

**State of California  
Governor's Office of Emergency Services  
([www.caloes.ca.gov](http://www.caloes.ca.gov))**

**FORENSIC MEDICAL REPORT:  
ELDER AND DEPENDENT ADULT ABUSE AND NEGLECT  
INSTRUCTIONS**

**CAL OES 2-602**



For copies of this form or assistance in completing the Cal OES 2-602, please contact  
**California Clinical Forensic Medical Training Center**  
[www.ccfmtc.org](http://www.ccfmtc.org)

**Cal OES 2-602**

**Forensic Medical Report: Elder and Dependent Adult Abuse and Neglect Examination**

**USE OF STANDARD STATE FORM**

Penal Code §11161.2 established the use of a standard form to record findings from examinations performed for suspected elder and dependent adult abuse and neglect. As such, this form is not a complete medical treatment record and does not supplant medical treatment records.

**SUGGESTED USE OF STANDARD STATE FORMS: FOLLOW LOCAL POLICY**

<b>Elder Abuse and Neglect Dependent Adult Abuse and Neglect</b>	<b>Cal OES 2-602</b>	<b>Forensic Medical Report: Elder and Dependent Adult Abuse and Neglect Examination</b> • Examination of persons age 65 and above • Examination of dependent adults between ages of 18 and 64
<b>Domestic Violence</b>	<b>Cal OES 2-502</b>	<b>Forensic Medical Report: Domestic Violence Examination</b> • Examination of persons involved in intimate partner violence including dating relationships
<b>Sexual Assault</b>	<b>Cal OES 2-923</b>	<b>Forensic Medical Report: Acute (&lt;72 hours) Adult/Adolescent Sexual Assault Examination</b> • History of acute sexual assault (< 72 hours)

**INSTRUCTIONS FOR Cal OES 2-602**

These instructions contain the recommended methods for meeting the legal standards established by Penal Code §11161.2 for performing examinations. PART I: Interview can be conducted by a trained nurse or social worker. Part II: Medical Assessment is to be conducted by a trained physician, or, physician assistant, nurse practitioner, or nurse within scope of practice. See California Medical Protocol for Examination of Domestic Violence and Elder and Dependent Adult Abuse and Neglect Victims for further discussion.

**LIABILITY AND RELEASE INFORMATION**

This medical report is subject to the confidentiality requirements of the Medical Information Act (Civ. Code §56 et seq), the Physician-Patient Privilege (Evid. Code §990) and the Official Information Privilege (Evid. Code §1040). It can only be released to those involved in the investigation and prosecution of the case: a law enforcement officer, district attorney, crime laboratory, Adult Protective Services, the Office of the Ombudsman, county licensing agency, coroner and other investigating agencies. Records may be released to the defense counsel only through discovery of documents in the possession of a prosecuting agency or after the appropriate court process (i.e., judicial review and a court order).

<b>Complete this report in its entirety. Print legibly. Use N/A (not applicable) when appropriate to show that the examiner attended to the question.</b>	<b>Patient Identification: This space is provided for hospitals and clinics using plastic plates for stamping identification information; or, for facilities to write in an identification number and date.</b>
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**A. GENERAL INFORMATION**

1. Enter the patient's name.
2. Enter the patient's address and telephone numbers.
3. Enter the patient's age, date of birth, gender and ethnicity.
4. Enter the name and address of the facility where the medical/evidentiary examination is being performed. If the patient has been transferred from another facility, enter the name and address of that facility.
5. Enter the patient's arrival and discharge dates/times for the facility where the medical/evidentiary exam is performed.
6. Enter the examination start and completion times to track facility usage and length of exams.
7. Enter whether an interpreter was used, the language used, and who provided interpreting services.

**B. MANDATORY REPORTING FOR ELDER AND DEPENDENT ADULT ABUSE**

1. Welfare and Institutions Code §15630 states that any health practitioner is a mandated reporter for suspected elder and dependent adult abuse and neglect. Make an immediate telephone report and submit a written report within two working days. The written report form is SOC 341, published by the California Department of Social Services.
2. Check the box to indicate whether a telephone report was made, the name of the person taking the report, whether a written report was submitted, and to which agency.

