

STATE OF MISSISSIPPI
CHILD/ADOLESCENT < 18 YEARS OF AGE
SEXUAL ASSAULT EXAMINATION FORM

NON ACUTE > 72 HOURS

DISTRIBUTION

Initial to indicate copies are made and distributed

- _____ Copy Law Enforcement
- _____ Original Medical Facility
- _____ Copy Department of Human Services
- _____ Copy (to request reimbursement from A.G.'s Office)
Office of the Attorney General
Division of Victim Compensation
Post Office Box 220
Jackson, MS 39205-0220
(include UB 92 form)

For more information on completing this document
please contact the Batson CARE Clinic at University of MS Medical Center
601.815.0115

This form is available on the following websites:

www.ago.state.ms.us

www.dps.state.ms.us

FORENSIC REPORT: NON-ACUTE (> 72 HOURS)

Confidential Document

Patient Identification

A. GENERAL INFORMATION (print or type)

Name of Medical Facility:

1. Name of patient First M. Last Patient ID number

2. Address City County State Telephone

3. Age DOB / / Gender M F Race Arrival Date Arrival Time Discharge Date Discharge Time

4. Name of : Legal Guardian/Relationship Address City County State Telephone W: H:

5. Name of : Accompanying Adult if other than #4 above Address City County State Telephone W: H:

6. Other Children in Household	Gender	Age	DOB	Other Children in Household	Gender	Age	DOB
	M F				M F		
	M F				M F		

B. REPORTING AND AUTHORIZATION Jurisdiction (city county other):

1. Telephone report made to Name Agency ID number Telephone

Law Enforcement
and/or
DHS

2. Responding Personnel (to medical facility) Name Agency ID number Telephone

Law Enforcement
and/or
DHS

3. Assigned Investigator (if known) Name Agency ID number Telephone

Law Enforcement
and/or
DHS

4. Law Enforcement Incident/Offense Report #

C. CONSENT FOR EXAMINATION BY PATIENT/PARENT/GUARDIAN

Note: Parental consent is not required for a suspected child sexual abuse examination if the child is in protective custody. See M.S.A. 43-21-103 et seq.

- Any female, regardless of age or marital status, is empowered to give consent for herself in connection with pregnancy or childbirth. M.S.A. 41-41-13
- Any physician, duly licensed to practice medicine in the State of Mississippi, or any nurse practitioner, who, in the exercise of due care, renders medical care to a minor for treatment of a venereal disease is under no obligation to obtain consent of a parent or guardian, as applicable, or to inform such parent or guardian of such treatment. M.S.A. 41-41-13
- I hereby consent to a medical forensic investigation for evidence of sexual assault. If conducted, the report of the examination and any evidence obtained will be released to law enforcement authorities and the Division of Victim Compensation - Office of the Attorney General. I further understand that medical providers are required to notify the Department of Human Services of known or suspected child abuse; and if child abuse is found or suspected, this form and any evidence obtained will be released to the Department of Human Services and law enforcement. _____ (Initial)
- I understand the examination may include photographing findings and that these photographs may include the genital area. _____ (Initial)
- I have been informed that victims of crime are eligible to submit claims to the Division of Victim Compensation - Office of Attorney General for out of pocket medical expenses, psychological counseling and loss of wages related to a criminal act. _____ (Initial)
- I understand that data without patient identity may be collected from this report for health and forensic purposes and provided to health authorities and other qualified persons with a valid educational or scientific interest for demographic and/or epidemiological studies. _____ (Initial)
- I hereby authorize, any doctor's office, hospital or medical clinic in this state to furnish to the Division of Victim Compensation - Office of Attorney General this form in order to receive payment for this forensic medical exam. _____ (Initial)

Signature _____ Date _____

- Patient Parent Guardian
 Other

D. PATIENT HISTORY

1. Record time or time frame of the incident(s)	Date(s)	Time or time frame
<input type="checkbox"/> More than 72 hours		
<input type="checkbox"/> Multiple incidents over time		
2. Where did the abuse occur?		

