

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

**FORENSIC MEDICAL REPORT: NON-ACUTE  
CHILD/ADOLESCENT SEXUAL ABUSE  
EVIDENTIARY EXAMINATION**

**ADOLESCENTS AGES 12–17 > 120 HOURS  
CHILDREN UNDER AGE 12: FOLLOW  
LOCAL SART POLICY**

**CAL OES 2-925**

**July 2020**



For copies of this form or assistance in completing  
the Cal OES 2-925, please contact

**California Clinical Forensic Medical Training Center**  
[www.ccfmtc.org](http://www.ccfmtc.org)

**FORENSIC MEDICAL REPORT: NON-ACUTE CHILD/ADOLESCENT SEXUAL ABUSE EXAMINATION**

**STATE OF CALIFORNIA** Governor's Office of Emergency Services

**Cal OES 2-925**

Confidential Document

Patient Identification

<b>A. GENERAL INFORMATION</b> (print or type)		<b>Name of medical facility:</b>			<b>Case Number:</b>			
<b>1. Name of patient</b>				<b>Arrival date</b>	<b>Arrival time</b>	<b>Discharge date</b>	<b>Discharge time</b>	
<b>2. Age</b>	<b>DOB</b>	<b>Biological Gender</b> <input type="checkbox"/> M <input type="checkbox"/> F	<b>Identified Gender</b> <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Trans F <input type="checkbox"/> Trans M <input type="checkbox"/> Non-conforming			<b>Preferred Pronouns</b> <input type="checkbox"/> He <input type="checkbox"/> She <input type="checkbox"/> They		<b>Ethnicity</b>
<b>3. Address</b>		<b>City</b>	<b>County</b>	<b>State</b>	<b>Telephone</b>			
<b>4. Name of:</b> <input type="checkbox"/> Parent <input type="checkbox"/> Stepparent <input type="checkbox"/> Guardian		<b>Address</b>	<b>City</b>	<b>County</b>	<b>State</b>	<b>Telephone (C) (W)</b>		
<b>5. Name of:</b> <input type="checkbox"/> Parent <input type="checkbox"/> Stepparent <input type="checkbox"/> Guardian		<b>Address</b>	<b>City</b>	<b>County</b>	<b>State</b>	<b>Telephone (C) (W)</b>		
<b>6. Name(s) of Siblings</b>	<b>Gender</b>	<b>Age</b>	<b>DOB</b>	<b>Name(s) of Siblings</b>	<b>Gender</b>	<b>Age</b>	<b>DOB</b>	
	M F				M F			
	M F				M F			

<b>B. REPORTING AND AUTHORIZATION</b>							
<b>Jurisdiction</b> ( <input type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> Other):							
<b>1. Telephone report made to:</b>		<b>Name</b>	<b>Agency</b>	<b>ID Number</b>	<b>Telephone</b>		
Law Enforcement <input type="checkbox"/> and/or Child Protective Services <input type="checkbox"/>							
<b>2. Responding Personnel</b> (med. facility)		<b>Name</b>	<b>Agency</b>	<b>ID Number</b>	<b>Telephone</b>		
Law Enforcement <input type="checkbox"/> and/or Child Protective Services <input type="checkbox"/>							
<b>3. Assigned Investigator</b> (if known)		<b>Name</b>	<b>Agency</b>	<b>ID Number</b>	<b>Telephone</b>		
Law Enforcement <input type="checkbox"/> and/or Child Protective Services <input type="checkbox"/>							

**4. Authorization for evidentiary exam requested by law enforcement or child protective services.** I request a forensic medical exam for suspected sexual abuse at public expense.

<b>TELEPHONE AUTHORIZATION</b> Agency: _____ Authorizing party: _____ ID number: _____ Date/time: _____	<b>Name</b>	<b>Signature</b>		
	<b>Agency</b>	<b>ID Number</b>		
	<b>Telephone</b>	<b>Date</b>	<b>Time</b>	<b>Case Number</b>

**C. CONSENT FOR EXAMINATION BY PATIENT/PARENT/GUARDIAN**

*Minors:* Family Code section 6927 permits minors (12-17 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. *NOTE:* Parental consent is not required for a suspected child sexual abuse examination if the child is in protective custody.