<b>Location Where Suspected Abuse and Neglect Occurred:</b>	<b>Report to:</b>
Private residence, hotel or homeless shelter	Law enforcement agency or Adult Protective Services
Long-term care facility (e.g. nursing home, community care facility, residential care facility, elderly or adult day health center)	Law enforcement agency or ombudsman program
State mental hospital	Law enforcement agency or the State Department of Mental Health
State developmental center	Law enforcement agency or the State Department of Developmental Services

**C. RESPONDING PERSONNEL TO MEDICAL FACILITY**

Check the box and indicate which agency and personnel responded to the medical facility

**D. REQUEST AND AUTHORIZATION FOR MEDICAL EVIDENTIARY EXAMINATION: Follow State Law.**

1. According to local policy: obtain the signature and identification number of the law enforcement officer, Adult Protective Services (APS) social worker, or the Office of the Ombudsman requesting and/or authorizing the medical/evidentiary exam.
2. Elder and dependent adult abuse medical/evidentiary exams are new to the field of victim and forensic medical services. As such, payment methods have not been formally established. Options include: the patient's public (Medicaid or Medi-Cal) or private insurance, the State Victim Compensation Program (VCP), law enforcement agencies, Adult Protective Services (APS), or Office of the Ombudsman. Follow local policy.
3. Authorization is not required by state law for healthcare providers to use this form, although a contractual payor may require it.

**E. PATIENT INFORMATION: See large print version in protocol which can be laminated for use.**

Ask the patient (or the patient's surrogate or conservator, if appropriate) to read the items, initial, and sign.

**F. PATIENT CONSENT: See large print version in protocol which can be laminated for use.**

Ask the patient (or the patient's surrogate or conservator, if appropriate) to read the items, initial, and sign.

**G. DISTRIBUTION OF Cal OES 2-602: Check all boxes that apply regarding distribution of the form.**

**PART I: INTERVIEW  
PATIENT HISTORY**

**H. SUSPECTED TYPES OF ABUSE BEING REPORTED**

1. Record whether the interview was audio or videotaped.
2. Record the name(s) of the person(s) providing the history, relationship to the patient, and telephone number.
3. Record forms of abuse and neglect described by patient or historian.
  - If any of the forms of abuse and neglect are marked “yes,” use the space provided to describe.
  - See California Medical Protocol for Examination of Domestic Violence and Elder and Dependent Adult Abuse and Neglect Victims for further discussion.
  - **For sexual assault**, use Cal OES 2-923 Forensic Medical Report: Acute (<72 hours) Adult/Adolescent Sexual Assault Examination. Consult with the local law enforcement agency if patient history indicates a possible sexual assault.

**I. ALLEGED PERPETRATORS**

Record the identity of the alleged perpetrator(s) by name or nickname, appropriate age or date of birth, gender, ethnicity, address, telephone, and relationship to patient.

**J. LOCATION WHERE ABUSE OR NEGLECT OCCURED**

Record the location of where the abuse or neglect occurred.

**PART I: INTERVIEW**

**FUNCTIONAL, COGNITIVE, MENTAL HEALTH, AND SUBSTANCE ABUSE SCREENING**

**K. FUNCTIONAL HISTORY: Indicate Any Limitations**

Assess the patient's capabilities with regard to all of the activities listed. If the patient has limitations in a given area, provide the date of onset or provide estimate of the date of onset.

**L. DISABILITY**

Record whether the patient has any cognitive, developmental, physical, or mental disabilities.

**M. COGNITIVE ASSESSMENT: Mini-Mental State Examination (MMSE)**

The reliability of the Mini-Mental State Examination (MMSE) may vary as a function of primary language or years of education. Provide the number of years of education and the primary language.

