

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

**NON ACUTE > 72 HOURS**

**DISTRIBUTION**

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- \_\_\_\_\_ 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](http://www.ago.state.ms.us)

[www.dps.state.ms.us](http://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?

3. Record patient's name for:	4. Assailant(s)	Patient Identification			
		Age	Gender	Race	Relationship to Patient
Female genitalia					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:	
	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?						
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						
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						
Were weapons used? <input type="checkbox"/> No <input type="checkbox"/> Yes						
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						
Loss of memory? <input type="checkbox"/> No <input type="checkbox"/> Yes						
Lapse of consciousness? <input type="checkbox"/> No <input type="checkbox"/> Yes						
Vomited after act(s)? <input type="checkbox"/> No <input type="checkbox"/> Yes						
Behavioral changes in patient? <input type="checkbox"/> No <input type="checkbox"/> Yes (Describe) _____						



# 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

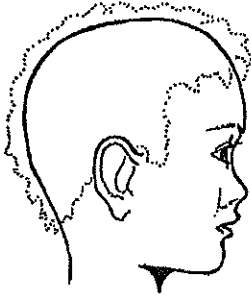


Diagram B

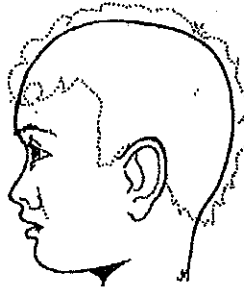


Diagram C

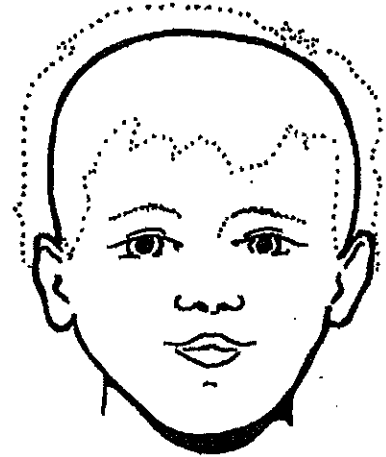


Diagram D

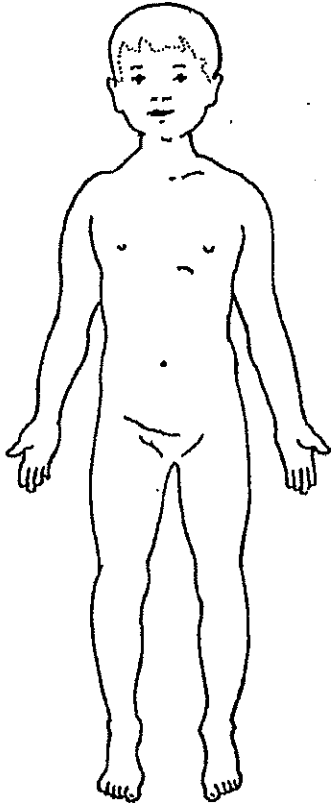


Diagram E

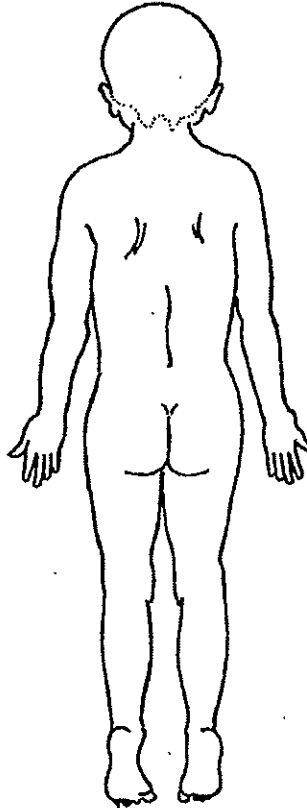
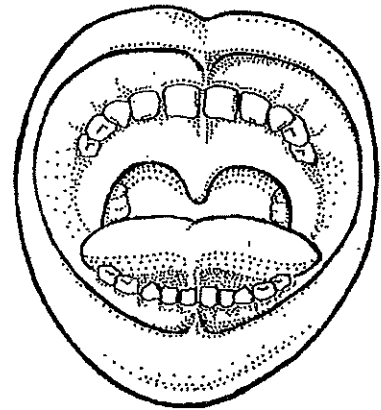