- I understand that a forensic medical examination for evidence of sexual assault at public expense can, with my consent, 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. \_\_\_\_\_ (initial)
- I understand that collection of evidence may include photographing injuries and that these photographs may include the genital area. \_\_\_\_\_ (initial)
- I hereby consent to a forensic medical examination for evidence of sexual assault. \_\_\_\_\_ (initial)
- 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. \_\_\_\_\_ (initial)
- I have been informed that victims of crime are eligible to submit crime victim compensation claims to the State Victims of Crime Restitution Fund for out of pocket medical expenses, psychological counseling, loss of wages and job retraining/rehabilitation. \_\_\_\_\_ (initial)

Signature \_\_\_\_\_  Patient  Parent  Guardian

**DISTRIBUTION OF Cal OES 2-925**

- Original – Law Enforcement     Copy within Evidence Kit – Crime Lab     Copy – Child Protective Services (if patient is a minor)     Copy – Medical Records

**D. PATIENT HISTORY**

<b>1. Most recent incident(s)</b>	<b>Date(s)</b>	<b>Time/time frame</b>
-----------------------------------	----------------	------------------------

Multiple incidents over time

**2. Location of most recent incident:**

Patient Identification

**3. Record patient's name for:**

Female genitalia: \_\_\_\_\_ Male genitalia: \_\_\_\_\_ Breasts: \_\_\_\_\_ Anus: \_\_\_\_\_

4. Alleged Assailant(s) Name(s)	Age	Gender	Ethnicity	Relationship to Patient	Information Provided By
#1		M F		<input type="checkbox"/> Known: _____ <input type="checkbox"/> Unknown	
#2		M F		<input type="checkbox"/> Known: _____ <input type="checkbox"/> Unknown	
#3		M F		<input type="checkbox"/> Known: _____ <input type="checkbox"/> Unknown	

**E. MEDICAL HISTORY**

1. Name of person providing history	Relationship to patient	Date and Time of Examination
-------------------------------------	-------------------------	------------------------------

**2. Any recent (60 days) anal-genital injuries, surgeries, diagnostic procedures, or medical treatment that may affect interpretation of physical findings?**  No  Yes

**3. Any other pertinent medical conditions that may affect the interpretation of physical findings?**  No  Yes

**4. Any pre-existing physical injuries?**  No  Yes \_\_\_\_\_

**5. Any previous history of physical abuse and/or neglect?**  No  Yes \_\_\_\_\_

**6. Any previous history of sexual abuse?**  No  Yes \_\_\_\_\_

**7. Other intercourse?** (For adolescents only) If yes,  No  Yes  
 < 5 days? When? \_\_\_\_\_  No  Yes \_\_\_\_\_

Did intravaginal ejaculation occur?  No  Yes \_\_\_\_\_

Was a condom used?  No  Yes \_\_\_\_\_

**8. Menstrual periods?**  No  Yes  
 If yes, age of menarche: \_\_\_\_\_ Last menstrual period: \_\_\_\_\_  Currently menstruating

9. Other symptoms disclosed	By patient		By historian		
Abdominal/pelvic pain	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown _____
Pain on urination	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown _____
Genital discomfort or pain	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown _____
Genital bleeding	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown _____
Genital itching	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown _____
Genital discharge	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown _____
Genital rash	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown _____
Anal discomfort or pain	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown _____
Anal itching	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown _____
Anal bleeding	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown _____
Constipation	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown _____
Enuresis (bed or daytime wetting)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown _____
Fecal soiling	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Unknown _____
Other _____					_____

If yes to any of the above, describe onset, duration, and intensity: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_





