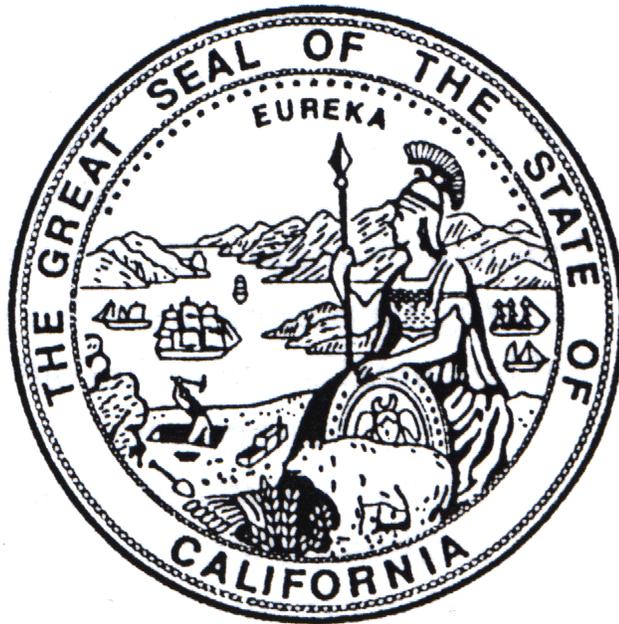


State of California
Governor's Office of Emergency Services
(www.caloes.ca.gov)

FORENSIC MEDICAL REPORT:

ACUTE (<72 HOURS) CHILD/ADOLESCENT SEXUAL ABUSE EXAMINATION

CAL OES 2-930



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

**FORENSIC MEDICAL REPORT: ACUTE (< 72 HOURS)
CHILD/ADOLESCENT SEXUAL ABUSE EXAMINATION**

**STATE OF CALIFORNIA
OFFICE OF EMERGENCY SERVICES**

Cal OES 2-930

Confidential Document

Patient Identification

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

1. Name of patient Patient ID number

2. Address City County State Telephone

3. Age DOB Gender Ethnicity Date/time of arrival Date/time of discharge

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

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

6. Name(s) of Siblings	Gender	Age	DOB	Name(s) of siblings	Gender	Age	DOB
	M F				M F		
	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
Child Protective Services

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

Law Enforcement
and/or
Child Protective Services

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

Law Enforcement
Child Protective Services

4. Authorization for evidential exam requested by law enforcement or child protective services agency

I request a forensic medical examination for suspected sexual abuse at public expense.

Telephone Authorization Authorizing party: ID number: Date/time:
--

Law enforcement officer ID number Agency
 Child Protective Services

Telephone Date Time Case number

C. CONSENT FOR EXAMINATION BY PATIENT/PARENT/GUARDIAN Note: Parental consent is not required for a suspected child sexual abuse examination. Family Code Section 6927 permits minors (12 to 17 years of age) to consent to medical examination, treatment, and evidence collection for sexual assault without parental consent. See instructions regarding parental notification requirements for minors.

- I hereby consent to a forensic medical examination for evidence of sexual abuse. I understand that collection of evidence may include photographing injuries and that these photographs may include the anal-genital area (private parts). I further understand that medical providers are required to notify child protective authorities of known or suspected child abuse; and, if child abuse is found or suspected, this form and any evidence obtained will be released to a child protective agency.
- I have been informed that victims of crime are eligible to submit crime victim compensation claims to the State Victims of Crime (VOC) Restitution Fund for out-of-pocket medical expenses, psychological counseling, loss of wages, and job retraining/rehabilitation.
- 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.

Signature Patient Parent Guardian

DISTRIBUTION OF Cal OES 2-930

Original – Law Enforcement Copy – Child Protective Services Copy within evidence kit – Crime Lab Copy – Medical Facility Records

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. 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
--------------------------	--------------------------------	-----------------------------	------------------	---

