

STATE OF CALIFORNIA
GOVERNOR'S OFFICE OF EMERGENCY SERVICES

www.caloes.ca.gov

**FORENSIC MEDICAL REPORT
DOMESTIC VIOLENCE
EXAMINATION**

Cal OES 2-502

2022



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the Cal OES 2-502, please contact the
California Clinical Forensic Medical Training Center
www.ccfmtc.org

**FORENSIC MEDICAL REPORT:
DOMESTIC VIOLENCE EXAMINATION
STATE OF CALIFORNIA**

Governor's Office of Emergency Services

Cal OES 2-502

Confidential Document

Patient Identification

A. GENERAL INFORMATION

1. Patient's Last Name		First Name		M.I.		
2. Street Address (optional)		City		County	State	Zip Code
Telephone (C)		(W)		Email Address		
3. Age	DOB	Gender <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> FTM <input type="checkbox"/> MTF <input type="checkbox"/> Other		Biological Sex <input type="checkbox"/> F <input type="checkbox"/> M	Ethnicity If Native American, name of tribe: _____	
4. Name of facility where forensic exam performed				Address of facility		
5. Patient Arrival			6. Patient Discharged			
Date		Time		Date		Time
7. Interpreter Used <input type="checkbox"/> No <input type="checkbox"/> Yes			Language Used			
Name of Interpreter			Telephone			
Affiliation of Interpreter <input type="checkbox"/> Facility Interpreting Services <input type="checkbox"/> Contracted Agency, specify: _____						

B. REPORTING AND AUTHORIZATION

1. Telephone report to law enforcement agency				Jurisdiction (<input type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> Other):		
Name of Officer	Agency	ID Number	Telephone	Reported by: Name	Date	Time
2. Responding Officer	Agency	ID Number	Telephone			

3. TELEPHONE AUTHORIZATION

Agency:	Law Enforcement Officer	ID Number	Agency			
Authorizing party:						
ID number:	Telephone	Date	Time	Case Number		
Date/Time:						

C. PATIENT INFORMATION

I understand that hospitals and health care professionals are required by Penal Code §§ 11160-11161 to report to law enforcement authorities cases in which medical care is sought when injuries have been inflicted upon any person in violation of any state penal law. The report must state the name of the injured person, current whereabouts, and the type and extent of injuries. _____ (initials)

D. PATIENT CONSENT

- I understand that a forensic medical examination for evidence of domestic violence, with my consent, will be conducted by a health care professional to discover and preserve evidence of the assault. If conducted, the report of the examination and any evidence obtained will be released to law enforcement authorities. I understand that the examination may include the collection of reference specimens at the time of the examination or at a later date. I understand that I may withdraw consent at any time for any portion of the examination. _____ (initials)
- I understand that collection of evidence may include audio/visual recordings and photographing injuries and that these photographs may include the genital area. _____ (initials)
- I hereby consent to a forensic medical examination for evidence of domestic violence. _____ (initials)
- I understand that data without patient identity may be collected from this report for health and forensic purposes and may be provided to health authorities and other qualified persons with a valid educational or scientific interest for demographic or epidemiological studies. _____ (initials)

Signature: _____ Patient Parent Guardian

E. DISTRIBUTION OF Cal OES 2-502 (CHECK ALL THAT APPLY)

- Law Enforcement Officer: Original Crime Lab: Copy Within Evidence Kit Medical or Agency Facility Records: Copy

F. PATIENT HISTORY

1. Disability No Yes
 If yes, Cognitive Physical Blind Deaf/HOH Mental

2. Obstetrical History Pregnant? No Yes Unknown

If yes, any possible problems related to current assaults? No Yes
 If yes, describe: _____
 Any possible problems in past pregnancies related to past assaults by this assailant? No Yes
 If yes, describe: _____

3. Name(s) of Children/Dependent Adults Living in Household	Present During Assault(s)			Gender	DOB or Age
	No	Yes	UNK		
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M F	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M F	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M F	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M F	

4. Voluntary Use of Alcohol/Drugs?

Any voluntary alcohol use within 24 hours prior to assault? No Yes
 Any voluntary drug use within 120 hours prior to assault? No Yes
 Any voluntary drug or alcohol use between time of assault and forensic exam? No Yes
 List drugs used: _____