**H. GENERAL PHYSICAL EXAMINATION**

1. BP	Pulse	Resp.	Temp.	Height	%	Weight	%	BMI

2. Record who is with child during exam.  N/A

3. Sexual Maturity Rating/Female Tanner Stage - Breast  
 1     2     3     4     5

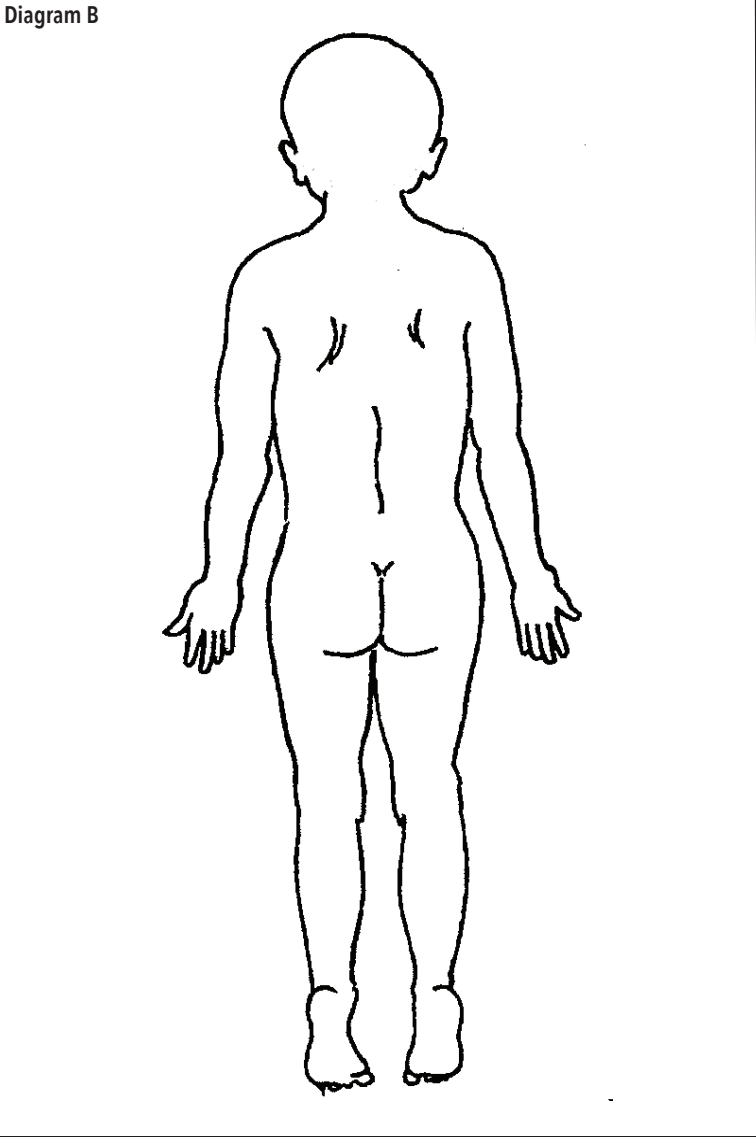
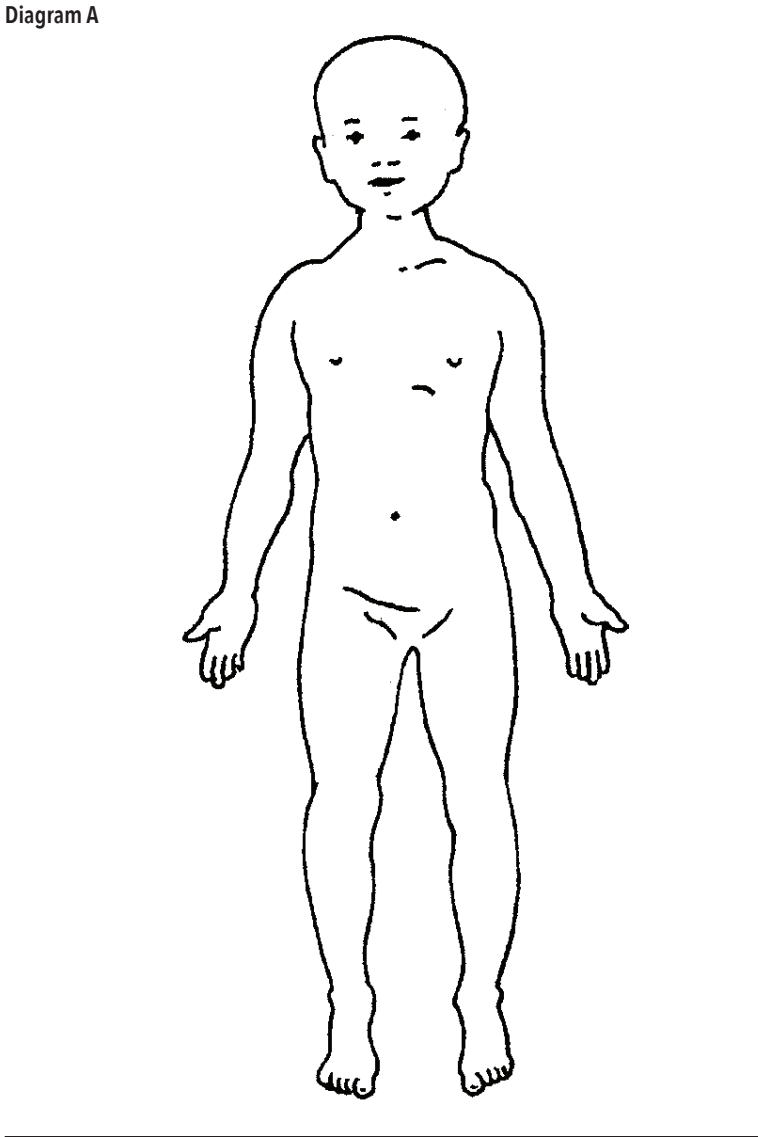
Patient Identification

