

State of California
Governor's Office of Emergency Services

(www.caloes.ca.gov)

**FORENSIC MEDICAL REPORT:
ABBREVIATED
ADULT/ADOLESCENT SEXUAL
ASSAULT EXAMINATION
CAL OES 2-924**



For copies of this form or assistance in completing the Cal OES 2-924, please contact the
California Clinical Forensic Medical Training Center
(916) 930-3080 or www.ccfmtc.org

**FORENSIC MEDICAL REPORT: ABBREVIATED
ADULT/ADOLESCENT SEXUAL ASSAULT EXAMINATION**

**STATE OF CALIFORNIA
California Office of Emergency Services**

Cal OES 2-924

Confidential Document

Patient Identification

A. GENERAL INFORMATION (print or type)

1. Name of Medical or Examination Facility

2. Name of Patient Patient ID Number Date Time

B. MANDATORY REPORTING RESPONSIBILITY

1. Jurisdiction (City County Other) Patient refused to disclose or unable to disclose location of assault

2. Telephone report made to law enforcement agency Yes No N/A
Name of Officer Agency ID Number Telephone Reported by: Name Date Time

3. Responding Officer Agency ID Number Telephone

4. Acknowledgement of Mandatory Reporting Law for Healthcare Professionals by Patient

I understand that Penal Code Sections 11160-11161 requires healthcare professionals to make both a telephone and written report to a law enforcement agency if they provide medical services for a physical condition to a patient whom he or she knows or reasonably suspects is suffering from any wound or other physical injury where the injury is a result of assaultive or abusive conduct. Sexual assault statutes are listed in this mandate and they include, but are not limited to: rape, attempted rape, assault to commit rape, oral copulation, sodomy, and sexual battery. Sexual battery is defined as touching the intimate part of another person against the person's will. Touching is defined as physical contact with another person, whether accomplished directly through the clothing or physical contact with the skin of another person against a person's will. Submit the Cal OES 2-920 Mandatory Reporting form to comply with the written report requirement. Use the Mandatory Report Case Number (also called Agency Incident Number) given by the law enforcement agency as identifying information for the Cal OES 2-920, the Cal OES 2-924, and the evidence kit; NOT the patient's name. Consult your local District Attorney's office if you have questions about this statute. Both the Cal OES 2-920 and 2-924 can be downloaded from www.ccfmtc.org or www.oes.ca.gov. Also enter this identifying number on the patient discharge instructions for the patient. _____(Initial)

Mandatory Report Case Number (also called Agency Incident Number) obtained from the law enforcement agency: _____

Alternate Case Number (per local protocol) if incident not consistent with mandatory reporting law (see instructions): _____

C. INFORMED PATIENT CONSENT FOR ABBREVIATED ADULT/ADOLESCENT SEXUAL ASSAULT EXAMINATION

1. In accordance with the Violence Against Women Act of 2005, 42 U.S.C. § 3796gg-4(d), states and territories may not "require a victim of sexual assault to participate in the criminal justice system or cooperate with law enforcement in order to be provided with a forensic medical exam." Abbreviated Forensic Medical Exams provide individuals who have been reportedly sexually assaulted access to a Sexual Assault Forensic Medical Exam (SAFE) without engaging with law enforcement. 1. _____(Initial)

2. By delaying an interview and not engaging with law enforcement at this time, the following may occur: 2. _____(Initial)

- An Abbreviated Sexual Assault Forensic Medical Exam collecting only perishable evidence will be performed.
- Evidence that would normally be collected by law enforcement will be permanently lost.
- Suspects and witnesses will not be interviewed, they may not be identifiable or located, or willing to cooperate at a later time.
- It may be more difficult, if at all possible, for a prosecutor to file charges against a suspect.
- I may or may not be eligible for California Victim Compensation Funds to pay for out-of-pocket expenses relating to this crime, including counseling, out-of-pocket medical expenses for medical evaluation and treatment, moving expenses and lost wages by not cooperating with law enforcement per State law.

3. If I decide instead to engage with law enforcement at this time, the benefits will include: 3. _____(Initial)

Law enforcement will have an opportunity to collect evidence from the crime scene(s), interview suspect(s) and witnesses in a timely fashion, and a complete Sexual Assault Forensic Examination will be performed.

4. I do not want to be interviewed at this time by law enforcement and request an Abbreviated Sexual Assault Forensic Medical Exam. 4. _____(Initial)

5. I understand that I will not be billed for this exam per Violence Against Women Act (VAWA) of 2005, 42 U.S.C. § 3796gg-4(d) 5. _____(Initial)

6. After a Sexual Assault Forensic Medical Exam is performed, law enforcement will transport the evidence collected to storage, and law enforcement will store this evidence for 2 years. 6. _____(Initial)

All evidence collected during the Abbreviated Sexual Assault Forensic Medical Exam may be destroyed by law enforcement agencies after 2 years and a 60 day notice will be given to me pursuant to the Sexual Assault Victim Bill of Rights. Law enforcement will need, however, a current address on file. If requested in writing, I will be notified before the evidence kit is destroyed.