**INSTRUCTIONS FOR COMPLETION OF THE MINI-MENTAL STATE EXAMINATION**

**Orientation:** Ask for the date. Then ask specifically for any item omitted, e.g., "Can you also tell me what season it is?" Score one point for each correct answer.  
Ask in turn, "Can you tell me the name of our state, county, town/city, this building and floor we are on?" Score one point for each correct answer.

**Registration:** Ask the patient if you may test his/her memory. Then say the names of three unrelated objects, clearly and slowly, about one second for each. After you have said all three, ask the patient to repeat them. This first repetition determines his/her score (0-3), but keep saying them until he/she can repeat all three, up to 6 trials. If all three are not eventually learned, recall cannot be meaningfully tested.

**Attention and Calculation:** Ask the patient to spell the word "world" backwards. The score is the number of letters in correct order (e.g. DLROW = 5, DLRW = 4, DLR = 3, OW = 2, DRLWO = 1).

**Recall:** Ask the patient if he/she can recall the 3 words you previously asked him/her to remember. Score 0 - 3.

**Language:**

**Naming** Show the patient a wristwatch and ask the patient what it is. Repeat for pencil. Score 0 - 2.

**Repetition** Ask the patient to repeat the sentence after you. Allow only one trial. Score 0 or 1.

**3-stage**

**Command** Give the patient a piece of plain blank paper and repeat the command. Score one point for each part correctly executed.

**Reading** **See laminated card in protocol.** On a blank piece of paper print the sentence, "Close your eyes," in letters large enough for the patient to see clearly. Ask the patient to read it and do what it says. Score 1 point only if the patient actually closes his/her eyes.

**Writing** Give the patient a blank piece of paper and ask the patient to write a sentence for you. Do not dictate a sentence; it is to be written spontaneously. It must contain a subject and a verb and be sensible. Correct grammar and punctuation are not necessary.

**Copying** **See laminated card in protocol.** On a clean piece of paper, draw intersecting pentagons, each side about 1 inch, and ask the patient to copy it exactly as it is. All 10 angles must be present and 2 must intersect to score 1 point. Tremor and rotation are ignored.

**Scoring** Add the total points the patient scores, then adjust the score using this table:

**Example:** An 80 year old college professor scores 28 on the MMSE.

Raw score                    28  
Adjustment for age  
and education                -2  
MMSAdj score                26

**MMSE Correction Associated with Different Education and Age Values**

Age	Education (years of schooling completed)					
	0	4	8	12	16	20
60	4	2	0	-1	-3	-5
65	4	3	1	0	-2	-4
70	5	3	1	0	-1	-3
75	6	4	2	0	-1	-3
80	6	5	3	1	0	-2
85	7	5	3	1	0	-1
90	8	6	4	2	0	-1

**MMSE Adj can be determined by adding the raw MMSE score and the indicated correction that corresponds to the individual's level of education and age.**

**N. MENTAL HEALTH AND SUBSTANCE ABUSE SCREENING**

Depression and substance abuse are common comorbidities with elder abuse. Record the patient's answers to the brief screening questions.

**O. INTERVIEWER FOR PART I**

Print and sign name. Record identification or license number, name of agency or facility, telephone number and date.

## **PART II: MEDICAL ASSESSMENT**

Part II is to be completed by a trained physician; or, physician assistant, nurse practitioner, or registered nurse within scope of practice.

### **P. ABUSE AND NEGLECT RELATED MEDICAL HISTORY**

**1. Record date(s) and time or time frame of abuse and/or neglect.**

- For time or timeframe, specify whether the abuse and/or neglect was within hours, days, weeks, or months of the exam.