4. Describe general physical appearance.

5. Describe general demeanor.

6. Record relevant statements made during exam. See addendum  N/A

7. Conduct a general examination  Findings  No findings    General exam within normal limits?  Yes  No



- |                           |                         |                        |                            |                                    |                                  |                     |
|---------------------------|-------------------------|------------------------|----------------------------|------------------------------------|----------------------------------|---------------------|
| AB Abrasion               | BU Burn                 | DI Discharge           | GT Granular Tissue         | OSC Other Skin Condition           | PHT Possible Hymenal Transection | SW Swelling         |
| AHT Absent Hymenal Tissue | CV Congenital Variation | EC Ecchymosis (bruise) | IN Induration              | PE Petechiae                       | PPW Possible Perianal Wart       | TE Tenderness       |
| AL Anal Laxity            | DE Debris               | ER Erythema (redness)  | LA Laceration              | PGW Possible Genital Wart          | PSI Potential Suction Injury     | VL Vesicular Lesion |
| BI Bite                   | DF Deformity            | FB Foreign Body        | OI Other Injury (describe) | PHN/C Possible Hymenal Notch/Cleft |                                  |                     |

Locator #	Type	Description	Locator #	Type	Description

**I. HEAD, NECK, AND ORAL EXAMINATION**

1. Examine the face, head, hair, scalp, and neck for injury.  
Use the diagrams and legend to record findings.

Findings       No findings

Patient Identification

Diagram C - Head (right-side view)

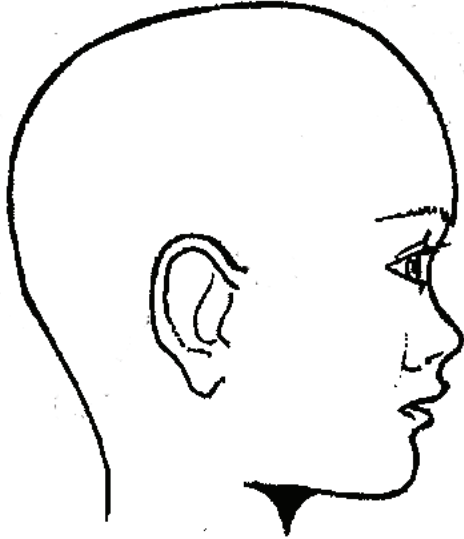


Diagram D - Head (left-side view)

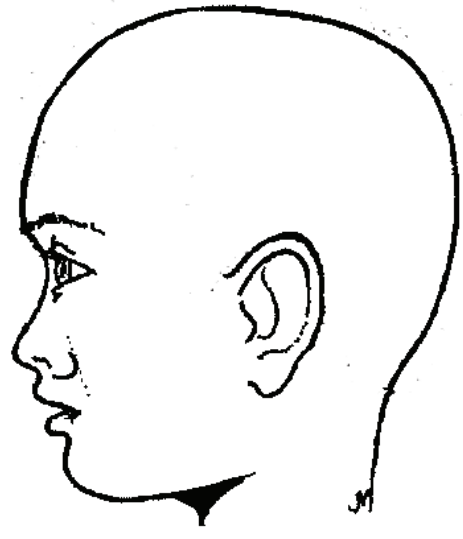


Diagram E - Head (front view)

