

STATE OF MISSISSIPPI CRIME LABORATORY
CHILD/ADOLESCENT
SEXUAL ASSAULT EXAMINATION FORM
ACUTE ≤ 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)
- _____ 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 on the following websites:

www.ago.state.ms.us

www.dps.state.ms.us

FORENSIC REPORT: ACUTE (≤72 HOURS)

Confidential Document

Patient Identification

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

1. Name of patient _____

2. Address _____ City _____ County _____ State _____ Telephone _____

3. Age	DOB	Gender	Ethnicity	Arrival Date	Arrival Time	Discharge Date	Discharge Time
		M F					

4. Name of : Mother Stepmother Guardian Address _____ City _____ County _____ State _____ Telephone _____
W: _____
H: _____

5. Name of : Father Stepfather Guardian Address _____ City _____ County _____ State _____ Telephone _____
W: _____
H: _____

6. Name(s) of Siblings	Gender	Age	DOB	Name(s) of Siblings	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 that collection of evidence may include photographing injuries 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 services rendered. _____ (Initial)

Signature _____ Date _____ Patient Parent Guardian

D. PATIENT HISTORY

1. Record time or time frame of the incident(s)	Date(s)	Time or time frame
<input type="checkbox"/> Less than 72 hours		
<input type="checkbox"/> Multiple incidents over time		

2. Pertinent physical surroundings of abuse/assault:

Patient Identification

3. Record patient's name for: Female genitalia	4. Alleged perpetrator(s) name(s)	Age	Gender	Ethnicity	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	History obtained by:	Telephone	Agency	<input type="checkbox"/> Not applicable
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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"/>	Where on body and by whom? _____
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	<input type="checkbox"/>	<input type="checkbox"/>				_____
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"/>	<input type="checkbox"/>	_____
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 <input type="checkbox"/> drugs or <input type="checkbox"/> alcohol 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					<input type="checkbox"/>	_____

* Collection of toxicology samples is recommended.

F. ACTS DESCRIBED BY PATIENT

1. Acts disclosed by patient to: Law Enforcement Officer
 Medical Examiner Multi-disciplinary Interview Team
 Social Worker Other:

	No	Yes	Attempted	Unsure	N/A
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 below)	<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 below)	<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)? <input type="checkbox"/>					
If yes: <input type="checkbox"/> Fondling <input type="checkbox"/> Licking <input type="checkbox"/> Kissing <input type="checkbox"/> Suction <input type="checkbox"/> Biting					
By whom and where on body? _____					
Other acts? (Describe below)	<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"/>					
If yes, note type/brand: _____					
Were force or threats used? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Force <input type="checkbox"/> Threats					
Were weapons used? <input type="checkbox"/> Yes <input type="checkbox"/> No <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 <input type="checkbox"/> drugs or <input type="checkbox"/> alcohol 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? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>					

* Collection of toxicology samples is recommended.

2. Describe pain and/or bleeding (using patient's exact words) and additional pertinent history from above.

Patient Identification

G. MEDICAL HISTORY (to be completed by medical personnel)

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

2. Any recent (60 days) anal-genital injuries, surgeries, diagnostic procedures, or medical treatment that may affect the interpretation of physical findings? No Yes

3. Any other pertinent medical conditions that may affect the interpretation of physical findings?

4. Any pre-existing physical injuries?

5. Any previous history of physical abuse and/or neglect?

6. Any previous history of sexual abuse?

7. Other intercourse? (For adolescents only)

If yes,

anal (within past 5 days)? When _____

vaginal (within past 5 days)? When _____

oral (within past 24 hours)? When _____

If yes, did ejaculation occur?

If yes, where? _____

If yes, was a condom used?

