

STATE OF MISSISSIPPI CRIME LABORATORY

ADOLESCENT/ADULT SEXUAL ASSAULT EXAMINATION FORM ACUTE \leq 72 HOURS

DISTRIBUTION

Initial to indicate copies are made and distributed

- _____ Copy Mississippi Crime Lab (place in kit)
- _____ Copy Law Enforcement
- _____ Original Medical Facility
- _____ Copy Department of Human Services (if Patient is a minor or Vulnerable Adult)
- _____ 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 and Assurance form)

For more information on completing this document,
please contact the S.A.F.E. Center at The University of MS Medical Center.
601.984.4004

This form is available at the following websites:

www.ago.state.ms.us

www.dps.state.ms.us

**FORENSIC MEDICAL REPORT: ACUTE (<72 HOURS)
 ADOLESCENT ADULT SEXUAL ASSAULT EXAMINATION
 STATE OF MISSISSIPPI OFFICE OF THE ATTORNEY GENERAL**

Confidential Document

Patient Identification

A. GENERAL INFORMATION (print or type) Name of Medical Facility:

1. Name of patient							
2. Address		City		County		State	Telephone (W) (H)
3. Age	DOB	Gender M F	Ethnicity	Arrival Date	Arrival Time	Discharge Date	Discharge Time

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

1. Telephone report made to law enforcement agency				Reported by:		
Name of Officer	Agency	ID Number	Telephone	Name	Date	Time
2. Responding Officer	Agency	ID Number	Telephone	Law Enforcement Incident Offense Report #		

C. PATIENT INFORMATION

- I understand that hospitals and health care professionals are required by Mississippi Statute Annotated (M.S.A.) 45-9-31 to report to law enforcement authorities cases in which medical care is sought when injuries have been inflicted by a gunshot or knife. _____ (Initial)
- I have been informed that victims of crime are eligible to submit crime victim compensation claims to the Division of Victim Compensation for out of pocket medical expenses, psychological counseling and loss of wages. _____ (Initial)

D. PATIENT CONSENT

- Any female, regardless of age or marital status, is empowered to give consent for herself in connection with pregnancy or childbirth. M.S.A. 41-41-3
- 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 / sexually transmitted 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. 41-41-3
- I understand that a forensic medical examination for evidence of sexual assault at public expense, can with my consent, be conducted by a health care professional to discover and preserve evidence of the 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. I understand that the examination may include the collection of reference specimens at the time of the examination or at a later date. I understand that I may withdraw consent at any time for any portion of the examination. _____ (Initial)
- I understand that collection of evidence may include photographing injuries and that these photographs may include the genital area. _____ (Initial)
- I hereby consent to a medical forensic examination for evidence of sexual assault. _____ (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 this form in order to receive payment for services rendered. _____ (Initial)

Signature _____ Date _____ Patient Guardian

E. PATIENT HISTORY

1. Name of person providing history: Relationship to patient: Date Time

2. Pertinent medical history:

- Last menstrual period
- Any recent (60 days) anal-genital injuries, surgeries, diagnostic procedures, or medical treatment that may affect the interpretation of current physical findings? No Yes
If yes, describe:
- Any other pertinent medical condition(s) that may affect the interpretation of current physical findings? No Yes
If yes, describe:
- Any pre-existing physical injuries? No Yes
If yes, describe:

3. Pertinent pre-and post-assault related history:

- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| | No | Yes | Unsure |
| • Other intercourse within past 5 days? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, | | | |
| anal (within past 5 days)? When _____ | <input type="checkbox"/> | <input type="checkbox"/> | |
| vaginal (within past 5 days)? When _____ | <input type="checkbox"/> | <input type="checkbox"/> | |
| oral (within past 24 hours)? When _____ | <input type="checkbox"/> | <input type="checkbox"/> | |
| If yes, did ejaculation occur? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, where? _____ | | | |
| If yes, was a condom used? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Any voluntary alcohol use within 12 hours prior to assault? | <input type="checkbox"/> | <input type="checkbox"/> | * |
| • Any voluntary drug use within 96 hours prior to assault? | <input type="checkbox"/> | <input type="checkbox"/> | * |
| • Any voluntary drug or alcohol use between the time of the assault and the forensic exam? | <input type="checkbox"/> | <input type="checkbox"/> | * |