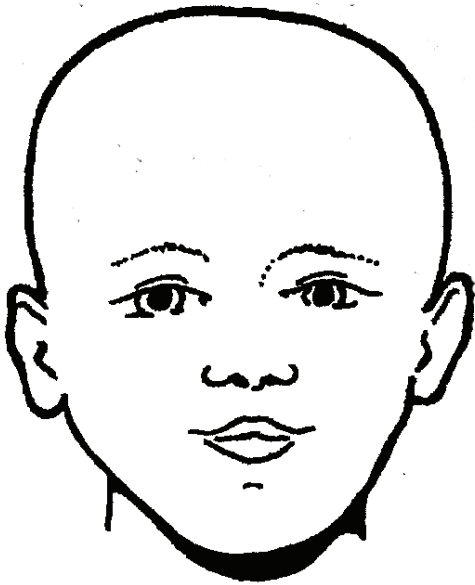
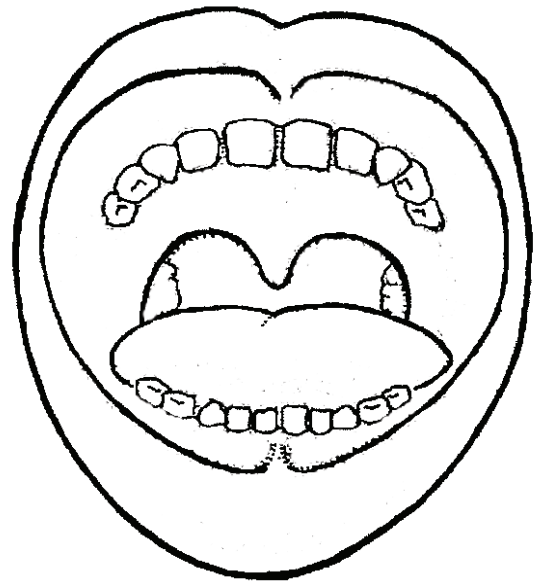


Diagram F - Mouth



- |                                  |                                |                               |                                   |   |   |                            |
|----------------------------------|--------------------------------|-------------------------------|-----------------------------------|---|---|----------------------------|
| <b>AB</b> Abrasion               | <b>BU</b> Burn                 | <b>DI</b> Discharge           | <b>GT</b> Granular Tissue         | <b>OSC</b> Other Skin Condition           | <b>PHT</b> Possible Hymenal Transection | <b>SW</b> Swelling         |
| <b>AHT</b> Absent Hymenal Tissue | <b>CV</b> Congenital Variation | <b>EC</b> Ecchymosis (bruise) | <b>IN</b> Induration              | <b>PE</b> Petechiae                       | <b>PPW</b> Possible Perianal Wart       | <b>TE</b> Tenderness       |
| <b>AL</b> Anal Laxity            | <b>DE</b> Debris               | <b>ER</b> Erythema (redness)  | <b>LA</b> Laceration              | <b>PGW</b> Possible Genital Wart          | <b>PSI</b> Potential Suction Injury     | <b>VL</b> Vesicular Lesion |
| <b>BI</b> Bite                   | <b>DF</b> Deformity            | <b>FB</b> Foreign Body        | <b>OI</b> Other Injury (describe) | <b>PHN/C</b> Possible Hymenal Notch/Cleft |   |                            |

Locator #	Type	Description	Locator #	Type	Description

**J. GENITAL EXAMINATION—FEMALES**

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

**1. Examine the inner thighs, external genitalia, and perineal area.**

**2. Exam Method**  Direct visualization  Colposcope  Other magnification

<b>Exam Position</b>	Separation	Traction	Knee-Chest
Prone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Exam Technique</b>	<input type="checkbox"/> Saline/water	<input type="checkbox"/> Moistened swab	<input type="checkbox"/> Toluidine Blue Dye
	<input type="checkbox"/> Catheter	<input type="checkbox"/> Speculum (only for patients w/ SMR of 4 or 5, and only if tolerated)	<input type="checkbox"/> Other

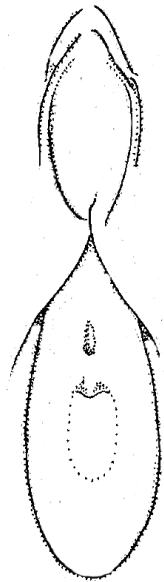
Patient Identification

**3. Sexual Maturity Rating/Genital Tanner Stage**  1  2  3  4  5

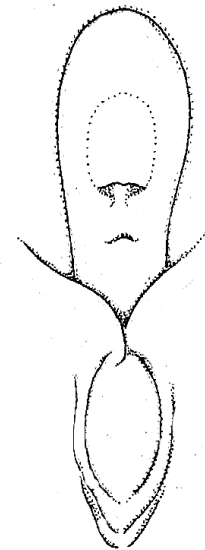
**4. Examine the genital structures. Check the ABN box(es) if there are abuse/assault-related findings.**  No findings