**2. Record patient's description of abuse and/or neglect.**

- Allow the patient to describe the incident(s) to the extent possible. Determine and use terms familiar to the patient. Follow-up questions may be necessary to ensure that all of the items are covered. A careful history must be taken as some patients may be reluctant to describe everything that occurred for many reasons. Or, they may have been forced to accommodate difficult circumstances to the extent that their perceptions and expectations about their treatment and care are below adequate standards.
- Use quotation marks to quote relevant statements.
- Document if statement(s) made by the patient were spontaneous (i.e. not in response to question or comment).
- Ask open-ended questions such as, "What happened to you? Tell me what happened to you. How did this happen?" These are the easiest questions to answer. Avoid WHY questions.

**3. Record whether there is a past history of abuse and/or neglect.**

- Record whether there has been a past history of suspected abuse and/or neglect, when this occurred, where this happened, and whether it was reported.

**4. Obtain recent (past 60 days) information about surgeries, diagnostic procedures, psychiatric or medical treatment that may affect the interpretation of current physical or cognitive findings.**

**5. Record whether there are any other pertinent medical condition(s) that may affect the interpretation of current physical findings.**

**6. Describe any pre-existing physical injuries.**

**7. Record the names, addresses, and telephone numbers of current or prior health care providers who have participated in caring for the patient in the past.**

**8. Record current medications such as aspirin, nonsteroidal anti-inflammatory drugs, and/or coumadin that the patient has been taking.**

- List all of the patient's current medications.
- If there is concern that a patient was either overdosed or denied medication(s), obtain blood levels if applicable.

**9. Record any abuse and/or neglect related cognitive changes.**

- Change in cognitive status means confusion or change in level of consciousness. Loss of consciousness includes, but is not limited to, loss of memory, change in level of consciousness, consumption of alcohol and/or drugs.
- Obtain toxicology, complete blood count, complete metabolic panel, and urinalysis if the patient has any neurosensory clouding.

## PART II: MEDICAL ASSESSMENT

### Q. GENERAL PHYSICAL EXAMINATION

1. **Describe the patient's general physical appearance and hygiene.**
2. **Describe the patient's general demeanor and behavior during the exam.**
  - Describe behaviors such as crying, wringing of hands, willingness or ability to cooperate, responsiveness, ability to give history, etc. Avoid the use of vague, subjective, or judgmental descriptors such as "strange," "spacey," etc.
  - Documenting helps the examiner recall the patient's behavior and response during the examination for future reference.
3. **Describe the condition of clothing upon arrival (rips, presence of urine, stool, or foreign materials).**
  - Collect clothing at the direction of the law enforcement officer.
  - Collect outer and under clothing worn during or immediately after the incident.
    - Coordinate with the law enforcement officer regarding clothing to be collected.
    - Wear gloves while collecting clothing.
    - Have patient disrobe on two sheets of paper placed one on top of the other on the floor. Have patient remove shoes before stepping onto the paper. Shoes may be collected, if indicated, and packaged separately.
    - Package each garment in an individual paper bag, label, and seal.
    - Carefully fold the top sheet of paper into a bindle, label, and seal. Discard the bottom sheet. Place this large bindle and all individually bagged garments into a large paper bag(s) with a chain of custody form, label and seal.
    - Wet stains or other wet evidence require special handling. Consult local policy.
4. **Describe the condition of patient's glasses, dentures, hearing aides, wheelchairs, canes, or walkers. Collect, if indicated.**
5. **Describe status of nutrition and hydration.**
  - Describe any evidence of inadequate nutrition (cachexia, temporal wasting, etc.) or dehydration (dry mucous membranes, poor skin turgor, etc).
6. **Pain Scale.**
  - Establish whether or not the patient is experiencing pain:
    - For non-verbal patients, use the 0-5 point scale with the smiley faces, 0 being pain-free and 5 being severe pain.
    - For verbal patients, use the patient's self-rated pain status on a 1-10 scale, with 10 being the highest level of pain.
  - Record location(s) of pain or record nonverbal evidence of pain (e.g, wincing, grimacing, moaning, etc.) and identify the location.
7. **Record vital signs to include postural pulse and blood pressure.**
8. **Conduct a general physical examination and record all findings.**
  - Check WNL for Within Normal Limits, ABN for abnormal. Briefly describe abnormal findings and use the diagrams on the next three pages to describe the locations of findings.