*If yes, collection of toxicology samples is recommended
 Blood Urine

4. Post-assault hygiene/activity: Not applicable if over 72 hours

- | | | |
|---|--------------------------|--------------------------|
| | No | Yes |
| Urinated | <input type="checkbox"/> | <input type="checkbox"/> |
| Defecated | <input type="checkbox"/> | <input type="checkbox"/> |
| Genital or body wipes | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, describe: _____ | | |
| Douched | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, with what _____ | | |
| Removed/inserted tampon <input type="checkbox"/> diaphragm <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Oral gargle/rinse | <input type="checkbox"/> | <input type="checkbox"/> |
| Bath/shower/wash | <input type="checkbox"/> | <input type="checkbox"/> |
| Brushed teeth/floss | <input type="checkbox"/> | <input type="checkbox"/> |
| Ate or drank | <input type="checkbox"/> | <input type="checkbox"/> |
| Changed clothing | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, describe: _____ | | |

5. Assault-related history:

- | | | |
|---|--------------------------|--------------------------|
| | No | Yes |
| Loss of memory? If yes, describe: | <input type="checkbox"/> | <input type="checkbox"/> |
| Lapse of consciousness? If yes, describe: | <input type="checkbox"/> | <input type="checkbox"/> |

*If yes, collection of toxicology samples is recommended
 Blood Urine

- Vomited? If yes, describe:
- Non-genital injury, pain, and/or bleeding?
If yes, describe:
- Anal-genital injury, pain, and/or bleeding?
If yes, describe:

Patient Identification

F. ASSAULT HISTORY

1. Date of assault(s): Time of assault(s):

2. Pertinent physical surroundings of assault(s):

3. Alleged assailant(s) name(s)	Age	Gender	Ethnicity	Relationship to patient	
				Known	Unknown
#1.		M F			
#2.		M F			
#3.		M F			
#4.		M F			

4. Methods employed by assailant(s):

- | | | | |
|---------------------------------|--------------------------|--------------------------|-------------------|
| | No | Yes | If yes, describe: |
| Weapons | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Threatened? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Injuries inflicted? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Type(s) of weapons? | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Physical blows | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Grabbing/holding/pinching | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Physical restraints | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Choking/strangulation | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Burns (thermal and/or chemical) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Threat(s) of harm | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| target(s) of threat(s) | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Other methods | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Position used by assailant | | | _____ |

Involuntary ingestion of alcohol/drugs No Yes Unsure

If yes, Alcohol Drugs

If yes, Forced Coerced Suspected

If yes, toxicology samples collected: Blood Urine None

5. Injuries inflicted upon the assailant(s) during assault? No Yes
If yes, describe injuries, possible locations on the body, and how they were inflicted.

G. ACTS DESCRIBED BY PATIENT

• If more than one assailant, identify by number.

Patient Identification

1. Penetration of vagina by:

	No	Yes	Attempted	Unsure
Penis	<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"/>
Object	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, describe the object:

Describe: _____

2. Penetration of anus by:

	No	Yes	Attempted	Unsure
Penis	<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"/>
Object	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, describe the object:

Describe: _____

3. Oral copulation of genitals:

	No	Yes	Attempted	Unsure
Of patient by assailant	<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"/>

Describe: _____

4. Oral copulation of anus:

	No	Yes	Attempted	Unsure
Of patient by assailant	<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"/>

Describe: _____

5. Non-genital act(s):

	No	Yes	Attempted	Unsure
Licking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kissing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suction injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Biting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Describe where on body and by whom? _____