Patient Identification

3. Record patient's name for: Female genitalia	4. Assailant(s)	Age	Gender	Race	Relationship to Patient	
					Known	Unknown
Male genitalia	#1.		M F			
Breasts	#2.		M F			
Anus	#3.		M F			

E. ACTS DESCRIBED BY HISTORIAN

Name of historian	Relationship to patient	Telephone	Agency	<input type="checkbox"/> Not applicable	History obtained by:
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	No	Yes	Attempted	Unsure	N/A	Describe pain and/or bleeding and additional pertinent history:
Genital/vaginal contact/penetration by:						
Penis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Finger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Object (Describe)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Associated pain?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Associated bleeding?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Anal contact/penetration by:						
Penis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Finger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Object (Describe)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Associated pain?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Associated bleeding?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
Oral copulation of genitals:						
Of patient by assailant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Of assailant by patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Oral copulation of anus:						
Of patient by assailant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Of assailant by patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anal/genital fondling:						
Of patient by assailant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Of assailant by patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Non-genital act(s)?						
If yes: <input type="checkbox"/> Fondling <input type="checkbox"/> Licking <input type="checkbox"/> Kissing <input type="checkbox"/> Suction <input type="checkbox"/> Biting						
Other acts? (Describe)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Did ejaculation occur?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	
If yes, note location(s):						
<input type="checkbox"/> Mouth <input type="checkbox"/> Vagina <input type="checkbox"/> Body surface <input type="checkbox"/> On bedding						
<input type="checkbox"/> Anus/Rectum <input type="checkbox"/> On clothing <input type="checkbox"/> Other						
Contraceptive or lubricant products? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unsure						
If yes, note. What happened to the condom? _____						
Were force or threats used?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Force	<input type="checkbox"/> Threats	<input type="checkbox"/>	
Were weapons used?	<input type="checkbox"/> No	<input type="checkbox"/> Yes			<input type="checkbox"/>	
If yes, describe: _____						
Were pictures/videotapes taken or shown or both? <input type="checkbox"/> Yes <input type="checkbox"/> No						
If yes, shown by whom _____ or taken by whom _____						
Were drugs <input type="checkbox"/> or alcohol <input type="checkbox"/> used?	<input type="checkbox"/> No	<input type="checkbox"/> Yes			<input type="checkbox"/>	
Loss of memory?	<input type="checkbox"/> No	<input type="checkbox"/> Yes			<input type="checkbox"/>	
Lapse of consciousness?	<input type="checkbox"/> No	<input type="checkbox"/> Yes			<input type="checkbox"/>	
Vomited after act(s)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes			<input type="checkbox"/>	
Behavioral changes in patient?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	(Describe)		<input type="checkbox"/>	

G. GENERAL PHYSICAL EXAMINATION

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

1. Exam Started		Exam Completed			
Date	Time	Date	Time		
2. Female Tanner Stage – Breast		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/> 5 <input type="checkbox"/>
3. Describe general physical appearance.					
4. Describe general demeanor and relevant statements made during exam.					
5. Conducted a physical examination. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> If no, why? _____					