	No	Yes	Attempted	Unsure	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"/>	_____
Finger	<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"/>	_____
Associated pain?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	_____
Associated bleeding?	<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"/>	_____
Finger	<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"/>	_____
Associated pain?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	_____
Associated bleeding?	<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"/>	_____
Of assailant by patient	<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"/>	_____
Of assailant by patient	<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"/>	_____
Of assailant by patient	<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 Injury <input type="checkbox"/> Biting					
Other acts? (Describe) <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>					
Did ejaculation occur? <input type="checkbox"/> <input type="checkbox"/>					
If yes, note location(s):					
<input type="checkbox"/> Vagina <input type="checkbox"/> Body surface <input type="checkbox"/> On bedding					
<input type="checkbox"/> Anus <input type="checkbox"/> On clothing <input type="checkbox"/> Other					
Contraceptive or lubricant products? <input type="checkbox"/> No <input type="checkbox"/> Yes					
If yes, note type/brand: <input type="checkbox"/> Foam <input type="checkbox"/> Jelly <input type="checkbox"/> Lubricant <input type="checkbox"/> Condom					
Were force or threats used? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Force <input type="checkbox"/> Threats					
Were pictures/videotapes taken or shown? <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> No <input type="checkbox"/> Yes					
If yes, note type(s): <input type="checkbox"/> Pictures <input type="checkbox"/> Videotapes					
Were drugs or alcohol used? <input type="checkbox"/> No <input type="checkbox"/> Yes* Describe: _____					
Loss of memory? <input type="checkbox"/> No <input type="checkbox"/> Yes* Describe: _____					
Lapse of consciousness? <input type="checkbox"/> No <input type="checkbox"/> Yes* Describe: _____					
Vomited after act(s)? <input type="checkbox"/> No <input type="checkbox"/> Yes Describe: _____					
Behavioral changes in patient? <input type="checkbox"/> No <input type="checkbox"/> Yes Describe: _____					

***Collection of toxicology samples is recommended according to local policy.**

F. ACTS DESCRIBED BY PATIENT

1. Acts disclosed by patient to:

- Medical Examiner Law Enforcement Officer
 Social Worker Multi-disciplinary Interview Team
 Other:

	No	Yes	Attempted	Unsure
Genital/vaginal contact/penetration by:				
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 (Describe below)	<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"/>
Finger	<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"/>
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"/>
Of assailant by patient	<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"/>
Of assailant by patient	<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"/>
Of assailant by patient	<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 injury <input type="checkbox"/> Biting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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"/>	<input type="checkbox"/>
If yes, note location(s):				
<input type="checkbox"/> Vagina <input type="checkbox"/> Body surface <input type="checkbox"/> On bedding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Anus <input type="checkbox"/> On clothing <input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contraceptive or lubricant products? <input type="checkbox"/> No <input type="checkbox"/> Yes				
If yes, note type/brand: <input type="checkbox"/> Foam <input type="checkbox"/> Jelly <input type="checkbox"/> Lubricant <input type="checkbox"/> Condom				
Were force or threats used? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Force <input type="checkbox"/> Threats				
Were pictures/videotapes taken or shown? <input type="checkbox"/> No <input type="checkbox"/> Yes				
If yes, note type(s): <input type="checkbox"/> Pictures <input type="checkbox"/> Videotapes				
Were drugs or alcohol used? <input type="checkbox"/> No <input type="checkbox"/> Yes* Describe:				
Loss of memory? <input type="checkbox"/> No <input type="checkbox"/> Yes* Describe:				
Lapse of consciousness? <input type="checkbox"/> No <input type="checkbox"/> Yes* Describe:				
Vomited after act(s)? <input type="checkbox"/> No <input type="checkbox"/> Yes Describe:				
Behavioral changes? <input type="checkbox"/> No <input type="checkbox"/> Yes Describe:				

*Collection of toxicology samples is recommended according to local policy.

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				
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?	<input type="checkbox"/>	<input type="checkbox"/>			
4. Any pre-existing physical injuries?	<input type="checkbox"/>	<input type="checkbox"/>			
5. Any previous history of physical abuse and/or neglect?	<input type="checkbox"/>	<input type="checkbox"/>			
6. Any previous history of sexual abuse?	<input type="checkbox"/>	<input type="checkbox"/>			
7. Other intercourse? (For adolescents only)	<input type="checkbox"/>	<input type="checkbox"/>			
If yes, < 5 days? When? _____	<input type="checkbox"/>	<input type="checkbox"/>			
If yes, did intravaginal ejaculation occur?	<input type="checkbox"/>	<input type="checkbox"/>			
If yes, was a condom used?	<input type="checkbox"/>	<input type="checkbox"/>			
8. Menstrual periods?	<input type="checkbox"/>	<input type="checkbox"/>			
If yes, age of menarche: _____					
If yes, last menstrual period: _____					
9. Other symptoms disclosed	by patient:		by historian:		
	No	Yes	No	Yes	Unk
Abdominal/pelvic pain	<input type="checkbox"/>				
Pain on urination	<input type="checkbox"/>				
Genital discomfort or pain	<input type="checkbox"/>				
Genital itching	<input type="checkbox"/>				
Genital discharge	<input type="checkbox"/>				
Genital bleeding	<input type="checkbox"/>				
Rectal discomfort or pain	<input type="checkbox"/>				
Rectal itching	<input type="checkbox"/>				
Rectal bleeding	<input type="checkbox"/>				
Constipation	<input type="checkbox"/>				
Other _____	<input type="checkbox"/>				
If yes, describe onset, duration, and intensity:					