	WNL	ABN	Describe any abnormal or unusual findings
Inner thighs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Inguinal adenopathy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Labia majora	<input type="checkbox"/>	<input type="checkbox"/>	_____
Labia minora	<input type="checkbox"/>	<input type="checkbox"/>	_____
Clitoral hood	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mons pubis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Perineum	<input type="checkbox"/>	<input type="checkbox"/>	_____
Periurethral tissue/urethral meatus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Perihymenal tissue (vestibule)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hymen <input type="checkbox"/> Supine <input type="checkbox"/> Prone	<input type="checkbox"/>	<input type="checkbox"/>	_____
Record morphology			_____
<input type="checkbox"/> Annular <input type="checkbox"/> Crescentric			_____
<input type="checkbox"/> Imperforate <input type="checkbox"/> Septate			_____
Fossa navicularis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vagina (pubertal adolescents)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cervix (pubertal adolescents)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genital discharge <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, describe: _____

**Diagram G - Genitals: vulva, vestibule, vagina (supine view)**



**Diagram H - Genitals: vulva, vestibule, vagina (knee-chest view)**



- |                                  |                                |                               |                                   |   |   |                            |
|----------------------------------|--------------------------------|-------------------------------|-----------------------------------|---|---|----------------------------|
| <b>AB</b> Abrasion               | <b>BU</b> Burn                 | <b>DI</b> Discharge           | <b>GT</b> Granular Tissue         | <b>OSC</b> Other Skin Condition           | <b>PHT</b> Possible Hymenal Transection | <b>SW</b> Swelling         |
| <b>AHT</b> Absent Hymenal Tissue | <b>CV</b> Congenital Variation | <b>EC</b> Ecchymosis (bruise) | <b>IN</b> Induration              | <b>PE</b> Petechiae                       | <b>PSW</b> Possible Perianal Wart       | <b>TE</b> Tenderness       |
| <b>AL</b> Anal Laxity            | <b>DE</b> Debris               | <b>ER</b> Erythema (redness)  | <b>LA</b> Laceration              | <b>PPW</b> Possible Genital Wart          | <b>PSI</b> Potential Suction Injury     | <b>VL</b> Vesicular Lesion |
| <b>BI</b> Bite                   | <b>DF</b> Deformity            | <b>FB</b> Foreign Body        | <b>OI</b> Other Injury (describe) | <b>PHN/C</b> Possible Hymenal Notch/Cleft |   |                            |

Locator #	Type	Description	Locator #	Type	Description



**K. GENITAL EXAMINATION - MALES**

**1. Examine the inner thighs, external genitalia, and perineal area.**

**Exam position**      Prone      Supine      Other

**Exam method**      Colposcope      Direct visualization only  
 Other magnification

Patient Identification

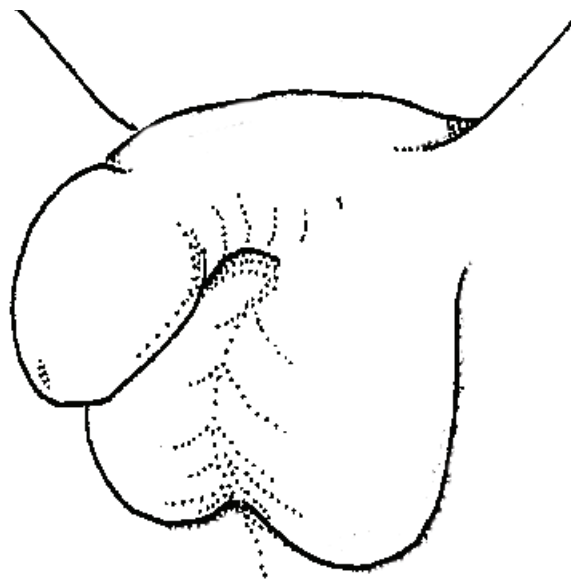
**2. Sexual Maturity Rating/Genital Tanner Stage**    1    2    3    4    5