8. Menstrual periods? If yes, age of menarche: _____

Last menstrual period: _____

9. Other symptoms disclosed	by patient:		by historian:		
	No	Yes	No	Yes	Unk
Abdominal/pelvic pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain on urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genital discomfort or pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genital itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genital discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genital bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rectal discomfort or pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rectal itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, describe onset, duration, and intensity:

10. Post-assault hygiene activity	by patient:		by historian:		
	No	Yes	No	Yes	Unk
<input type="checkbox"/> Not applicable if over 72 hours					
Urinated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Defecated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genital or body wipes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, describe: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oral gargle/rinse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bath/shower/wash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brushed teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ate or drank	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Changed clothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, describe					

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. 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. Describe condition of clothing upon arrival.			
6. Collect outer and underclothing if indicated. <input type="checkbox"/> Not indicated			
7. Conduct a physical examination. <input type="checkbox"/> Findings <input type="checkbox"/> No Findings General exam within normal limits: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> If no, describe:			
8. Collect dried and moist secretions, stains, and foreign materials from the body. Scan the entire body with an Alternate Light Source <input type="checkbox"/> Findings <input type="checkbox"/> No Findings			
9. Collect fingernail scrapings or cuttings. <input type="checkbox"/> Collected <input type="checkbox"/> Not Collected			

Patient Identification

Diagram A

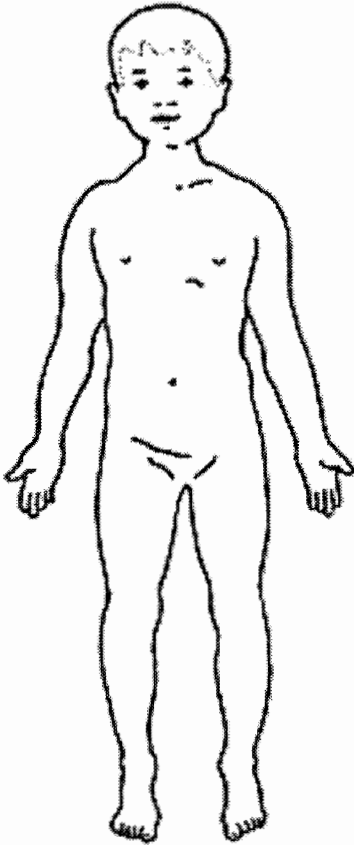
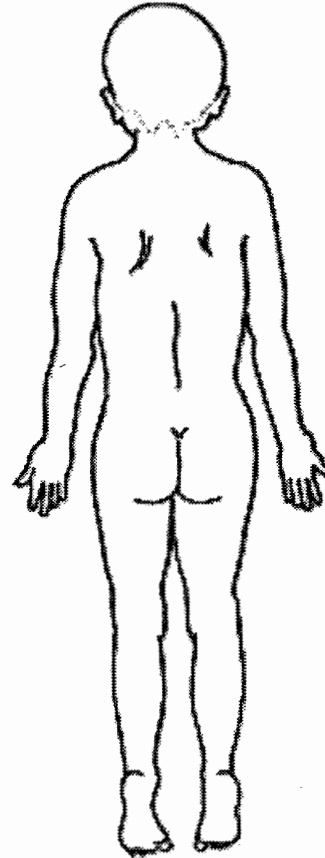


Diagram B



LEGEND: Types of Findings

AB Abrasion	CS Control Swab	DS Dry Secretion	HC Hymenal cleft	OI Other Injury (describe)	PE Petechiae	SW Swelling
AL Anal Laxity	CV Congenital Variation	EC Ecchymosis/contusion	IN Induration	PGW Possible Genital Wart	TB Toluidine Blue	TE Tenderness
ALS Alternate Light Source	DE Debris	ER Erythema (redness)	IW Incised Wound	OSC Other Skin Condition	PS Potential Saliva	V/S Vegetation/Soil
BI Bite	DF Deformity	FB Foreign Body	LA Laceration	OT Other	SH Sample Per History	VL Vesicular Lesion
BU Burn	DI Discharge	F/H Fiber/Hair	MS Moist Secretion	PW Perianal Wart	S Suction	
		GT Granulation Tissue	OF Other Foreign Materials(describe)			

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. Exam method: Direct visualization Colposcope Other magnification
3. Collect dried and moist secretions, stains, and foreign materials from the face, head, hair, scalp, and neck. Findings No Findings
4. Examine the oral cavity for injury and foreign materials. Collect foreign materials. Findings No Findings
5. Collect 2 swabs from the oral cavity up to 12 hours post assault. Collected Not Collected
6. Collect head hair reference samples. Collected Not Collected