G. CURRENT ASSAULT HISTORY

1. Sexual contact with assailant as part of this assault? No Yes
 If yes, consider using Cal OES Form 2-923 or 2-924.

2. Examination audio and/or videotaped?
 No Yes Audio Video

3. Name of person providing history Relationship to patient

4. Date(s) of assault Time of assault

5. Alleged assailant(s) names	Age	Gender	Ethnicity	Relationship to Patient	
				Known	Unknown
#1		M F			
#2		M F			

6. Describe the physical surroundings of the assault. Additional pages attached.

Patient Identification

7. Patient description of assault. Additional pages attached.

8. Method(s) employed by assailant(s).

Weapons? No Yes
 Threatened? Shown Believed
 If yes, describe: _____

Injuries inflicted? No Yes
 If yes, describe: _____

Type(s) of weapons? No Yes
 If yes, describe: _____

Physical blows? No Yes
 If yes, use page 4 and, if applicable, the Head Trauma Addendum

Grabbing/shaking/holding/pinching? No Yes
 If yes, use page 4.

Physical restraints? No Yes
 If yes, describe: _____

Strangulation/choking? No Yes
 If yes, use Strangulation Addendum

Suffocation? No Yes
 If yes, use page 4.

Water Immersion? No Yes
 If yes, use page 4.

Bites? No Yes
 If yes, use page 4.

Suction? No Yes
 If yes, use page 4.

Burns (thermal and/or chemical)? No Yes
 If yes, use page 4.

Threats of harm? No Yes
 Present Future
 If yes, describe: _____

Target(s) of threat(s)? No Yes
 If yes, describe: _____

Threats to others, including animals? No Yes
 If yes, describe: _____

Injuries inflicted to others, including animals? No Yes
 If yes, describe: _____

Other methods? No Yes
 If yes, use page 4.

Involuntary ingestion of alcohol/drugs? No Yes Unsure
 If yes, Alcohol Drugs
 If yes, Forced Coerced Suspected

G. CURRENT ASSAULT HISTORY (CONT.)

Patient Identification

9. Injuries inflicted upon assailant(s) during assault?

- No Yes Attempted Unsure

If yes, describe injuries, possible locations on the body, and how they were inflicted?

10. History of prior physical assault(s) with this assailant?

- No Yes

If yes, past injuries to patient?

- No Yes

If yes, describe:

11. Prior history of forced or coerced sexual acts with or for this assailant?

- No Yes, describe:

Approximate date(s):

12. Has patient sought medical care for prior assault(s) by this assailant?

- No Yes

If yes, name of facility(ies):

If yes, under what name(s)?:

If yes, approximate date(s):

1. Physical blows?

No Yes Attempted Unsure If no, skip this section.

What did the suspect use?

Part of suspect's body Object Surface Other

If yes, describe: _____

2. Burns?

No Yes Attempted Unsure If no, skip this section.

If yes, describe: _____

3. Bites?

No Yes Attempted Unsure If no, skip this section.

If yes, describe: _____

4. Suction?

No Yes Attempted Unsure If no, skip this section.

If yes, describe: _____

5. Grabbing/shaking/holding/pinching?

No Yes Attempted Unsure If no, skip this section.

If yes, describe: _____

6. Suffocation, water immersion, or other?

No Yes Attempted Unsure If no, skip this section.

If yes, describe: _____

I. GENERAL PHYSICAL EXAMINATION					
1. Blood pressure	Pulse	Resp.	Temp.	2. Exam Started	Completed
				Date & Time	Date & Time
2. Describe general physical appearance					
3. Describe general demeanor					

Patient Identification

4. Describe condition of clothing upon arrival. Collect outer and under clothing, if applicable.

Not Applicable

5. Examine the face, head, ears, hair, scalp, neck, and mouth for injury. Document findings using photographs, diagrams, legend, and consecutive numbering system.