10. Post-assault hygiene activity Not applicable if over 72 hours

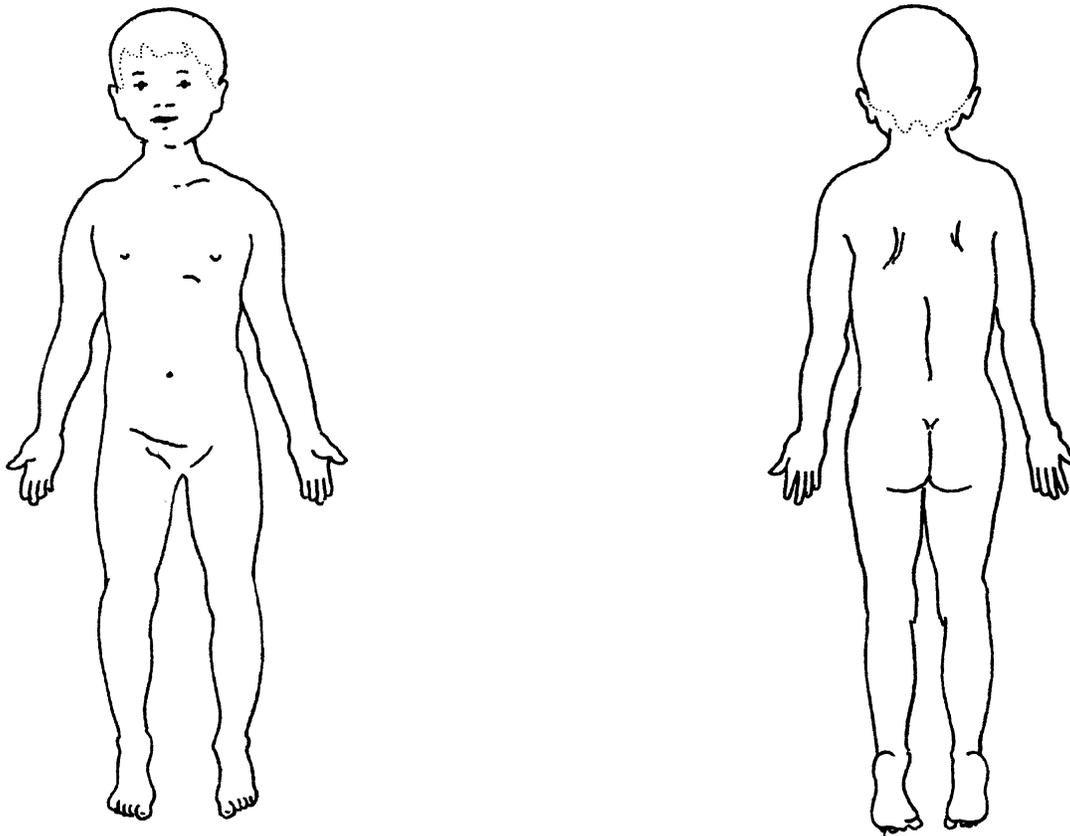
	by patient:		by historian:		
	No	Yes	No	Yes	Unk
Urinated	<input type="checkbox"/>				
Defecated	<input type="checkbox"/>				
Genital or body wipes	<input type="checkbox"/>				
If yes, describe: _____	<input type="checkbox"/>				
Douched	<input type="checkbox"/>				
If yes, with what? _____	<input type="checkbox"/>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

H. GENERAL PHYSICAL EXAMINATION

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

1. BP	Pulse	Resp	Temp	Height	Weight	2. Date/time examination		Patient Identification		
						Started	Completed			
3. Female Tanner Stage – Breast						1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
4. Describe general physical appearance.										
5. Describe general demeanor and relevant statements made during exam.										
6. Describe condition of clothing upon arrival.										
7. Collect outer and underclothing if indicated. <input type="checkbox"/> Not indicated										
8. 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 If no, describe:										
9. Collect dried and moist secretions, stains, and foreign materials from the body. Scan the entire body with a Wood's Lamp.										
<input type="checkbox"/> Findings <input type="checkbox"/> No Findings										
10. Collect fingernail scrapings or cuttings according to local policy.										