7. I understand that medication is available to decrease the risk of pregnancy and/or sexually transmitted diseases that may occur as a result of the sexual assault. The SAFE can provide you with a referral for this follow up medical care, if needed. 7. _____(Initial)

8. Material from the exam, including photographs, may be used without identifiers for education and scientific purpose. 8. _____(Initial)

I have read and understand all of the above and consent to an Abbreviated Sexual Assault Forensic Medical Exam.

Patient's Name (please print)

Signature

Date

D. PATIENT HISTORY: FORENSIC MEDICAL EXAM QUESTIONNAIRE TO BE COMPLETED BY PATIENT

Name _____ Age _____ Date of Birth _____ Gender M F Date/Time _____

Who is filling out this form, if not patient? _____ Relationship _____

Please answer all of the following questions. The answers will help preserve the details of the sexual assault if you decide to report to law enforcement later. The answers will be kept confidential. If you do not understand any of the words in this questionnaire, please ask the medical provider.

When did the sexual assault occur? Date _____ Time _____

Where did the sexual assault occur? _____

Name of assailant(s) _____ Age _____ Gender M F Relationship _____
 _____ Age _____ Gender M F Relationship _____

#	Sexual Acts that Occurred	No	Yes	Unsure	Choose not to answer	Additional Details
1.	Did the assailant put any of the following in your vagina?					
	Penis					
	Finger					
	Other object (what?)					
2.	Did the assailant put any of the following in your anus?					
	Penis					
	Finger					
	Other objects (what?)					
3.	Did assailant's mouth touch your genitals?					
4.	Did assailant's penis touch your mouth?					
5.	Did assailant's mouth touch your anus?					
6.	Did the assailant make you put your mouth on his/her anus?					
7.	Did assailant lick you with his/her tongue, kiss you, suck on you (hickey) or bite you? If yes, where?					
8.	Did the assailant ejaculate (cum/finish)?					
	In your mouth?					
	In your vagina?					
	In your anus?					
	On your skin?					
	On any of the clothes you were wearing?					
9.	Did the assailant use any lubricants, such as: saliva, lotions, gels, or creams? Please circle					
10.	Did the assailant use a condom?					

#	Other information about the assault, before the assault and since the assault:	No	Yes	Unsure	Choose not to answer	Additional Details
1.	Did the assailant have or use a weapon? Please circle.					
2.	Did the assailant strangle/choke you?					
3.	Did the assailant force you to drink alcohol or take drugs?					
4.	Do you think you might have been drugged without your knowledge?					
5.	Did you scratch or injure the assailant?					
6.	Did you pass out or lose consciousness?					
7.	Do you remember what happened clearly?					
8.	Did you vomit during or afterwards?					
9.	Do you think your genitals were injured?					
10.	Do you think your anus was injured?					
11.	Do you think your body was injured anywhere? Where?					
12.	Have you had intercourse with anyone else within the past 5 days: anal, vaginal, or oral? Please circle.					
13.	If the answer to #12 is yes, was a condom used?					
14.	Did you voluntarily use alcohol within 12 hours prior to the assault?					
15.	Did you voluntarily use any drugs or prescription medications within 96 hours prior to the assault?					
16.	Did you voluntarily use drugs or prescription medications or alcohol between the time of the assault and now?					
17.	What was the first day of your last menstrual period?	Answer:				

#	Since the assault, have you...	No	Yes	Unsure	Choose not to answer	Additional Details
1.	Urinated?					
2.	Had a bowel movement?					
3.	Washed, bathed or showered? Circle.					
4.	Douched?					
5.	Removed or inserted a tampon or a diaphragm? Circle.					
6.	Gargled or rinsed your mouth out?					
7.	Wiped off your genitals?					
8.	Brushed your teeth?					
9.	Had anything to eat or drink? Circle.					
10.	Changed your clothing?					