6. Collect dried and moist secretions, stains, and foreign materials from the scalp, head, and neck, if applicable.

Not Applicable

7. Collect two (2) swabs from each side of the neck, if applicable.

Not Applicable

Diagram A

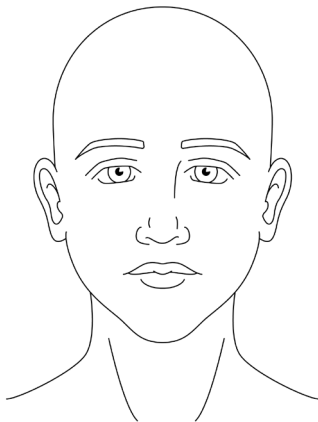


Diagram C

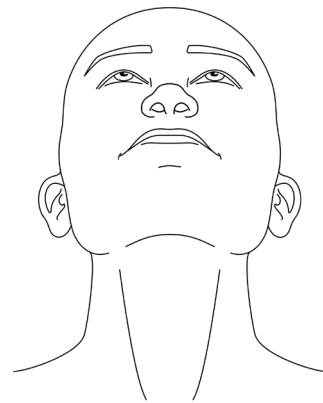


Diagram B

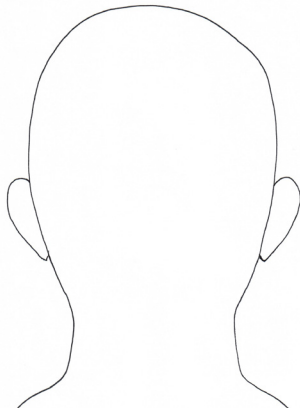
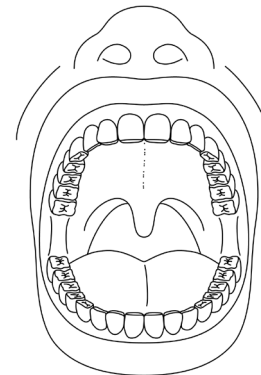


Diagram D



LEGEND: TYPES OF FINDINGS

AB Abrasion	DF Deformity	FB Foreign Body	OF Other Foreign Materials (describe)	SI Suction Injury
ALS Alternate Light Source ⊕	DS Dry Secretion	IN Induration	OI Other Injury (describe)	SW Swelling
BI Bite	EC Ecchymosis (bruise)	IW Incised Wound	PE Petechiae	TB Toluidine Blue ⊕
BU Burn	ER Erythema (redness)	LA Laceration	PS Potential Saliva	TE Tenderness
DE Debris	F/H Fiber/Hair	MS Moist Secretion	SXH Sample Per History	V/S Vegetation Soil

Locator #	Type	Description	Locator #	Type	Description

I. GENERAL PHYSICAL EXAMINATION (CONT.)

8. Conduct a head-to-toe physical examination. Record findings using photographs, diagrams, legend, and a consecutive numbering system.

9. Collect dried and moist secretions, stains, and foreign materials from body.

Done Not Applicable

10. Collect fingernail swabbings according to local policy.

Done Not Applicable

Patient Identification

Diagram E

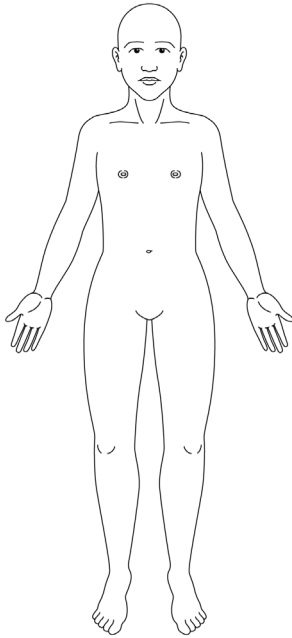
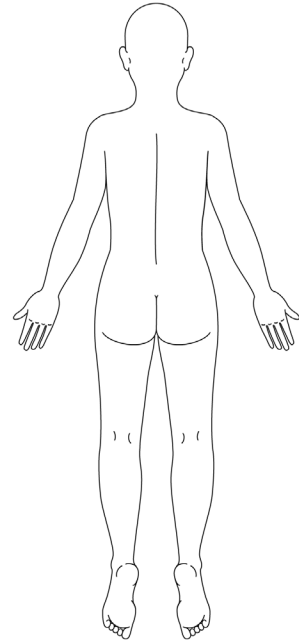


Diagram F



LEGEND: TYPES OF FINDINGS

AB Abrasion	DF Deformity	FB Foreign Body	OF Other Foreign Materials (describe)	SI Suction Injury
ALS Alternate Light Source ⊕	DS Dry Secretion	IN Induration	OI Other Injury (describe)	SW Swelling
BI Bite	EC Ecchymosis (bruise)	IW Incised Wound	PE Petechiae	TB Toluidine Blue ⊕
BU Burn	ER Erythema (redness)	LA Laceration	PS Potential Saliva	TE Tenderness
DE Debris	F/H Fiber/Hair	MS Moist Secretion	SXH Sample Per History	V/S Vegetation Soil

Locator #	Type	Description	Locator #	Type	Description

J. EVIDENCE COLLECTED AND SUBMITTED TO CRIME LAB.
IF NOT APPLICABLE, SKIP THIS SECTION. Not Applicable

1. Post-assault hygiene activity Not applicable if over 120 hours
 Body wipes? No Yes
 If yes, describe: _____
 Bath/shower/wash? No Yes
 Applied makeup/cream/lotion/medication? No Yes
 Changed clothing? No Yes
 If yes, describe: _____