Diagram A - Full Body



LEGEND: Types of Findings

AB Abrasion	BU Burn	DI Discharge	HC Hymenal Cleft	OF Other Foreign Materials (describe)	PW Perianal Wart	SW Swelling
AHT Absent Hymenal Tissue	CS Control Swab	DS Dry Secretion	IN Induration	PE Petechiae	TE Tenderness	TB Toluidine Blue⊕
AL Anal Laxity	DE Debris	EC Ecchymosis (bruise)	IW Incised Wound	OI Other Injury (describe)	PGW Possible Genital Wart	TE Tenderness
BI Bite	DF Deformity	ER Erythema (redness)	LA Laceration	OSC Other Skin Condition	PS Potential Saliva	V/S Vegetation/soil
		FB Foreign Body	MS Moist Secretion	SI Suction Injury	VL Vesicular Lesion	WL Wood's Lamp⊕
		F/H Fiber/hair				

Locator #	Type	Description	Locator #	Type	Description

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 and prepare one dry mount slide from one of the swabs.
6. Collect head hair reference samples according to local policy

Patient Identification _____

Diagram B: Head and Mouth

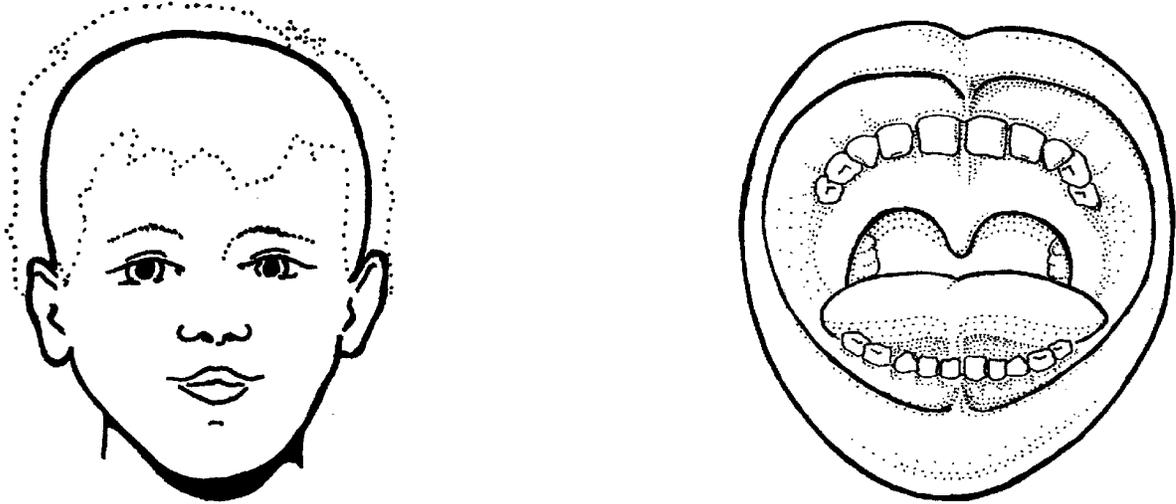
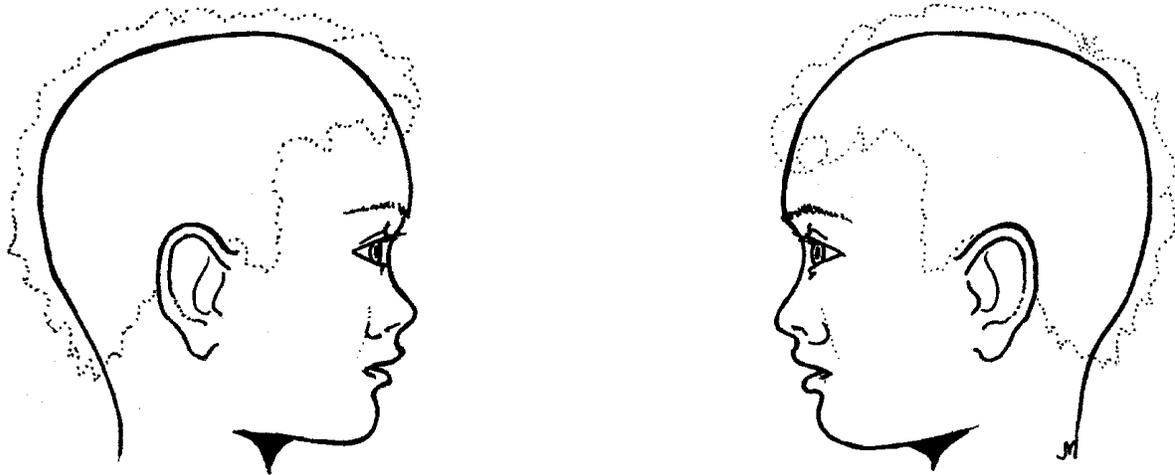