Patient Identification

Diagram A

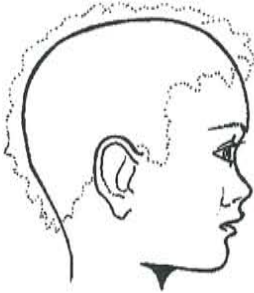


Diagram B

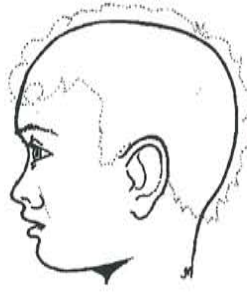


Diagram C

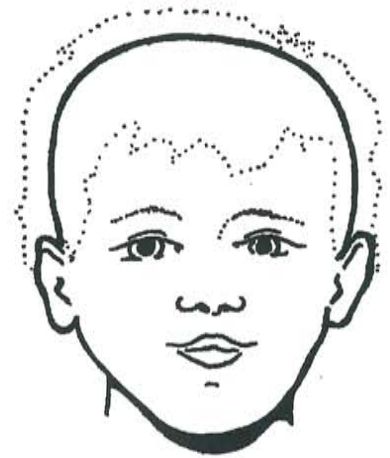


Diagram D

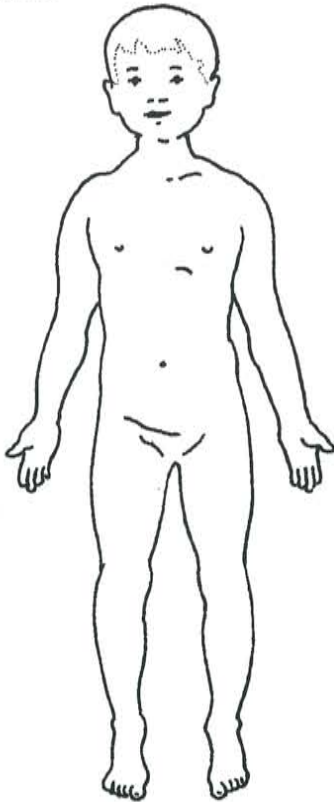


Diagram E

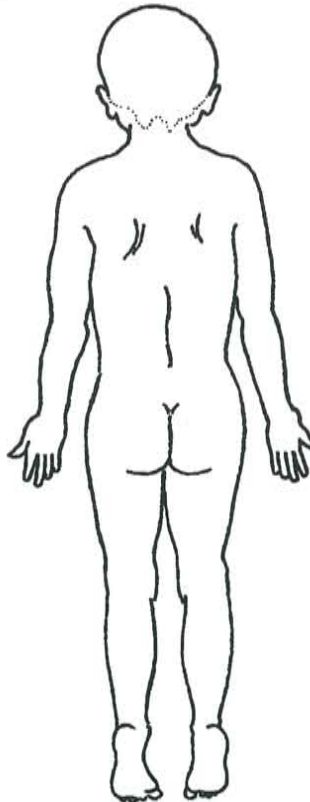
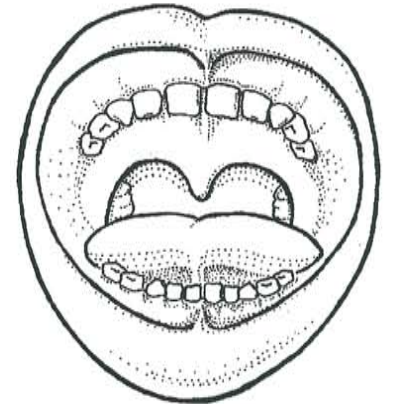


Diagram F



LEGEND: Types of Findings

AB Abrasion	EC Ecchymosis/Contusion	LA Laceration	OT Other	SH Submucosal Hemorrhage	VL Vesicular Lesion
BI Bite	ER Erythema (redness)	OI Other Injury (describe)	PE Petechiae	SHX Sample Per History	
BU Burn	FB Foreign Body	OSC Other Skin Condition	PGW Possible Genital Wart	SW Swelling	
CV Congenital Variation	IN Induration		SC Scar	TE Tenderness	
DI Discharge	IW Incised Wound				

Diagram Letter	Type	Description	Photo	Diagram Letter	Type	Description	Photo
			<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No

H. EXAMINATION OF THE EXTERNAL GENITALIA AND PERINEAL AREA

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

1. Use a colposcope or employ other means of magnification.
2. Examine the genital structures.
 - Diagram the position that best illustrates your findings.

