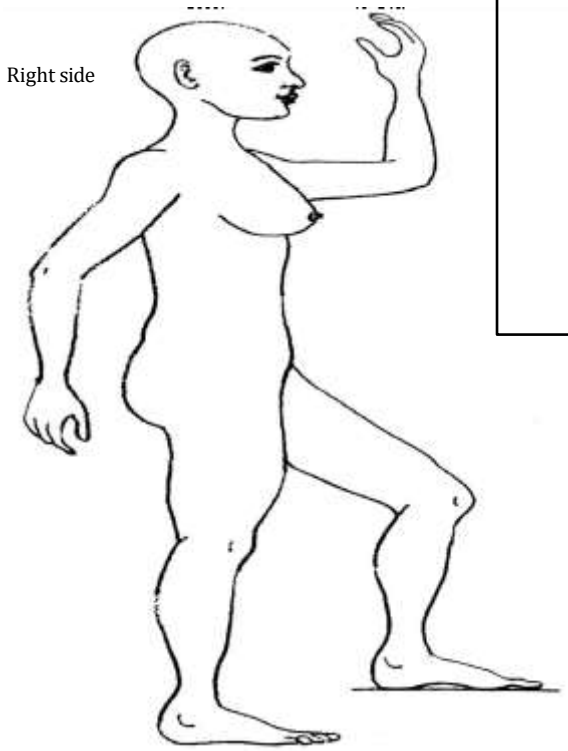
Patient Name
DOB
Case #

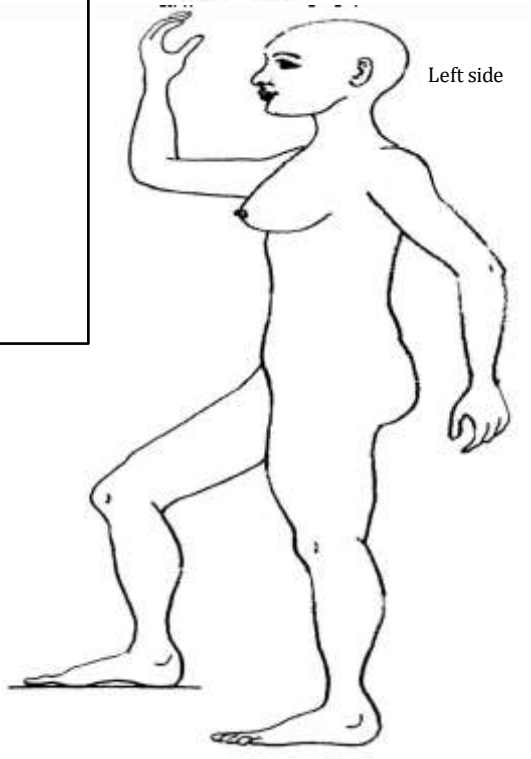
Adult/Adolescent Female Body Diagram





COMMENTS (see legend pages 5 or 7):