Signed _____

(Patient)

Reviewed _____

(SAFE) – Print Name

Date _____

(SAFE) – Signature

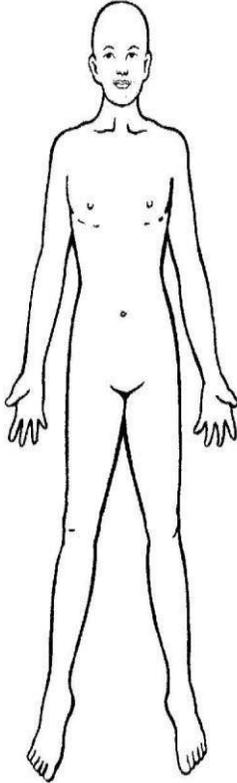
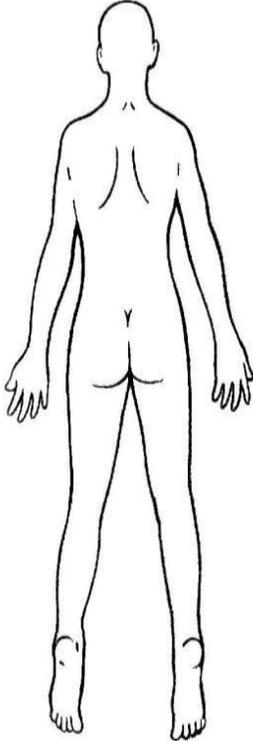
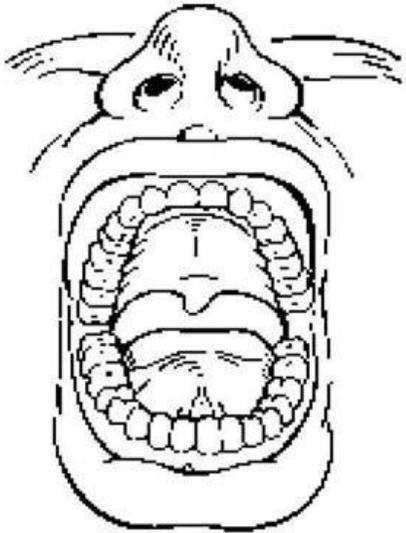
E. GENERAL INFORMATION (print or type)					
1. Name of Patient			Patient ID Number		
2. Address			City		
County		State		Zip	
Telephone (H)			(C)		
Patient Identification					
3. Age	DOB	Gender M F	Ethnicity	Date/Time Patient Arrived at Facility	Date/Time Patient Discharged from Facility

F. GENERAL PHYSICAL EXAMINATION

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

1. Blood Pressure	Pulse	Date/Time History and the Exam Process Started	Date/Time Exam Process Completed	2. Was patient able to cooperate with exam: <input type="checkbox"/> Yes <input type="checkbox"/> No
				If no explain:

- 3. Collect clothing that is nearest to genital structures.
- 4. Review patient questionnaire and conduct a physical examination for findings relevant to assault. Injuries? Yes No Foreign Materials? Yes No
- 5. Collect samples per patient history and per Wood's Lamp®. Samples Collected? Yes No
- 6. Collect fingernail scrapings or cuttings according to local policy.
- 7. Collect 2 swabs from the oral cavity up to 24 hours post assault, if indicated per history, or if history absent or incomplete.

Diagram A	Diagram B	Diagram C
		

LEGEND: Types of Findings

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

Locator #	Type	Description	Locator #	Type	Description

G. FEMALE GENITALIA

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

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

<input type="checkbox"/> No Findings	<input type="checkbox"/> Periurethral tissue/urethral meatus
<input type="checkbox"/> Inner thighs	<input type="checkbox"/> Perihymenal tissue (vestibule)
<input type="checkbox"/> Perineum	<input type="checkbox"/> Hymen
<input type="checkbox"/> Labia Majora	<input type="checkbox"/> Fossa Navicularis
<input type="checkbox"/> Labia Minora	<input type="checkbox"/> Posterior Fourchette
<input type="checkbox"/> Clitoris/surrounding area	<input type="checkbox"/> Cervix
<input type="checkbox"/> Vagina	
- Collect dried and moist secretions, stains, and foreign materials. Findings No Findings
- Examine vagina and cervix for injury, foreign materials, foreign bodies and other findings.
- Collect 4 swabs from the vagina pool.
- Collect 2 cervical swabs.

Patient Identification



Diagram D

H. MALE GENITALIA

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

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

<input type="checkbox"/> No Findings	<input type="checkbox"/> Glans penis	<input type="checkbox"/> Scrotum
<input type="checkbox"/> Inner thighs	<input type="checkbox"/> Penile Shaft	<input type="checkbox"/> Testes
<input type="checkbox"/> Perineum	<input type="checkbox"/> Urethral meatus	
<input type="checkbox"/> Foreskin		
- Circumcised: No Yes
- Collect dried and moist secretions, stains, and foreign materials. Findings No Findings
- Collect 2 penile swabs, if indicated by assault history. N/A
- Collect 2 scrotal swabs, if indicated by assault history. N/A