Diagram F



### LEGEND: Types of Findings

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

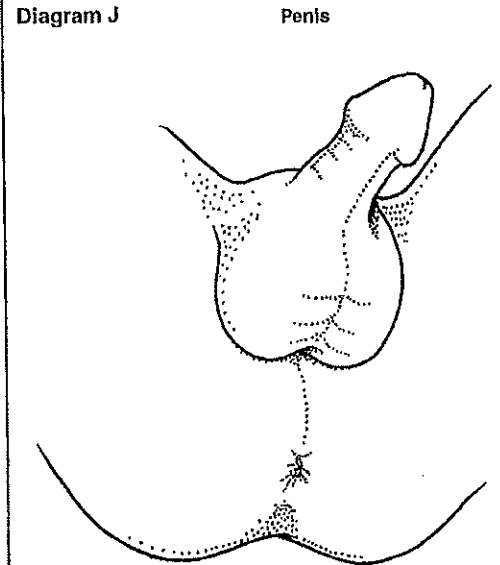
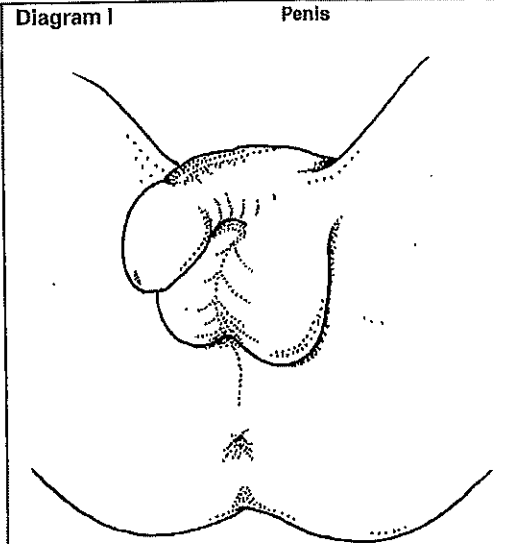
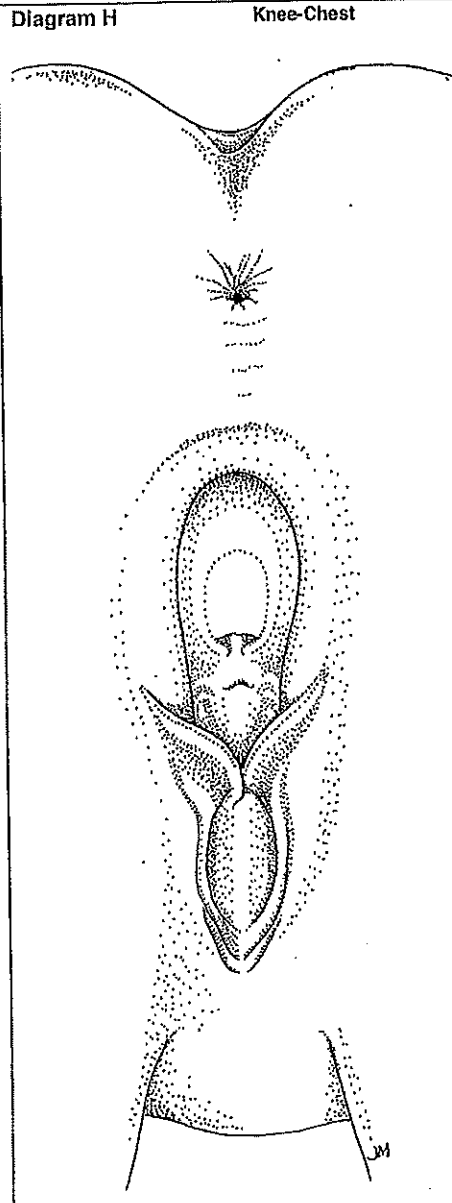
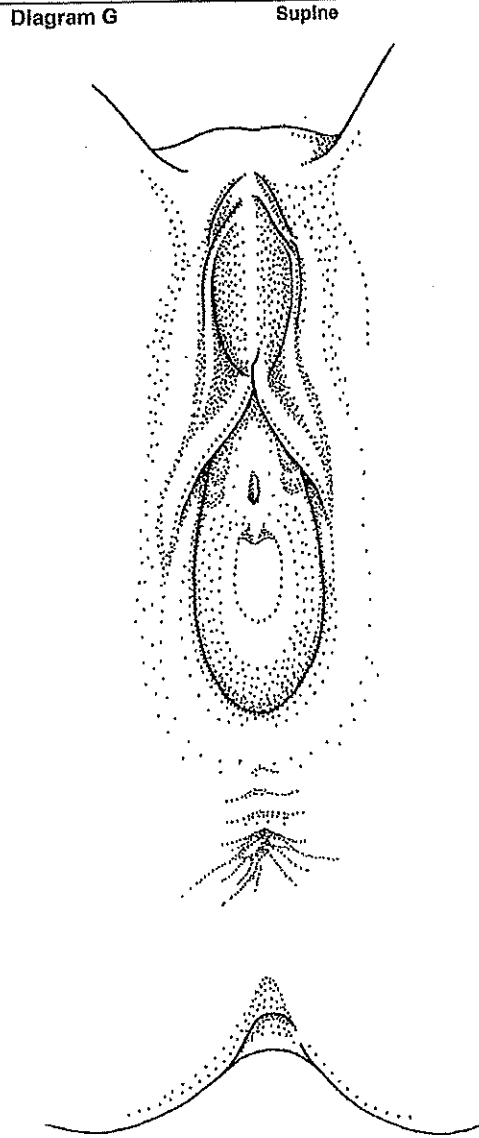
Diagram Letter	Type	Description	Photo	Diagram Letter	Type	Description	Photo
			<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/>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