**3. Circumcised**      Yes      No

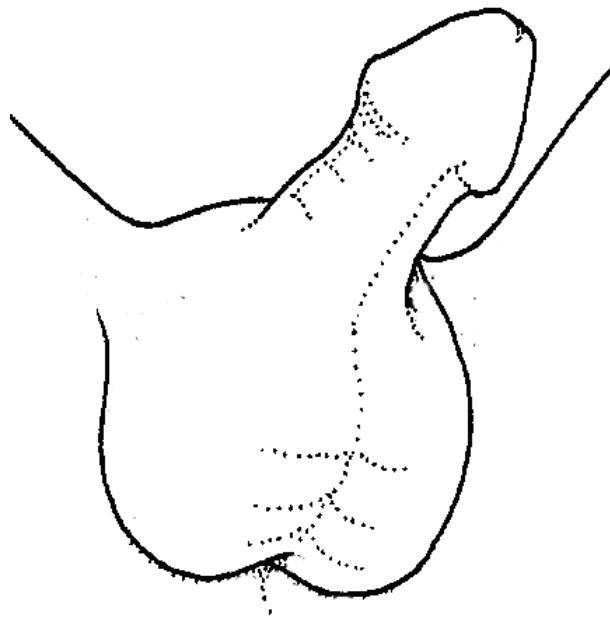
**4. Check the ABN box(es) if there are abuse/assault-related findings.**

<input type="checkbox"/> No findings	<b>WNL</b>	<b>ABN</b>	<b>Describe:</b>
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"/> Yes <input type="checkbox"/> No	If yes, describe:		_____

**Diagram I - Male Genitals**



**Diagram J - Male Genitals**



- |                                  |                                |                               |                                   |   |   |                            |
|----------------------------------|--------------------------------|-------------------------------|-----------------------------------|---|---|----------------------------|
| <b>AB</b> Abrasion               | <b>BU</b> Burn                 | <b>DI</b> Discharge           | <b>GT</b> Granular Tissue         | <b>OSC</b> Other Skin Condition           | <b>PHT</b> Possible Hymenal Transection | <b>SW</b> Swelling         |
| <b>AHT</b> Absent Hymenal Tissue | <b>CV</b> Congenital Variation | <b>EC</b> Ecchymosis (bruise) | <b>IN</b> Induration              | <b>PE</b> Petechiae                       | <b>PPW</b> Possible Perianal Wart       | <b>TE</b> Tenderness       |
| <b>AL</b> Anal Laxity            | <b>DE</b> Debris               | <b>ER</b> Erythema (redness)  | <b>LA</b> Laceration              | <b>PGW</b> Possible Genital Wart          | <b>PSI</b> Potential Suction Injury     | <b>VL</b> Vesicular Lesion |
| <b>BI</b> Bite                   | <b>DF</b> Deformity            | <b>FB</b> Foreign Body        | <b>OI</b> Other Injury (describe) | <b>PHN/C</b> Possible Hymenal Notch/Cleft |   |                            |

Locator #	Type	Description	Locator #	Type	Description

**L. FEMALE/MALE PERIANAL/ANAL EXAMINATION**

**1. Examine buttocks, perianal skin, anal folds, and anus for injury,**

Exam position	Observation	Separation	Traction
Supine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Supine knee-chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prone knee-chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lateral recumbent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Exam method**  Colposcope  Direct visualization only  
 Other magnification

**Exam technique**  Toluidine Blue dye  Moistened swab  Other

**2. Check the ABN box(es) if there are abuse/assault-related findings.**

Describe any abnormal or unusual findings.  No findings

	WNL	ABN	Unsure	Describe, if applicable:
Buttocks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Perianal skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anal verge/folds/rugae	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anal dilation	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	If yes: <input type="checkbox"/> Immediate <input type="checkbox"/> Delayed
Stool present in rectal ampulla	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	Undetermined