## R. GENERAL PHYSICAL EXAMINATION

### 1. Record results and findings from the physical examination.

**Physical Findings:** A physical finding includes observable or palpable tissue injuries, physiologic changes, or foreign material (e.g., grass, sand, stains, dried or moist secretions, or positive fluorescence). If none, mark "No Findings."

- Be observant for erythema (redness), abrasions, bruises, swelling, lacerations, fractures, bites, pressure ulcers, cachexia or evidence of dehydration, and burns.
- Note areas of tenderness or induration.
- Record size and appearance of injuries and other findings using the diagrams, the legend, and a consecutive numbering system. Describe shape, size, and color of injuries and findings.
- Document bruises and bite marks: see next page for additional information.  
Use the legend to list and describe the injury/finding drawn on the diagram. Show the diagram letter followed by the finding number. Use the abbreviations in the legend to describe the type of finding.  
Example: A-1, EC 2x3cm red/purple indicates that the first finding on Diagram A is an ecchymosis (bruise) that is red/purple in color and 2x3 centimeters in size. See example below.

Locator #	Type	Description
A-1	EC	2x3 cm red/purple ecchymosis
A-2	PU	Stage IV pressure ulcer
A-3	CS	Control swab

- **Photograph injuries and other findings according to local policy using proper photographic techniques. Describe shape, size, and color of bruises.**
    - Use appropriate light source.
    - Use accurate ruler or scale for size reference in the photograph.
    - Ensure that the plane of the film is parallel to the plane of the finding.
    - Use a camera with a macro lens and appropriate flash attachment to adequately record small or subtle injuries. Determine preference of local jurisdiction for 35mm or digital imaging.
    - Any good quality camera may be used as long as it can be focused for undistorted, close-up photographs and provides an accurate color rendition.
2. **Examine the face, head, ears, hair, scalp, and neck for injury and foreign materials. Document findings.**
- Give special focus to the lips, perioral region, and nares in the examination.
  - Examine the head closely for scalp trauma. Record any bruises, areas of scalp swelling, or hair loss from possible abuse.
  - Examine earlobes carefully for any bruising or petechiae.
3. **Examine the mouth for injury, chipped or missing teeth due to possible abuse, and foreign material. Document findings.**
- Give special focus to frenulum, buccal surfaces, gums, and soft palate.
  - Signs and symptoms of dentofacial trauma may include: avulsed teeth, lip lacerations, tongue injuries, frenulum injuries, and jaw and facial fractures.
  - Signs and symptoms of dental neglect may include: untreated rampant cavities, untreated pain, infection, bleeding, or trauma, and/or lack of continuity of care once informed that these conditions exist.
4. **Collect dried and moist secretions, stains (including blood stains, saliva from bites), and foreign materials from the face, head, hair, scalp, neck and mouth.**
- **Swab moist secretions** on the skin with a dry swab to avoid dilution. Label and air dry before packaging.
  - **Swab dried stains** with a swab (or multiple swabs for large stains) moistened with sterile, deionized, or distilled water. Label and air dry the evidence swabs) before packaging. Make a control swab by swabbing an unstained area adjacent to the stain (when possible). Label, air dry, and package the control swab separately from the evidence sample.
  - **Collect** foreign materials such as fibers, sand, hair, grass, soil, and vegetation. Place in bindles and/or envelopes as appropriate for each location on the body. Label and seal.
  - **Cut** matted head or facial hairs (for males) bearing crusted material and place in a bindle. Package, label, and seal.
  - **Record** all findings on the diagrams and legend.
    - Use the legend locator number to label evidence collection envelopes.
    - Record the locations of swab collection sites and control swabs.