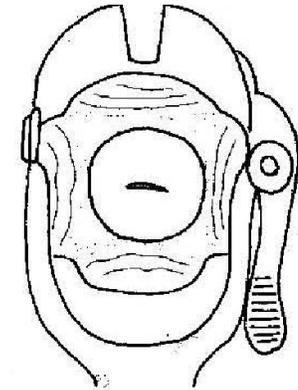


Diagram E

I. ANAL AND RECTAL EXAM

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

- Examine the buttocks, perianal skin, and anal folds for injury and foreign materials.
Check findings if relevant to assault:

<input type="checkbox"/> No Findings	<input type="checkbox"/> External anus/anal verge/folds/rugae
<input type="checkbox"/> Buttocks	<input type="checkbox"/> Rectum
<input type="checkbox"/> Perianal Skin	
- Collect dried and moist secretions, stains, and foreign materials.
- Collect 2 anal and/or rectal swabs.
- Conduct an anoscopic exam if rectal injury is suspected or if there is any sign of rectal bleeding. Collect 2 rectal swabs, if anoscopy done.

Rectal Bleeding:	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:
Rectal Injuries/Other:	<input type="checkbox"/> No	<input type="checkbox"/> Yes, describe:
- Exam position used: Supine Other describe:

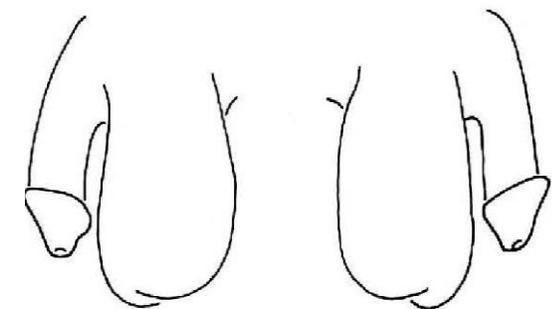


Diagram F

LEGEND: Types of Findings

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

Locator #	Type	Description

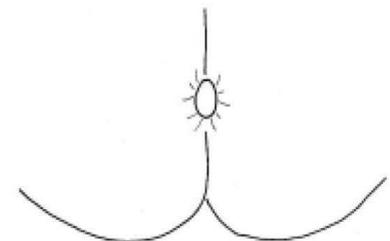


Diagram G

J. EVIDENCE COLLECTED

1. Underwear Collected? No Yes

2. Foreign materials collected Collected by: _____

	No	Yes	
Swabs/suspected blood	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dried secretions	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fiber/loose hairs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vegetation soil/debris	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swabs/suspected semen	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swabs/suspected saliva	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swabs/Wood's Lamp [⊕]	<input type="checkbox"/>	<input type="checkbox"/>	_____
Control swabs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fingernail scrapings/cuttings	<input type="checkbox"/>	<input type="checkbox"/>	_____
Matted hair cuttings	<input type="checkbox"/>	<input type="checkbox"/>	_____
Intravaginal foreign body	<input type="checkbox"/>	<input type="checkbox"/>	_____

If yes, describe: _____

Other types: _____ _____

3. Oral/genital/anal/rectal/samples

Oral			
Vaginal			
Cervical			
Anal			
Rectal			
Penile			
Scrotal			

K. TOXOLOGY SAMPLES

	No	Yes	Collected By:
Blood alcohol/toxicology	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urine toxicology	<input type="checkbox"/>	<input type="checkbox"/>	_____

L. PHOTO DOCUMENTATION METHODS

	No	Yes	Colposcope	Macrolens	Other Optics
Body	<input type="checkbox"/> _____				
Genitals	<input type="checkbox"/> _____				

Still images, video images? (Circle)

Photographed by: _____

DISTRIBUTION OF Cal OES 2-924

Copy within evidence kit Copy to Exam Facility Records

Patient Identification

M. RECORD EXAM METHODS

	NO	YES
Colposcopy	<input type="checkbox"/>	<input type="checkbox"/>
Toluidine Blue Dye	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal Speculum Exam	<input type="checkbox"/>	<input type="checkbox"/>
Anoscopic Exam	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

Describe: _____

N. RECORD EXAM FINDINGS

Physical Findings No Physical Findings

O. SUMMARY OF POSITIVE FINDINGS:

P. PRINT NAMES OF PERSONNEL INVOLVED

Exam performed by: _____	Telephone: _____
Specimens labeled and sealed by: _____	
Assisted by: <input type="checkbox"/> N/A	
Signature of examiner: _____	License No. _____

Q. SIGNATURE OF OFFICER RECEIVING EVIDENCE

Signature: _____

Print Name and ID No. _____

Agency: _____

Date: _____

R. OTHER STORAGE LOCATION No Yes

If yes, specify: _____

S. DATE/TIME EXAM COMPLETED, EVIDENCE DRIED AND PACKAGED, AND WRITE-UP COMPLETED

Date _____ Time _____