6. Other act(s):

	No	Yes	Attempted	Unsure
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Describe: _____

7. Did ejaculation occur?

	No	Yes	Unsure
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Describe any other details noted about assailant _____

If yes, note location(s):

- Mouth
- Vagina
- Anus/Rectum
- Body surface
- On clothing
- On bedding
- Other

8. Contraceptive or lubricant products:

	No	Yes	Unsure
Foam used?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jelly used?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lubricant used?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Condom used?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Location of Condom?	_____		<input type="checkbox"/>

Describe Type/Brand, if known: _____

H. GENERAL PHYSICAL EXAMINATION

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

1. Exam Started		Exam Completed	
Date	Time	Date	Time
2. Describe general physical appearance		3. Describe general demeanor	

Patient Identification

4. Describe condition of clothing upon arrival.

5. Collect outer and underclothing if indicated. Not indicated Why clothing not collected _____

6. Conduct a physical examination. Findings No Findings

7. Collect dried and moist secretions, stains, and foreign materials from the body. Scan the entire body with an Alternate Light Source (ALS) _____ list

Findings No Findings

8. Collect fingernail scrapings or cuttings

Diagram A

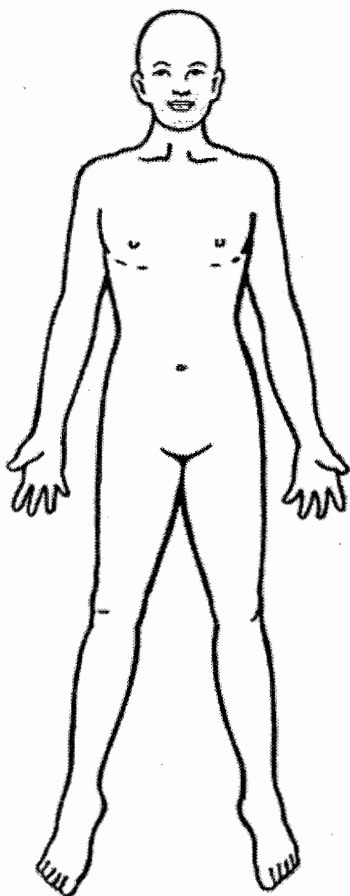
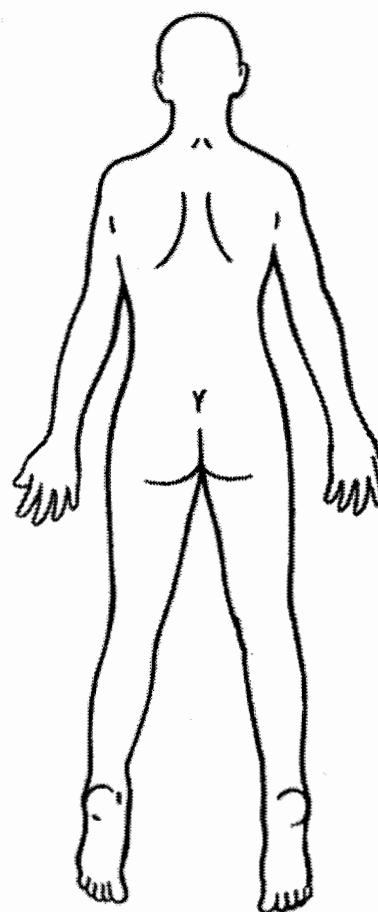


Diagram B



LEGEND: Types of Findings

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

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 # _____

RECORD ALL CLOTHING AND SPECIMENS COLLECTED ON PAGE 8

I. HEAD, NECK, AND ORAL EXAMINATION

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

1. Examine the face, head, hair, scalp, and neck for injury and foreign materials. Findings No Findings
2. Collect dried and moist secretions, stains, and foreign materials from the face, head, hair, scalp, and neck. Findings No Findings
3. Examine the oral cavity for injury and foreign materials (if indicated by assault history). Collect foreign materials.
Exam done: No Yes Findings No Findings
4. Collect 2 swabs from the oral cavity up to 12 hours post assault. Collected Not Collected
5. Collect head hair reference samples according to local policy.