**3. Additional Information:**

\_\_\_\_\_

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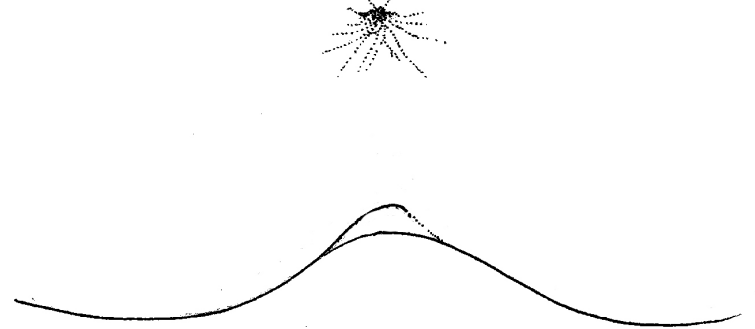
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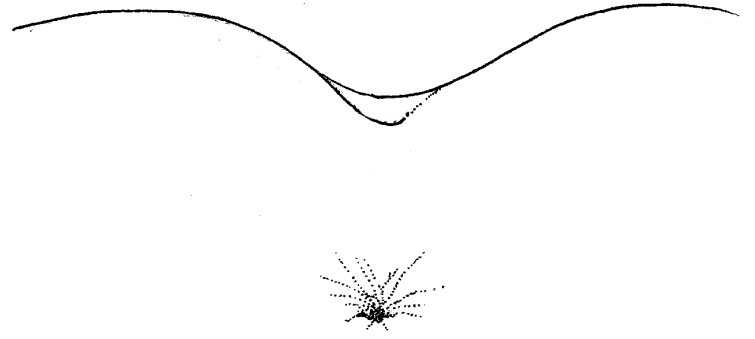
\_\_\_\_\_

Patient Identification

**Diagram K - Anus (supine view)**



**Diagram L - Anus (prone view)**



- |                           |                         |                        |                            |                                    |                                  |                     |
|---------------------------|-------------------------|------------------------|----------------------------|------------------------------------|----------------------------------|---------------------|
| AB Abrasion               | BU Burn                 | DI Discharge           | GT Granular Tissue         | OSC Other Skin Condition           | PHT Possible Hymenal Transection | SW Swelling         |
| AHT Absent Hymenal Tissue | CV Congenital Variation | EC Ecchymosis (bruise) | IN Induration              | PE Petechiae                       | PPW Possible Perianal Wart       | TE Tenderness       |
| AL Anal Laxity            | DE Debris               | ER Erythema (redness)  | LA Laceration              | PGW Possible Genital Wart          | PSI Potential Suction Injury     | VL Vesicular Lesion |
| BI Bite                   | DF Deformity            | FB Foreign Body        | OI Other Injury (describe) | PHN/C Possible Hymenal Notch/Cleft |                                  |                     |

Locator #	Type	Description	Locator #	Type	Description

**M. FINDINGS AND INTERPRETATIONS**

**1. Medical findings of injury.** Summarize all identified findings.

- Anal  Yes  No  Unsure  Limited exam
- Body  Yes  No  Unsure  Pending further review
- Genital  Yes  No  Unsure  Pending follow-up exam
- Oral  Yes  No  Unsure  Other

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**2. Interpretations pending final review (check all that apply)**

- Normal/normal variant exam (does not negate the possibility of abuse)
- Other medical conditions present unrelated to injury that could impact the way the exam is interpreted.
- Findings with unclear significance with respect to abuse.
- Clear evidence of injury.
- Findings of unexplained injury and unaccounted for by history (or no history).
- Pregnancy confirms sexual contact
  - Pending formal laboratory results
- Presence of sexually transmitted infection
  - Pending formal laboratory results

**3. Final interpretation pending formal review of photographic record and a follow up exam.** *Note:* Examining clinician reserves the right to amend or revise final interpretation pending further consideration, laboratory results, and/or follow-up exam.

- Not applicable

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Patient Identification

**N. LAB TESTS PERFORMED**

Oral  GC  Chlamydia  Other Collected by \_\_\_\_\_  
Describe: \_\_\_\_\_

Genital  GC  Chlamydia  Other Collected by \_\_\_\_\_  
Describe: \_\_\_\_\_

Anal  GC  Chlamydia  Other Collected by \_\_\_\_\_  
Describe: \_\_\_\_\_

Urine  GC  Chlamydia  Other Collected by \_\_\_\_\_  
Describe: \_\_\_\_\_

Serology  HIV  Syphilis  Hepatitis Collected by \_\_\_\_\_  
Describe: \_\_\_\_\_

Pregnancy test  Blood  Urine Results: \_\_\_\_\_

**O. PHOTO DOCUMENTATION METHODS**

- Colposcope with camera  Digital camera/macrolens  Other imaging modality

- Extra-genital** **Anal-genital**
- Still images  Video images  Still images  Video images

Photographed by: \_\_\_\_\_

**P. PRINT NAMES OF PERSONNEL INVOLVED**

History taken by: \_\_\_\_\_

Phone: \_\_\_\_\_

Exam performed by: \_\_\_\_\_

Phone: \_\_\_\_\_

Signature of Examiner: \_\_\_\_\_

License # \_\_\_\_\_