2. Clothing placed in evidence kit No Yes N/A
Other clothing placed in bags

3. Foreign Materials N/A No Yes **Collected by:**

Swabs/suspected blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dried secretions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fibers/loose hairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Soil/debris/vegetation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Swabs/suspected saliva	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Foreign body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fingernail scrapings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Neck swabs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

4. Reference Samples Blood Saliva Buccal N/A
 Collected by: _____

K. SUPPLEMENTAL DOCUMENTS AND MEDIA

1. Laboratory Results **Additional Page** No Yes
 Pregnancy Positive Negative N/A
 Additional Labs No Yes, specify: _____
 See Hospital Record

2. X-Ray/Imaging Results **Additional Page** No Yes
 No Yes, specify: _____
 See Hospital Record

3. Photo Documentation Methods

Body No Yes Colposcope Digital Camera/Macrolens
 Colposcope/Videocamera Other Optics: _____

Genitals No Yes Colposcope Digital Camera/Macrolens
 Colposcope/Videocamera Other Optics: _____

Photographed by: _____

L. SUMMARY OF KEY FINDINGS

Describe: _____

Patient Identification

4. Voice Recording for Strangulation Injuries
 No Yes If Yes, Audio Audiovideo
 If yes, obtained by: Examiner Law Enforcement

M. DISTRIBUTION OF EVIDENCE N/A **Status**

Clothing (items not placed in evidence kit)	<input type="checkbox"/> N/A	
Evidence kit	<input type="checkbox"/> N/A	
Reference samples	<input type="checkbox"/> N/A	
Recording(s) <input type="checkbox"/> Audio <input type="checkbox"/> Audiovideo		

N. PERSONNEL INVOLVED **Telephone**

History Taken By: (Print) _____

Physical Exam Performed By: (Print) _____

Specimens Labeled and Sealed By: (Print) N/A

Assisted By: (Print) N/A

Additional Narrative By: (Print) N/A

Signature of Examiner	License Number	Date
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O. SIGNATURE OF LAW ENFORCEMENT RECEIVING EVIDENCE N/A

Signature: _____
 Print Name: _____ ID#: _____
 Agency: _____
 Date: _____ Telephone: _____

HEAD INJURY ADDENDUM

Patient Identification

Did the suspect hit you in the head with a part of his/her body, an object, a surface, or something else at any time during the assault?

-
- NO**
- , skip this page
-
-
- YES**
- , fill this page out

What did the suspect use to hit your head (e.g., body parts, objects, surface, something else)?

Approximately how many times did the suspect hit you in the head?

LOSS OF AWARENESS SYMPTOMS ASSOCIATED WITH HEAD TRAUMA

Did you lose consciousness?

-
- No
-
- Yes

Are there any gaps in your memory **before** the hit(s) to your head?

-
- No
-
- Yes

Are there any gaps in your memory **after** the hit(s) to your head?

-
- No
-
- Yes

Did your position change during the hits to your head (e.g., standing to laying)?
If yes, do you remember?

-
- No
-
- Yes
-
-
- No
-
- Yes

HEAD SYMPTOMS EXPERIENCED AFTER THE HEAD TRAUMA (indicate if present at time of exam)

Pain to the head (e.g., scalp, face)?

-
- No
-
- Yes
-
- At time of exam

Pain with eye movements?

-
- No
-
- Yes
-
- At time of exam

Pain to the nose?

-
- No
-
- Yes
-
- At time of exam

Pain to the lip/mouth/tongue?

-
- No
-
- Yes
-
- At time of exam

Pain with jaw opening/closing?

-
- No
-
- Yes
-
- At time of exam

Bruising to the head/face?

-
- No
-
- Yes
-
- At time of exam

Swelling to the head/face?

-
- No
-
- Yes
-
- At time of exam

Deviated nose?

-
- No
-
- Yes
-
- At time of exam

Nose bleeding?

-
- No
-
- Yes
-
- At time of exam

Lip/mouth/tongue bleeding?

-
- No
-
- Yes
-
- At time of exam

Tooth pain?

-
- No
-
- Yes
-
- At time of exam

Chipped or loose teeth?

-
- No
-
- Yes
-
- At time of exam

Difficulty breathing (through nose of mouth)?

-
- No
-
- Yes
-
- At time of exam

Other?

-
- No
-
- Yes
-
- At time of exam

NEUROLOGICAL (NEURO) SYMPTOMS EXPERIENCED AFTER THE HEAD TRAUMA (indicate if present at time of exam)

Problems with memory, recall, concentration? If yes, give examples.

-
- No
-
- Yes
-
- At time of exam

Examples: _____

Vision changes or problems?