Patient Identification

Diagram C

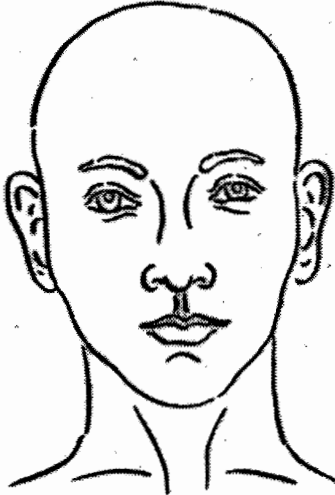


Diagram D

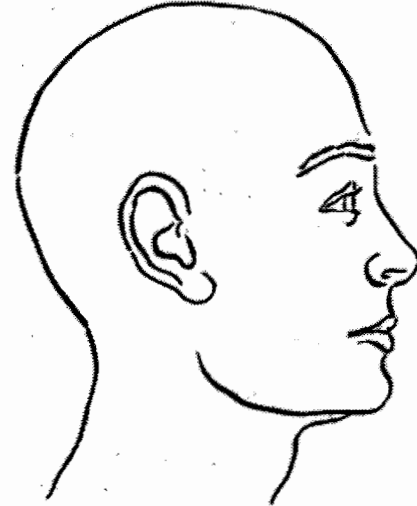


Diagram E

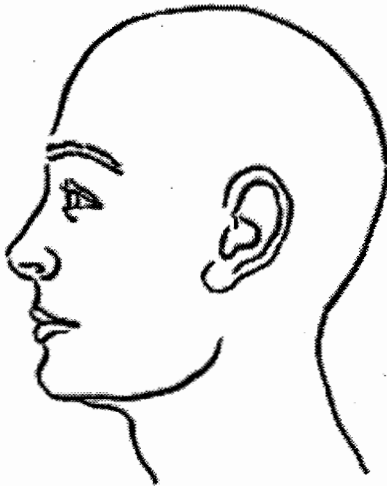
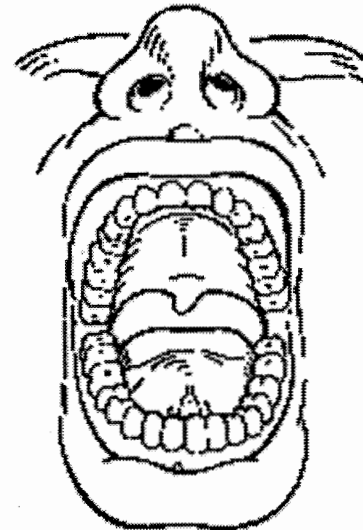


Diagram F



LEGEND: Types of Findings

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

Diagram Letter	Type	Description	Photo	Diagram Letter	Type	Description	Photo
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			<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 #

RECORD ALL SPECIMENS COLLECTED ON PAGE 8

J. GENITAL EXAMINATION - FEMALES

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

1. Examine the inner thighs, external genitalia, and perineal area. Check the box(es) if there are assault related findings:

- No Findings
- Inner thighs
- Perineum
- Labia majora
- Labia minora
- Clitoris/surrounding area
- Periurethral tissue/urethral meatus
- Perihymenal tissue (vestibule)
- Hymen
- Fossa navicularis
- Posterior fourchette

2. Collect dried and moist secretions, stains, and foreign materials. Scan the area with an ALS No Yes Findings No Findings

3. Collect pubic hair combing or brushing.

4. Collect pubic hair reference 5. Collect 2 vulvar swabs

6. Examine the vagina and cervix. Check the box(es) if there are any assault findings, indicate on diagram and describe below.