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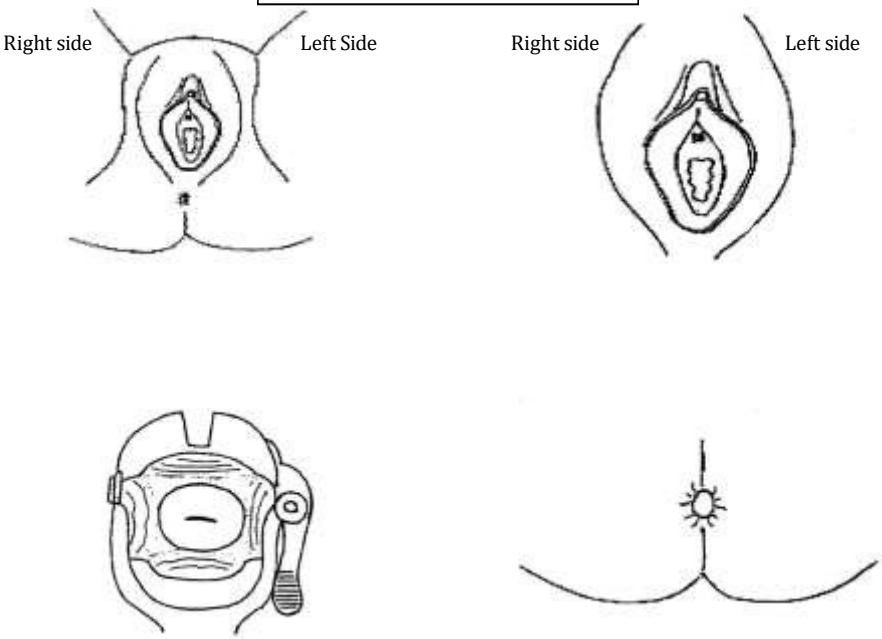
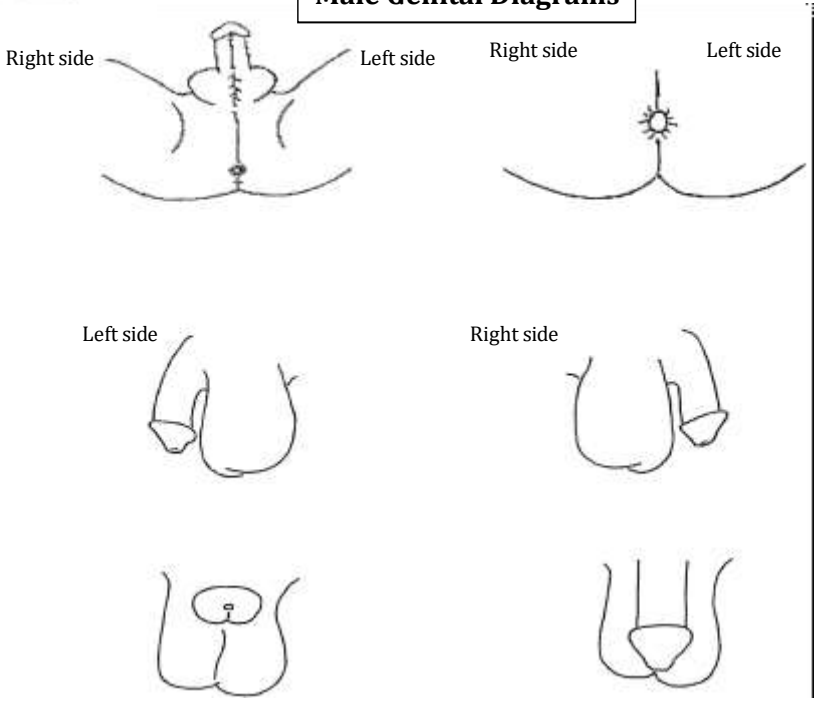
LEGEND: Types of Findings							
AB	Abrasion	**EC**	Ecchymosis	**MS**	Moist Secretion	**SO**	Suction occurred
BI	Bite	**ER**	Erythema (redness)	**OF**	Other Foreign Materials (describe)	**SW**	Swelling
BU	Burn	**F/H**	Fiber/Hair	**OI**	Other Injury (describe)	**TB**	Toluidine Blue⊕
BR	Bruise	**FB**	Foreign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

COMMENTS:

Female Genital Diagrams



Male Genital Diagrams



Examiner Initials: _____

Patient Name
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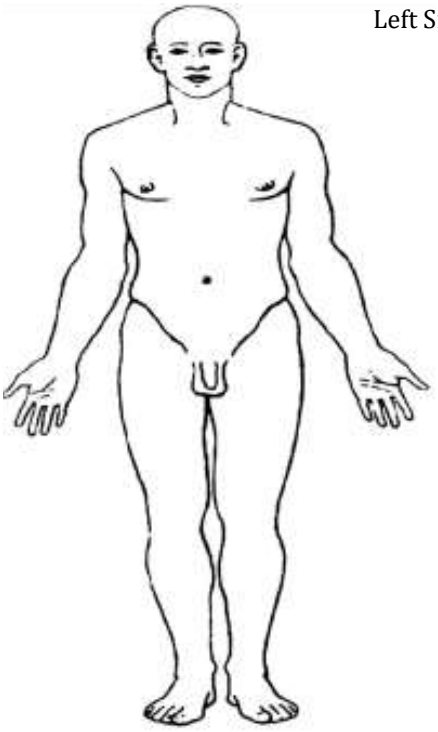
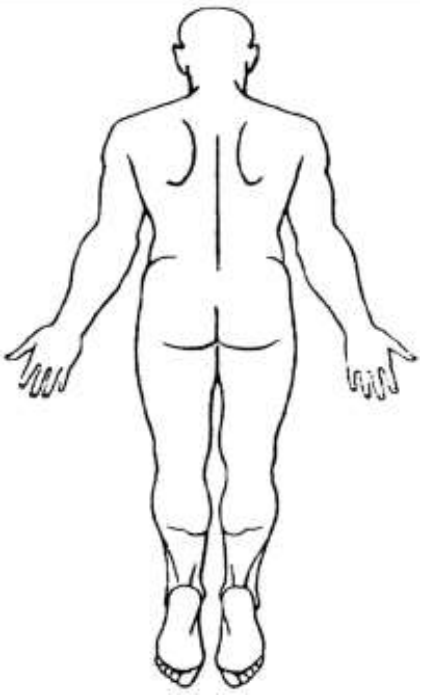
Adult/Adolescent Male Body Diagram