Patient Identification

Diagram G

Supine

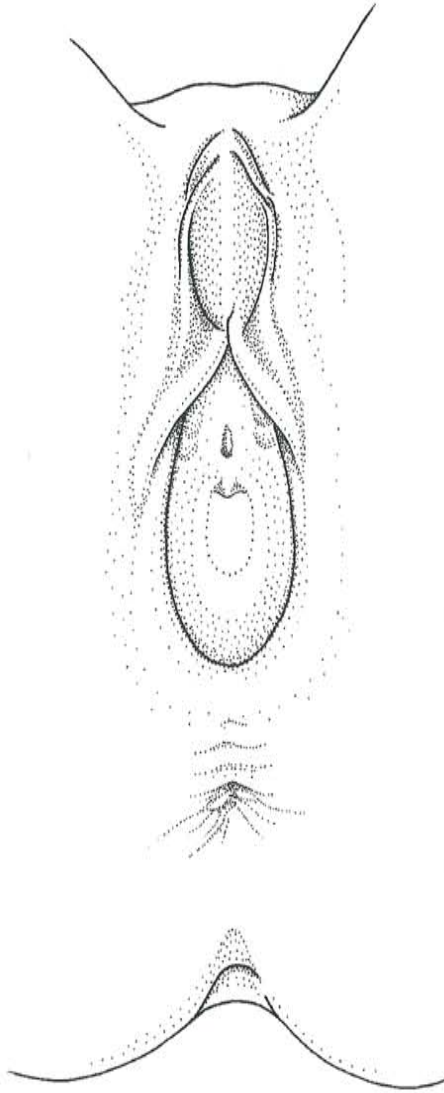


Diagram H

Knee-Chest

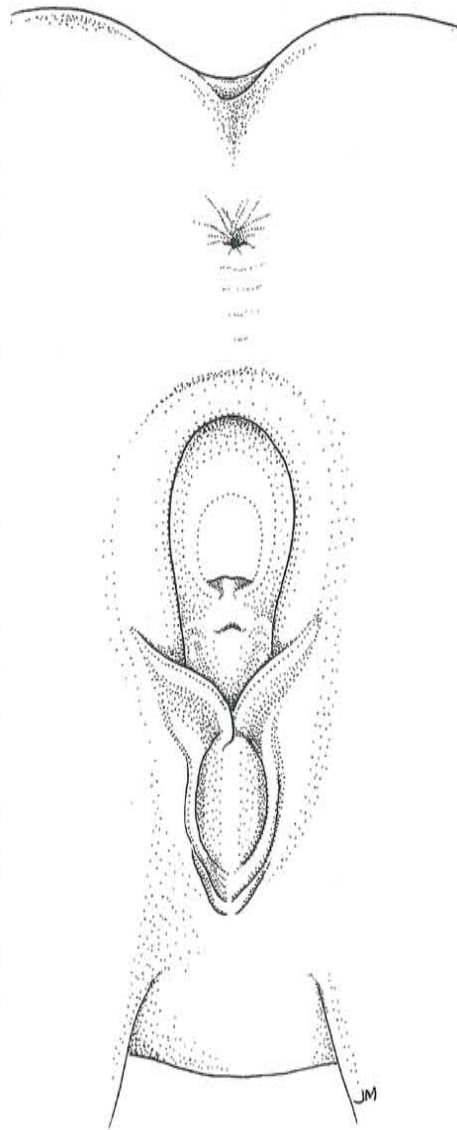


Diagram I

Penis

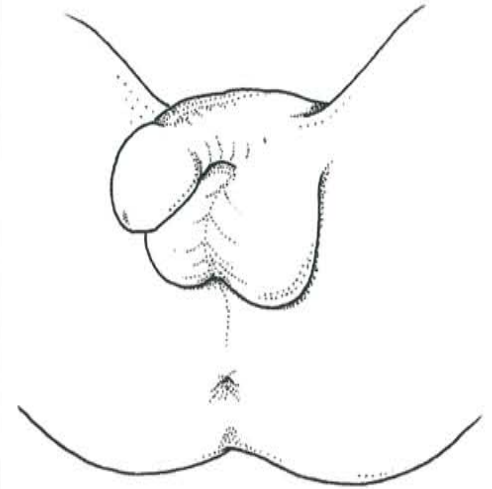
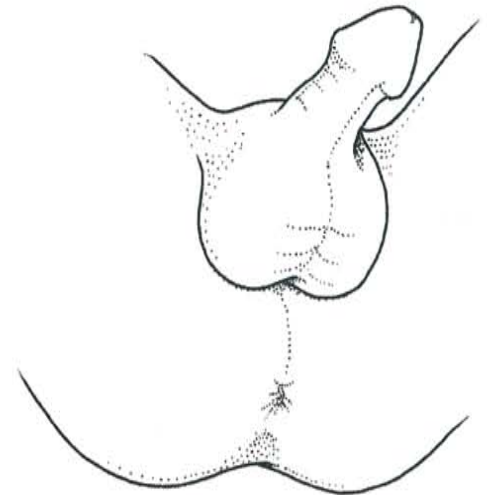


Diagram J

Penis



LEGEND: Types of Findings

AB Abrasion	DI Discharge	HT Hymenal Transection	OSC Other Skin Condition	SHX Sample Per History
AD Anal Dilatation	EC Ecchymosis/Contusion	HV Hymenal Variation	OT Other	SW Swelling
BI Bite	ER Erythema (redness)	IN Induration	PE Petechiae	TE Tenderness
BU Burn	FB Foreign Body	LA Laceration	SC Scar	VL Vesicular Lesion
CV Congenital Variation	GW Genital Wart	OI Other Injury (describe)	SH Submucosal Hemorrhage	

Diagram Letter	Type	Description	Photo
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

I. ANAL-GENITAL FINDINGS

1. Exam method:
 Direct visualization Colposcope Other magnification

2. General Female/Male WNL ABN Describe
 Inguinal adenopathy _____
 Perineum _____

3. Genital Tanner Stage 1 2 3 4 5

4. Female Genitalia

Exam positions/methods:	Separation	Traction	Knee Chest
Supine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Saline/water Moistened swab Catheter Other: _____

	WNL	ABN	Describe
Labia majora	<input type="checkbox"/>	<input type="checkbox"/>	
Labia minora	<input type="checkbox"/>	<input type="checkbox"/>	
Clitoral hood	<input type="checkbox"/>	<input type="checkbox"/>	
Perihymenal tissues (vestibule)	<input type="checkbox"/>	<input type="checkbox"/>	
Hymen <input type="checkbox"/> Supine <input type="checkbox"/> Prone	<input type="checkbox"/>	<input type="checkbox"/>	