Patient Identification

Diagram C

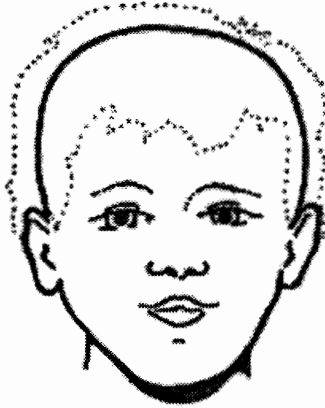


Diagram D

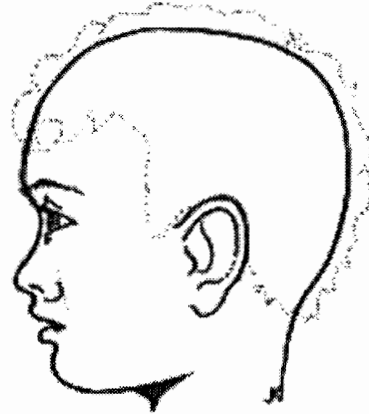


Diagram E

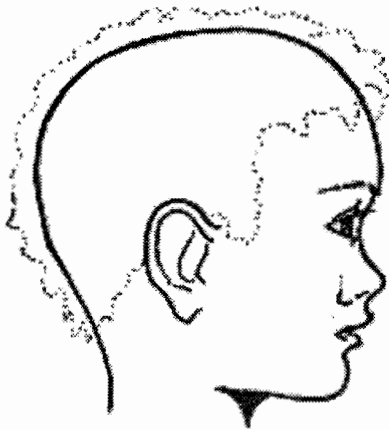
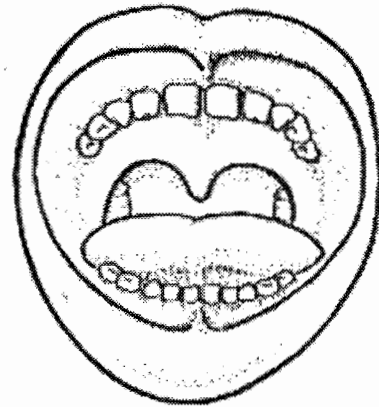


Diagram F



LEGEND: Types of Findings

AB Abrasion	CS Control Swab	DS Dry Secretion	HC Hymenal cleft	OI Other Injury (describe)	PE Petechiae	SW Swelling
AL Anal Laxity	CV Congenital Variation	EC Ecchymosis/contusion	IN Induration		PGW Possible Genital Wart	TB Toluidine Blue
ALS Alternate Light Source	DE Debris	ER Erythema (redness)	IW Incised Wound	OSC Other Skin Condition	PS Potential Saliva	TE Tenderness
BI Bite	DF Deformity	FB Foreign Body	LA Laceration	OT Other	SH Submucosal Hemorrhage	V/S Vegetation/Soil
BU Burn	DI Discharge	F/H Fiber/Hair	MS Moist Secretion	PW Perianal Wart	SHX Sample Per History	VL Vesicular Lesion
		GT Granulation Tissue	OF Other Foreign Materials(describe)		S Suction	

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

J. GENITAL EXAMINATION - FEMALES

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

- Examine the inner thighs, external genitalia, and perineal area.
- Exam method: Direct visualization Colposcope Other magnification
 Exam positions/methods: Separation Traction Knee Chest
 Supine
 Prone
 Saline/Water Moistened swab Toluidine Blue Dye
 Catheter Other:

3. Genital Tanner Stage 1 2 3 4 5

4. Examine the genital structures. Check the ABN box(es) if there are abuse/ assault related findings and describe.

	WNL	ABN	Describe:
Inner thighs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Inguinal adenopathy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Labia majora	<input type="checkbox"/>	<input type="checkbox"/>	_____
Labia minora	<input type="checkbox"/>	<input type="checkbox"/>	_____
Clitoral hood	<input type="checkbox"/>	<input type="checkbox"/>	_____
Perineum	<input type="checkbox"/>	<input type="checkbox"/>	_____
Periurethral tissue/urethral meatus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Perihymenal tissue (vestibule)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hymen <input type="checkbox"/> Supine <input type="checkbox"/> Prone	<input type="checkbox"/>	<input type="checkbox"/>	_____
Record morphology:			
<input type="checkbox"/> Annular <input type="checkbox"/> Estrogenized			_____
<input type="checkbox"/> Crescentic <input type="checkbox"/> Non-Estrogenized			_____
<input type="checkbox"/> Imperforate <input type="checkbox"/> Other			_____
<input type="checkbox"/> Septate			_____
Fossa navicularis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Posterior fourchette	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vagina (pubertal adolescents)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cervix (pubertal adolescents)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Discharge <input type="checkbox"/> No <input type="checkbox"/> Yes			
If yes, describe: _____			
No Findings <input type="checkbox"/>			

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

Scan the area with an ALS Findings No Findings

6. Collect swabs

- Prepubertal female
 - Collect at least 2 vulvar swabs
- Pubertal female
 - Collect 2 swabs from the vaginal pool.
- Cervical swabs collected? No Yes

7. Collect pubic hair combing Not applicable Shaved/Not Present

8. Collect pubic hair reference samples. Not applicable

LEGEND: Types of Findings

AB Abrasion	DF Deformity	LA Laceration	SH Submucosal Hemorrhage
AL Anal Laxity	DI Discharge	MS Moist Secretion	
ALS Alternate Light Source	DS Dry Secretion	OF Other Foreign Materials(describe)	SHX Sample Per History
	EC Ecchymosis/contusion	OI Other Injury(describe)	S Suction
BI Bite	ER Erythema (redness)	OSC Other Skin Condition	SW Swelling
BU Burn	FB Foreign Body	OT Other	TB Toluidine Blue
CS Control Swab	F/H Fiber/Hair	PW Perianal Wart	TE Tenderness
CV Congenital Variation	GT Granulation Tissue	PE Petechiae	V/S Vegetation/Soil
DE Debris	HC Hymenal cleft	PGW Possible Genital Wart	VL Vesicular Lesion
	IN Induration	PS Potential Saliva	
	IW Incised Wound		

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 # _____

RECORD ALL CLOTHING AND SPECIMENS COLLECTED ON PAGE 8

Patient Identification

Diagram the position that best illustrates your findings.

Diagram G Genitalia - Supine

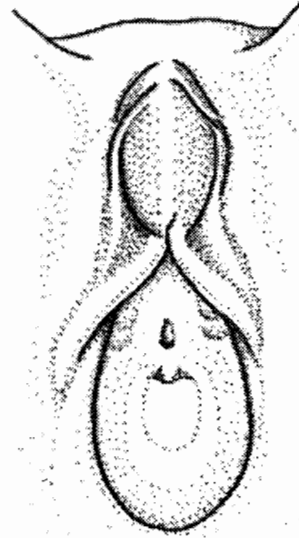
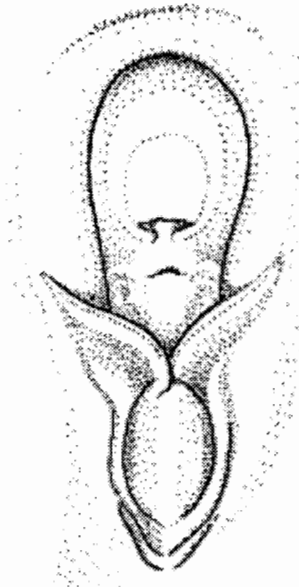


Diagram H Genitalia - Knee-Chest



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.
2. Exam method: Direct visualization Colposcope Other magnification
Exam positions/methods:
 Supine Prone Moistened swab
 Toluidine Blue Dye Other: _____

3. Genital Tanner Stage 1 2 3 4 5

4. Circumcised: No Yes

5. Check the ABN box(es) if there are abuse/assault related findings and describe.

	WNL	ABN	Describe:
Inner thighs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Inguinal adenopathy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Perineum	<input type="checkbox"/>	<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 <input type="checkbox"/> No <input type="checkbox"/> Yes			If yes, describe: _____
No Findings <input type="checkbox"/>			