Right Side Left Side



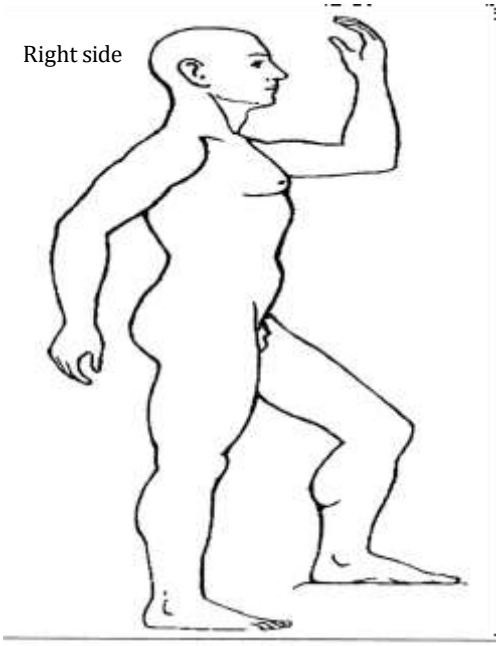
Left Side Right Side



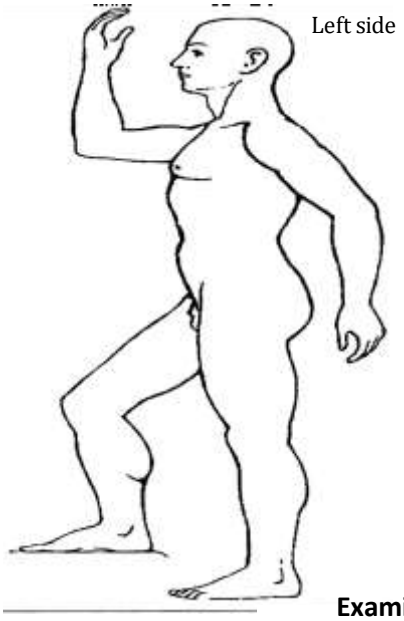
LEGEND: Types of Findings			
AB Abrasion	**EC** Ecchymosis	**MS** Moist Secretion	**SO** Suction occurred
BI Bite	**ER** Erythema (redness)	**OF** Other Foreign Materials (describe)	**SW** Swelling
BU Burn	**F/H** Fiber/Hair	**OI** Other Injury (describe)	**TB** Toluidine Blue⊕
BR Bruise	**FB** Foreign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

COMMENTS:

Right side



Left side



Examiner Initials: _____

Patient Name

DOB

Case #

FORENSIC PHOTOGRAPHY

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

Camera Type: _____

Injury #	**Photo #**	**Location of Injury/ Photo**	**Type of Photo taken,** e.g. orientation shot, macro with scale, macro without scale
N/A	1	N/A	Patient Label /Case Identification Card / Other (explain)

Photo documentation continued on additional pages: ☐ Yes ☐ No

Examiner Initials: _____

Patient Name
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EVIDENCE COLLECTION

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.	☐ **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	

Examiner Initials: _____

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 Combings 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:			

Examiner Initials: _____

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 Evidence Kit Sealed:_____ Signature: _____

EVIDENCE NOTES (Document any additional information as needed): _____

_____

_____

_____

Evidence Received From:_____

(Printed name)

Date/Time: _____Signature:_____

Received By: _____

(LEO printed name)

Date/Time:_____Signature:_____

Original Copy – Medical Chart Copy 2 – Law Enforcement