## R. GENERAL PHYSICAL EXAMINATION (continued)

5. **Conduct a physical examination of the trunk and extremities and record findings using Diagrams G and H for anterior and posterior located findings and Diagrams I and J on the next page for medial or lateral located findings.**

### Documenting bruises:

- Describe shape, size, and color of bruises.
- Bruises evolve and change color in an unpredictable sequence. Determination of the age of bruising can only be done in the broadest of time frames. Use caution in the identification of bruises of different ages, and describe color and character in detail.
- Photograph bruises to document injuries and to assist in the identification of the object that inflicted the injury.
- Deep tissue injuries may not be seen or felt initially.
- Arrange or recommend to the law enforcement agency to have follow-up photographs taken in 1-2 days after the bruising develops more fully.

### Documenting bite marks:

- Photograph or arrange to have bite marks photographed. Individuals can be identified by the size and shape of their bite marks. Properly taken photographs of bite marks can assist in the identification of the person who inflicted the injury.
- DNA of the person who inflicted the injury may be recovered from the saliva remaining at the bite mark site.
- Swab the general area of trauma with a swab moistened with sterile, deionized, or distilled water. Label and air dry swab(s) prior to packaging.
- Collect a control swab by swabbing an unbiten atraumatic area adjacent to the suspected saliva stain. Label, air dry, and package the control swab separately from the evidence sample.
- Casting bite marks:
  - If the bite has perforated, broken, or left indentations in the skin, a cast of the mark may be indicated. The impressions left in the skin from a bite mark fade very quickly. If casting is indicated, it must be performed expeditiously.
  - A forensic dentist should be consulted in these cases. The procedure for consulting such experts varies among jurisdictions. Consult with the law enforcement agency having jurisdiction over the case.
  - Bite marks may not be obvious immediately following an assault, but may become more apparent with time. Recommend to the law enforcement agency to arrange for follow-up inspection within one to two days and to have additional photographs taken.

6. **Collect dried and moist secretions and foreign materials.**

- **Swab moist secretions** on the skin with a dry swab to avoid dilution. Label and air dry before packaging.
- **Swab dried stains** with a swab (or multiple swabs for large stains) moistened with sterile, de-ionized, or distilled water. Label and air dry the evidence swab(s) before packaging. Make a control swab by swabbing an unstained area adjacent to the stain (when possible). Label, air dry, and package the control swab separately from the evidence sample.
- **Collect** foreign materials such as fibers, sand, hair, grass, soil, and vegetation. Place in bindles and/or envelopes as appropriate for each location on the body. Label and seal.
- **Record** all findings on the diagrams and legend.
  - Use the legend locator number to label evidence collection envelopes.
  - Record the locations of swab collection sites and control swabs.

7. **Collect fingernail scrapings or cuttings, if indicated by history.**

- Use clean toothpicks or manicure sticks to collect scrapings from under the fingernails. Place scrapings from each hand into separate containers or bindles, then place into envelopes. Label (indicating right or left hand) and seal; OR,
- Use a clean fingernail cutter or scissors to cut the fingernails, and place the cuttings from each hand into separate containers or bindles. Package and label as above.



## **R. GENERAL PHYSICAL EXAMINATION (continued)**

- 8. Use diagrams I and J to record findings (injuries, secretions, foreign materials) to lateral and medial aspect of trunk or extremities as per previous instructions.**
  
- 9. If genital injuries are sustained, use pages 6 and 7 from the Cal OES 2-923 Forensic Medical Report: Acute Adult/Adolescent Sexual Assault Examination Form to document findings; or, use that form to document all findings, if the history indicates that the patient has been sexually and physically abused. These forms can be downloaded from [www.ccfmtc.org](http://www.ccfmtc.org) or [www.caloes.ca.gov](http://www.caloes.ca.gov).**

**PART II: MEDICAL ASSESSMENT  
SUMMARY OF FINDINGS**

**All swabs and slides must be air dried prior to packaging (Pen. code §13823.11). Air dry in a stream of cool air for 60 minutes. Only place samples from one patient at a time in the swab drying box. Wipe or spray the swab drying box with 10% bleach before each use.**

**Labeling requirements:** Swabs, bindles, and small containers must be individually labeled with the patient's name and sample source. Containers for these individual items must be labeled with the name of the patient, date of collection, description of the evidence including location from which it was taken, and signature or initials of the person who collected the evidence. Include the legend locator number, if the legend was used to document the location from which the evidence was located. Package containers in an Assault Evidence Collection Kit, or bag. Record all evidence transfers, also known as the chain of custody.