Record pre-pubescent morphology

Annular _____
 Crescentic _____
 Imperforate _____
 Septate _____

Fossa navicularis

Posterior fourchette

Vagina (pubertal adolescents)

Cervix (pubertal adolescents)

Discharge No Yes If yes, describe: _____

Patient Identification

5. Male Genitals WNL ABN Describe

	WNL	ABN	Describe
Penis	<input type="checkbox"/>	<input type="checkbox"/>	
Circumcised	<input type="checkbox"/>		
Uncircumcised	<input type="checkbox"/>		
Foreskin	<input type="checkbox"/>	<input type="checkbox"/>	
Glans Penis	<input type="checkbox"/>	<input type="checkbox"/>	
Penile Shaft	<input type="checkbox"/>	<input type="checkbox"/>	
Urethral meatus	<input type="checkbox"/>	<input type="checkbox"/>	
Scrotum	<input type="checkbox"/>	<input type="checkbox"/>	
Testes	<input type="checkbox"/>	<input type="checkbox"/>	

Discharge No Yes If yes, describe: _____

6. Female/Male Anus and Rectum

Exam positions	Observation	Observation with traction
Supine	<input type="checkbox"/>	<input type="checkbox"/>
Supine knee chest	<input type="checkbox"/>	<input type="checkbox"/>
Prone knee chest	<input type="checkbox"/>	<input type="checkbox"/>
Lateral recumbent	<input type="checkbox"/>	<input type="checkbox"/>

Exam methods: Moistened swab Other: _____
 Anoscopy

	WNL	ABN	Describe:
Buttocks	<input type="checkbox"/>	<input type="checkbox"/>	
Perianal skin	<input type="checkbox"/>	<input type="checkbox"/>	
Anal verge/folds	<input type="checkbox"/>	<input type="checkbox"/>	
Rectum	<input type="checkbox"/>	<input type="checkbox"/>	

Anal dilation No Yes If yes: Immediate Delayed
 Stool present in rectal ampulla No Yes Undetermined

J. FINDINGS AND INTERPRETATION

1. Anal-Genital Findings

Normal anal-genital exam
 Abnormal anal-genital exam
 Indeterminate anal-genital exam

2. Assessment of Anal-Genital Findings

Consistent with history
 Inconsistent with history
 Limited/Insufficient history

3. Interpretation of Anal-Genital Findings

Normal exam: can neither confirm nor negate sexual abuse
 Non specific: may be caused by sexual abuse or other mechanisms
 Sexual abuse is highly suspected
 Definite evidence of sexual abuse and/or sexual contact.

4. Need further consultation/investigation

5. Lab results or photo review pending (may alter assessment)

6. Additional comments regarding findings, interpretations, and recommendations.

K. MEDICAL LAB TESTS PERFORMED

STD Cultures	GC	Chlamydia	Other	Describe	Taken by
Oral	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Vestibular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Vaginal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Cervical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Rectal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Penile	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Wet mount	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Serology	Syphilis <input type="checkbox"/>	HIV <input type="checkbox"/>	Hepatitis <input type="checkbox"/>		
Pregnancy test	Blood <input type="checkbox"/>	Urine <input type="checkbox"/>			
Other test(s)					

L. PHOTO DOCUMENTATION**M. PRINT NAMES OF PERSONNEL INVOLVED**

- | | | | |
|---------------|--------------------------|--------------------------|-----------------|
| | No | Yes | |
| 1. Colposcope | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| | | | (magnification) |
| 2. Camera | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| | | | (list type) |

3. Photograph Log
 Number of Photographs: _____

List:

- #1 _____
- #2 _____
- #3 _____
- #4 _____
- #5 _____
- #6 _____
- #7 _____
- #8 _____
- #9 _____
- #10 _____
- #11 _____
- #12 _____
- #13 _____
- #14 _____
- #15 _____
- #16 _____
- #17 _____
- #18 _____
- #19 _____
- #20 _____
- #21 _____
- #22 _____
- #23 _____
- #24 _____
- #25 _____
- #26 _____
- #27 _____
- #28 _____
- #29 _____
- #30 _____

History taken by: _____	Telephone _____
Exam performed by: _____	_____
Assisted by: _____	_____
Signature of examiner _____	Title _____
Other people in the exam room _____	

ADDITIONAL / NOTES

Patient Identification

ADDITIONAL / NOTES

Patient Identification