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

Scan the area with an ALS Findings No Findings

7. Collect pubic hair combing or brushing. Not applicable

8. Collect pubic hair reference samples. Not applicable

9. Collect 2 penile swabs, if indicated by assault history. Not applicable

L. FEMALE/MALE ANAL AND RECTAL EXAMINATION

1. Examine the buttocks, perianal skin, and anal folds for injury, foreign materials and other findings.

2. Record exam positions, methods, observations:

Direct visualization Colposcope Other magnification

Exam positions Observation Observation with traction

Supine

Supine knee chest

Prone knee chest

Lateral recumbent

Exam methods: Moistened swab Toluidine blue dye Anoscopy Other: _____

3. Check the ABN box(es) if there are abuse/assault related findings and describe any abnormal or unusual findings.

No Findings Findings No Findings

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

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

Findings No Findings

5. Collect 2 rectal swabs. Collected Not collected

6. Rectal bleeding: No Yes If yes, describe: _____

LEGEND: Types of Findings

AB Abrasion	DF Deformity	LA Laceration	SH Submucosal Hemorrhage
AL Anal Laxity	DI Discharge	MS Moist Secretion	SHX Sample Per History
ALS Alternate Light Source	DS Dry Secretion	OF Other Foreign Materials(describe)	S Suction
EC Ecthymosis/contusion	ER Erythema (redness)	OI Other Injury(describe)	SW Swelling
FB Foreign Body	FB Foreign Body	OSC Other Skin Condition	TB Toluidine Blue
FH Fiber/Hair	OT Other	PE Petechiae	TE Tenderness
GT Granulation Tissue	PW Perianal Wart	V/S Vegetation/Soil	VL Vesicular Lesion
HC Hymenal cleft	PE Petechiae	PGW Possible Genital Wart	
IN Induration	PS Potential Saliva		
IW Incised Wound			

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 # _____

RECORD ALL CLOTHING AND SPECIMENS COLLECTED ON PAGE 8

Patient Identification

Diagram I - Penis

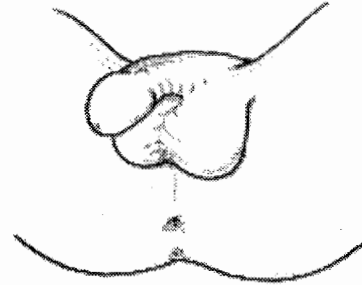


Diagram J - Penis

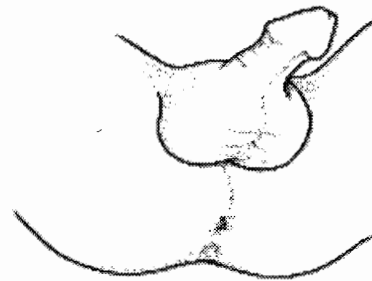


Diagram K - Anus Supine

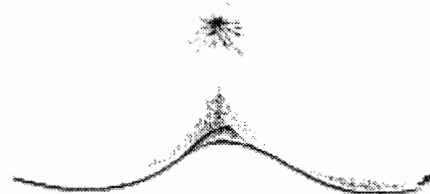


Diagram L - Anus Prone



M. 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.

N. 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"/>		

O. PHOTO DOCUMENTATION

	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**P. 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:**

MD/DO/NP/CNM _____ Telephone _____
(Print Name)

MD/DO/NP/CNM _____

Signature _____

Q. MEDICAL LAB TESTS PERFORMED

STD Cultures	GC	Chlamydia	Other	Describe:	Collected 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"/>	_____	_____

Serology Syphilis HIV Hepatitis Pregnancy test Blood Urine

Other test(s) _____

R. PRINT NAMES OF PERSONNEL INVOLVED

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

S. EVIDENCE DISTRIBUTION**GIVEN TO:**

Toxicology Samples	_____
Other Items	_____
Evidence Kit and # _____ bags	_____