**S. RECORD ALL EVIDENCE COLLECTED AND SUBMITTED TO THE CRIME LABORATORY**

- 1. Record all item(s) of clothing collected and whether it was placed in an evidence kit or paper bags. Handle wet clothing according to local procedures.**
- 2. Record all foreign materials collected and the name of the person who collected them.**

**T. RECORD CLINICAL STUDIES**

- 1. Record laboratory results, or indicate whether results are pending.**
- 2. Record results from x-ray/imaging studies, or indicate whether results are pending.**
- 3. Toxicology samples.**
  - Collect samples of blood for alcohol/toxicology at the discretion of the examiner and/or law enforcement officer in accordance with local policy.
  - Cleanse the arm with a non-alcoholic solution and collect 5cc of blood in a gray stoppered evacuated vial. Label vial and envelope, and seal.
  - Up to 96 hours after suspected ingestion of drugs, collect a urine specimen (100cc) in a clean container. It is important to collect the first available sample.
  - Record whether toxicology samples were taken, and the name of the person who collected them.
- 4. Reference sample.**

Policies pertaining to whether reference samples are collected at the time of the exam or later vary by jurisdiction. If collected at the time of the exam, ALWAYS collect after the evidence samples. For those jurisdictions not performing conventional serology, a buccal swab can be taken in place of the blood reference sample. Consult your local crime laboratory.

**Blood:**

- Collect blood sample in lavender and/or yellow stoppered evacuated vials as specified by local policy.
- A blood card is optional in some jurisdictions.
- Label vial(s) and envelope(s) and seal.

**Buccal (inner cheek) swabs:**

- Collect as a DNA reference sample.
- Rub two swabs gently but firmly along the inside of the cheek in a rotating motion to ensure even sampling.
- Air dry, package, and seal.

**Saliva:**

- Collect sample by placing two swabs in the mouth and allowing them to saturate.
- Air dry, package, label and seal.

**U. RECORD PHOTO DOCUMENTATION**

- Document whether or not photographs were taken, type of camera used, name of photographer, number of rolls/images used, and whether follow-up photographs are recommended.
- Documentation must clearly link the patient's identity to the specific photographs of injuries and/or findings. For example, include a picture of the patient identification on the roll or use a databack camera which can be programmed with the patient's identification number.

**V. RECORD EVIDENCE DISTRIBUTION**

- List to whom the evidence was released.

**W. DOCUMENT VOICE RECORDING FOR STRANGULATION INJURIES**

Document whether or not a voice recording of strangulation injuries was made. Note whether the recording is obtained by law enforcement or the examiner.

**X. RECORD SUMMARY AND INTERPRETATION OF FINDINGS**

- 1. Summarize history and physical findings.**
- 2. Document assessment of whether or not abuse and/or neglect occurred.**
- 3. Document injuries that may have caused great bodily harm.**
- 4. Advocate for an autopsy if the patient expires.**

**Y. DOCUMENT FOLLOW-UP**

- 1. Enter the patient's location following the conclusion of the examination and contact names for family member or friend.**
- 2. Indicate whether a follow-up exam is needed and specify reason.**  
Consider whether bruising may be more apparent in 48-72 hours in determining whether a follow-up exam is needed.

**Z. SIGN AND DATE THE FORENSIC EXAMINATION FORM AT THE CONCLUSION OF PART II AND REQUEST THE LAW ENFORCEMENT OFFICER WHO RECEIVES EVIDENCE TO SIGN AND DATE THE FORM.**