Diagram C: Head Profiles



LEGEND: Types of Findings

AB Abrasion	BU Burn	DS Dry Secretion	HC Hymenal Clef	OF Other Foreign	PW Perianal Wart	SW Swelling
AHT Absent Hymenal Tissue	CS Control Swab	EC Ecchymosis (bruise)	IN Induration	Materials (describe)	PE Petechiae	TB Toluidine Blue®
AL Anal Laxity	DE Debris	ER Erythema (redness)	IW Incised Wound	OI Other Injury (describe)	PGW Possible Genital Wart	TE Tenderness
BI Bite	DF Deformity	FB Foreign Body	LA Laceration	OSC Other Skin Condition	PS Potential Saliva	V/S Vegetation/soil
	DI Discharge	F/H Fiber/hair	MS Moist Secretion		SI Suction Injury	VL Vesicular Lesion
						WL Wood's Lamp®

Locator #	Type	Description	Locator #	Type	Description

RECORD ALL SPECIMENS COLLECTED ON PAGE 8

K. GENITAL EXAMINATION – MALES

Record all findings 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:
 - Supine Prone Moistened swab
 - Toluidine Blue Dye Other: _____
- Genital Tanner Stage 1 2 3 4 5
- Circumcised: No Yes
- Check the ABN box(es) if there are abuse/assault related findings. Describe any abnormal or unusual findings.

<input type="checkbox"/> No Findings	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: _____		
- Collect dried and moist secretions, stains, and foreign materials. Scan the area with a Wood's Lamp. Findings No Findings
- Collect pubic hair combing or brushing. Not applicable
- Collect pubic hair reference samples according to local policy. Not applicable
- Collect 2 penile swabs, if indicated by assault history. Not applicable
- Collect 2 scrotal swabs, if indicated by assault history. Not applicable

Patient Identification

Diagram F - Penis

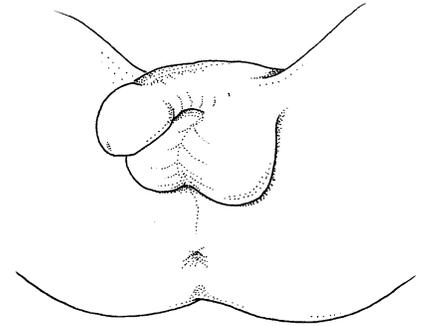
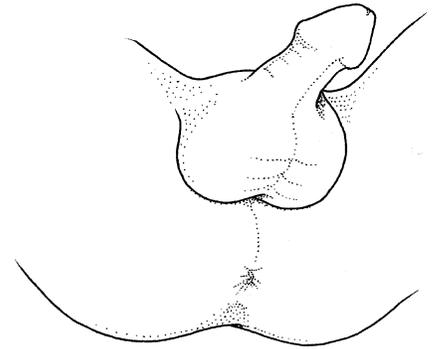


Diagram G - Penis



L. FEMALE/MALE ANAL AND RECTAL EXAMINATION

- Examine the buttocks, perianal skin, and anal folds for injury, foreign materials, and other findings.
- 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: _____
- Check the ABN box(es) if there are abuse/assault related findings. Describe any abnormal or unusual findings.