### 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

Inginal adenopathy                  \_\_\_\_\_

Perineum                  \_\_\_\_\_

**3. Genital Tanner Stage**

1       2       3       4       5

**4. Female Genitalia**

Exam positions/methods:      Separation      Traction      Knee Chest

Supine                 

Prone                 

Saline/water       Moistened swab       Catheter       Other: \_\_\_\_\_

WNL      ABN      Describe

Labia majora           

Labia minora           

Clitoral hood           

Perihymenal tissues (vestibule)           

Hymen  Supine       Prone           

**Record pre-pubescent morphology**

Annular      \_\_\_\_\_

Crescentic      \_\_\_\_\_

Imperforate      \_\_\_\_\_

Septate      \_\_\_\_\_

Fossa navicularis           

Posterior fourchette           

Vagina (pubertal adolescents)           

Cervix (pubertal adolescents)           

Discharge       No       Yes      If yes, describe: \_\_\_\_\_

### 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.**

**Patient Identification**

**5. Male Genitals**

WNL      ABN      Describe

Penis                  \_\_\_\_\_

    Circumcised            \_\_\_\_\_

    Uncircumcised            \_\_\_\_\_

Foreskin                  \_\_\_\_\_

Glans Penis                  \_\_\_\_\_

Penile Shaft                  \_\_\_\_\_

Urethral meatus                  \_\_\_\_\_

Scrotum                  \_\_\_\_\_

Testes                  \_\_\_\_\_

Discharge       No       Yes      If yes, describe: \_\_\_\_\_

**6. Female/Male Anus and Rectum**

Exam positions      Observation      Observation with traction

Supine           

Supine knee chest           

Prone knee chest           

Lateral recumbent           

Exam methods:       Moistened swab       Other: \_\_\_\_\_

Anoscopy

WNL      ABN      Describe:

Buttocks                  \_\_\_\_\_

Perianal skin                  \_\_\_\_\_

Anal verge/folds                  \_\_\_\_\_

Rectum                  \_\_\_\_\_

Anal dilation       No       Yes      If yes:  Immediate       Delayed

Stool present in rectal ampulla       No       Yes       Undetermined

### K. MEDICAL LAB TESTS PERFORMED

STD Cultures      GC      Chlamydia      Other      Describe      Taken by

Oral                        \_\_\_\_\_      \_\_\_\_\_

Vestibular                        \_\_\_\_\_      \_\_\_\_\_

Vaginal                        \_\_\_\_\_      \_\_\_\_\_

Cervical                        \_\_\_\_\_      \_\_\_\_\_

Rectal                        \_\_\_\_\_      \_\_\_\_\_

Penile                        \_\_\_\_\_      \_\_\_\_\_

Wet mount                        \_\_\_\_\_      \_\_\_\_\_

Serology      Syphilis            HIV            Hepatitis     

Pregnancy test      Blood            Urine     

Other test(s)      \_\_\_\_\_      \_\_\_\_\_

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

1. Colposcope  No  Yes \_\_\_\_\_  
 (magnification)
2. Camera  No  Yes \_\_\_\_\_  
 (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**