-
- No
-
- Yes
-
- At time of exam

Photosensitivity?

-
- No
-
- Yes
-
- At time of exam

Hearing changes or problems?

-
- No
-
- Yes
-
- At time of exam

Dizziness or dizzy spells?

-
- No
-
- Yes
-
- At time of exam

Feeling faint?

-
- No
-
- Yes
-
- At time of exam

Lightheaded?

-
- No
-
- Yes
-
- At time of exam

Confusion?

-
- No
-
- Yes
-
- At time of exam

Disoriented?

-
- No
-
- Yes
-
- At time of exam

Headache?

-
- No
-
- Yes
-
- At time of exam

Numbness or tingling?

-
- No
-
- Yes
-
- At time of exam

Fatigue or sleepiness?

-
- No
-
- Yes
-
- At time of exam

Other?

-
- No
-
- Yes
-
- At time of exam

TOTAL # OF INJURIES INFLICTED BY THE SUSPECT

Total # of head injuries?

Total # of head injuries with **neuro** symptoms?**SUPPLEMENTAL HISTORY SECTION**

STRANGULATION ADDENDUM

Patient Identification

Did the suspect apply any pressure to your neck with any part of his/her body or an object, at any point during the assault? NO, skip this page YES, fill this page out

What did the suspect strangle you with (e.g., hands, chokehold, cord)?

Were you able to breathe? If yes, were you able to speak? What did you say?

Did the suspect say anything while strangling you?

Did the suspect do anything else (e.g., hit, kick, headbutt) while strangling you?

Were you able to do anything to physically stop the strangulation? If yes, what?

What did you think during the strangulation?

NECK SYMPTOMS EXPERIENCED DURING THE STRANGULATION

Difficulty breathing? No Yes
 Unable to breathe? No Yes
 Neck pain? No Yes
 Other? No Yes

BRAIN HYPOXIA SYMPTOMS EXPERIENCED DURING THE STRANGULATION

Vision changes (e.g., tunnel, spot, darkness)? No Yes
 Hearing loss or changes (e.g., ringing, vibration)? No Yes
 Dizziness? No Yes
 Feeling faint? No Yes
 Lightheaded? No Yes
 Disoriented? No Yes
 Headache? No Yes
 Other? No Yes

BRAIN ANOXIA SYMPTOMS EXPERIENCED DURING THE STRANGULATION

Did you lose consciousness? No Yes
 From the start of the hypoxic symptoms to the end of the strangulation, is there a gap in your memory? No Yes
 Did your position change during the strangulation (e.g., standing to laying)? No Yes
 If yes, do you remember changing positions? No Yes
 Do you remember the suspect letting go? No Yes
 After the strangulation, did you notice you had urinated or defecated? No Yes
 If yes, do you remember urinating or defecating? No Yes

UPPER BODY SYMPTOMS EXPERIENCED AFTER THE STRANGULATION (indicate if present at time of exam)

Neck pain? No Yes At time of exam
 Difficulty breathing? No Yes At time of exam
 Pain with breathing? No Yes At time of exam
 Coughing? No Yes At time of exam
 With blood? No Yes At time of exam
 Without blood? No Yes At time of exam
 Raspy/hoarse voice/voice changes? No Yes At time of exam
 Pain with speaking? No Yes At time of exam
 Trouble swallowing? No Yes At time of exam
 Painful swallowing? No Yes At time of exam
 Sore throat? No Yes At time of exam
 Nausea? No Yes At time of exam
 Dry heaving/vomiting? No Yes At time of exam
 Other? No Yes At time of exam

NEUROLOGICAL (NEURO) SYMPTOMS EXPERIENCED AFTER THE STRANGULATION (indicate if present at time of exam)

Problems with memory, recall, concentration? If yes, give examples. No Yes At time of exam
 Examples: _____
 Vision changes or problems? No Yes At time of exam
 Photosensitivity? No Yes At time of exam
 Hearing changes or problems? No Yes At time of exam
 Dizziness or dizzy spells? No Yes At time of exam
 Feeling faint? No Yes At time of exam
 Lightheaded? No Yes At time of exam
 Confusion? No Yes At time of exam
 Disoriented? No Yes At time of exam
 Headache? No Yes At time of exam
 Numbness or tingling? No Yes At time of exam
 Fatigue or sleepiness? No Yes At time of exam
 Other? No Yes At time of exam

TOTAL # OF INJURIES INFLICTED BY THE SUSPECT

Total # of strangulations?

Total # of strangulations with LOC or memory gap?

SUPPLEMENTAL HISTORY SECTION