<input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> Yes	If yes: <input type="checkbox"/> Immediate <input type="checkbox"/> Delayed		
Stool present in rectal ampulla <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined			
- Collect dried and moist secretions, stains, and foreign materials. Findings No Findings
- Collect 2 anal and/or rectal swabs and prepare one dry mount slide.
- Rectal bleeding: No Yes If yes, describe: _____

Diagram H - Anus Supine

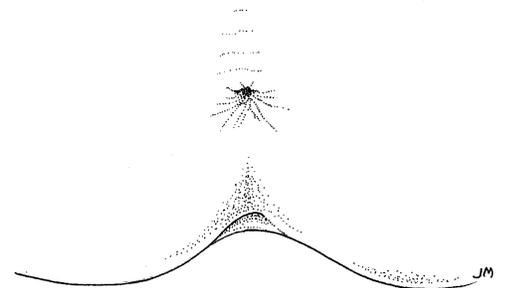
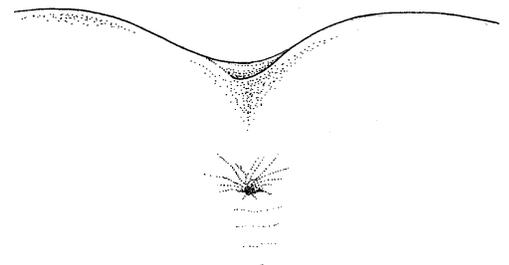


Diagram I - Anus Prone



LEGEND: Types of Findings

AB Abrasion	DF Deformity	IW Incised Wound	PGW Possible Genital Wart
ABT Absent	DI Discharge	LA Laceration	PS Potential Saliva
Hymenal Tissue	DS Dry Secretion	MS Moist Secretion	SI Suction Injury
AL Anal Laxity	EC Ecchymosis (bruise)	OF Other Foreign Materials (describe)	SW Swelling
BI Bite	ER Erythema (redness)	OI Other Injury (describe)	TB Toluidine Blue⊕
BU Burn	FB Foreign Body	OSC Other Skin Condition	TE Tenderness
CS Control Swab	FH Fiber/hair	PW Perianal Wart	V/S Vegetation/Soil
DE Debris	HC Hymenal Cleft	PE Petechiae	VL Vesicular Lesion
	IN Induration		WL Wood's Lamp⊕

Locator #	Type	Description

RECORD ALL SPECIMENS COLLECTED ON PAGE 8

M. EVIDENCE COLLECTED AND SUBMITTED TO CRIME LAB

1. Clothing placed in evidence kit:	Other clothing placed in bags:

2. Foreign materials collected

	No	Yes	Collected by:
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	<input type="checkbox"/>	<input type="checkbox"/>	_____
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 [⊕] area(s)	<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"/>	_____
Pubic hair combings/brushings	<input type="checkbox"/>	<input type="checkbox"/>	_____
Intravaginal foreign body	<input type="checkbox"/>	<input type="checkbox"/>	_____
Describe: _____			
Other types. Describe: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

3. Oral/genital/anal/rectal samples

	# Swabs	# Slides	Time collected	Collected by:
Oral				
Vulvar				
Vestibular				
Vaginal				
Cervical				
Anal				
Rectal				
Penile				
Scrotal				
Aspirate/washings (optional) <input type="checkbox"/> No <input type="checkbox"/> Yes				

4. Vaginal wet mount slide

	No	Yes	Time	Examiner:
Prepared				
Motile sperm observed				
Non-motile sperm observed				

N. TOXICOLOGY SAMPLES

	No	Yes	Time	Collected by:
Blood alcohol/toxicology (gray top tube)				
Urine toxicology				

O. REFERENCE SAMPLES

	No	Yes	Collected by:
Blood (lavender top tube)			
Blood (yellow top tube)			
Blood Card (optional)			
Buccal swabs (optional)			
Saliva swabs			
Head hair			
Pubic Hair			

P. PHOTO DOCUMENTATION METHODS

	No	Yes	Colposcope/ 35mm	Macrolens/ 35mm	Colposcope/ Videocamera	Other Optics
Body	<input type="checkbox"/>	<input type="checkbox"/>				
Genitals	<input type="checkbox"/>	<input type="checkbox"/>				
Photographed by: _____						

Patient Identification

Q. 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:

R. 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"/>	_____	_____
Wet mount	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Serology Syphilis <input type="checkbox"/> HIV <input type="checkbox"/> Hepatitis <input type="checkbox"/>				_____	_____
Pregnancy test Blood <input type="checkbox"/> Urine <input type="checkbox"/>				_____	_____
Other test(s)				_____	_____

S. PRINT NAMES OF PERSONNEL INVOLVED

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

T. EVIDENCE DISTRIBUTION GIVEN TO:

Clothing (item(s) not placed in evidence kit)	
Evidence Kit	
Reference blood samples	
Toxicology samples	

U. SIGNATURE OF OFFICER RECEIVING EVIDENCE

Signature: _____

Print name and ID#: _____

Agency: _____

Date: _____ Telephone: _____