- No Findings
- Vagina
- Cervix

7. Collect 2 swabs from the vaginal pool.

8. Cervical swabs collected? No Yes

9. Examine the buttocks, anus, and rectum.

Exam done: Yes No

Check the box(es) if there are assault related findings:

- No Findings
- Buttocks
- Anal verge/folds/rugae
- Perianal skin
- Rectum

10. Collect dried and moist secretions, stains, and foreign materials. Findings No Findings

11. Collect 2 rectal swabs.

12. Conduct an anoscopic exam if rectal injury is suspected or if there is any sign of rectal bleeding.

Rectal bleeding No Yes

If yes, describe: _____

Exam position used:

- Supine Lithotomy
- Other Describe: _____

Patient Identification

Diagram G

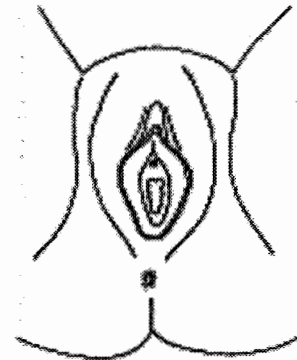


Diagram H

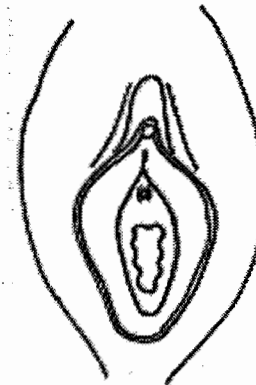


Diagram I

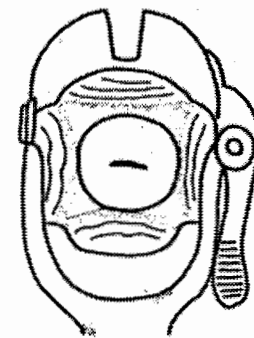
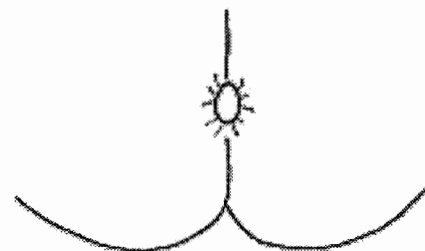


Diagram J



LEGEND: Types of Findings

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

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

RECORD ALL SPECIMENS COLLECTED ON PAGE 8

K. GENITAL EXAMINATION - MALES

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

1. Examine the inner thighs, external genitalia, and perineal area. Check the

box(es) if there are assault related findings:

No Findings

Inner thighs

Urethral meatus

Perineum

Scrotum

Foreskin

Testes

Glans penis

Penile shaft

2. Circumcised: No Yes

3. Collect dried and moist secretions, stains, and foreign materials.

Scan the area with an ALS Findings No Findings

4. Collect pubic hair combing or brushing.

5. Collect pubic hair reference samples according to local policy.

6. Collect 2 penile swabs, if indicated by assault history. N/A

7. Examine the buttocks, anus, and rectum.

Exam done: Yes Not applicable

Check the box(es) if there are assault related findings:

No Findings

Buttocks

Anal verge/folds/rugae

Perianal skin

Rectum

8. Collect dried and moist secretions, stains, and foreign materials.

Findings No Findings

9. Collect 2 rectal swabs.

10. Conduct an anoscopic exam if rectal injury is suspected or if there is any sign of rectal bleeding.

Rectal bleeding: No Yes

If yes, describe: _____

11. Exam position used:

Supine Other Describe: _____

Patient Identification

Diagram K

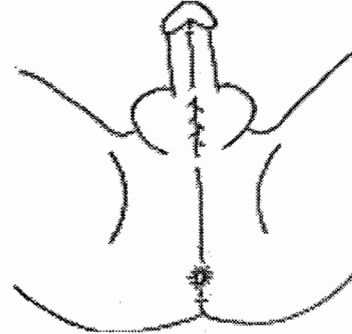


Diagram L

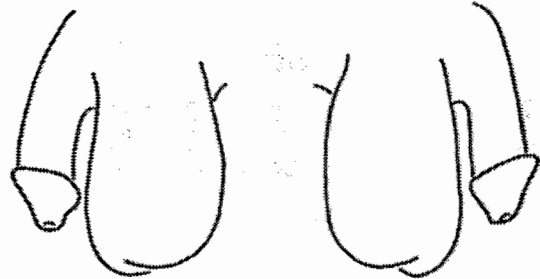


Diagram M

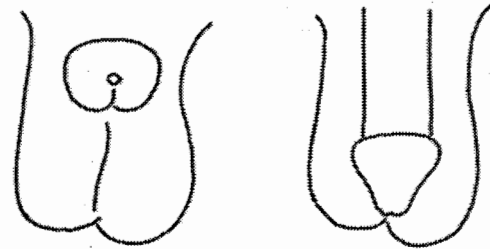
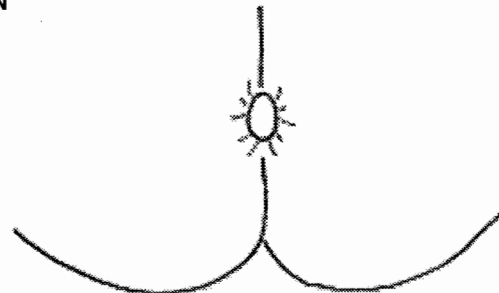


Diagram N



LEGEND: Types of Findings

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

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

RECORD ALL SPECIMENS COLLECTED ON PAGE 8

L. EVIDENCE COLLECTED AND SUBMITTED TO CRIME LAB

ENVELOPES	No	Yes	Collected by:
1. Foreign Material	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Contact/Outer Clothing	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Contact/Outer Clothing	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Undergarments	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Undergarments	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Debris Collection	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Right Hand Fingernail Scrapings	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Left Hand Fingernail Scrapings	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Dried Secretions	<input type="checkbox"/>	<input type="checkbox"/>	_____
10. Oral/Skin Contact Evidence	<input type="checkbox"/>	<input type="checkbox"/>	_____
11. Pubic Hair Combing	<input type="checkbox"/>	<input type="checkbox"/>	_____
12. Pulled Pubic Hair	<input type="checkbox"/>	<input type="checkbox"/>	_____
13. Oral Swabs	<input type="checkbox"/>	<input type="checkbox"/>	_____
14. Vulvar Swabs	<input type="checkbox"/>	<input type="checkbox"/>	_____
15. Vulvar/Penile Swabs	<input type="checkbox"/>	<input type="checkbox"/>	_____
16. Vaginal Swabs	<input type="checkbox"/>	<input type="checkbox"/>	_____
17. Rectal Swabs	<input type="checkbox"/>	<input type="checkbox"/>	_____
18. Pulled Head Hairs	<input type="checkbox"/>	<input type="checkbox"/>	_____
19. Known Blood Sample	<input type="checkbox"/>	<input type="checkbox"/>	_____
20. Other Evidence	<input type="checkbox"/>	<input type="checkbox"/>	_____
21. Other Evidence	<input type="checkbox"/>	<input type="checkbox"/>	_____

NOTE: Please document any necessary deviations/additions to the kit.

M. TOXICOLOGY SAMPLES

	No	Yes	Time	Collected by:
Blood alcohol/toxicology (gray top tube)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Urine toxicology	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

N. PHOTO DOCUMENTATION METHODS

	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	_____		

Patient Identification

O. PRINT NAMES OF PERSONNEL INVOLVED

History taken by:	Telephone:
Exam performed by:	
Other people present at time of examination	
Assisted by:	
Signature of examiner	Title

P. EVIDENCE DISTRIBUTION

GIVEN TO:

Toxicology Samples	
Other Items	
Evidence Kit and # _____ bags	

Q. MEDICATIONS OFFERED

	Yes	No
Disease Prevention	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy Prevention	<input type="checkbox"/>	<input type="checkbox"/>

R. SUMMARIZE MAJOR FINDINGS