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	Biological Sex	Ethnicity
		☐F ☐M ☐FTM ☐MTF ☐Other	☐F ☐M	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 ☐ No ☐ Yes	Language Used
Name of Interpreter	Telephone

Affiliation of Interpreter

☐ Facility Interpreting Services ☐ Contracted Agency, specify: _____

B. REPORTING AND AUTHORIZATION

Jurisdiction (☐ City ☐ County ☐ Other):

1. Telephone report to law enforcement agency

Name of Officer	Agency	ID Number	Telephone	Reported by: Name	Date	Time

2. Responding Officer

Agency	ID Number	Telephone

3. TELEPHONE AUTHORIZATION

Agency:
Authorizing party:
ID number:
Date/Time:

Law Enforcement Officer	ID Number	Agency

Telephone	Date	Time	Case Number

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	M	F	
	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	

4. Voluntary Use of Alcohol/Drugs?

Any voluntary alcohol use within 24 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 M	Gender F	Ethnicity	Relationship to Patient: Known	Relationship to Patient: Unknown
#1		☐	☐		☐	☐
#2		☐	☐		☐	☐

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):

H. ACTS DESCRIBED BY PATIENT

Patient Identification

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

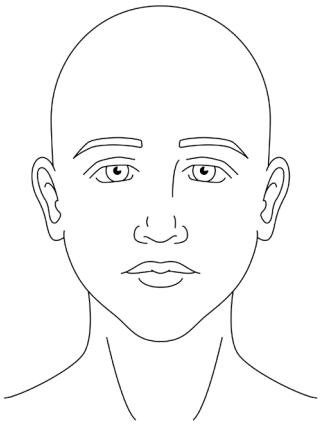


Diagram C

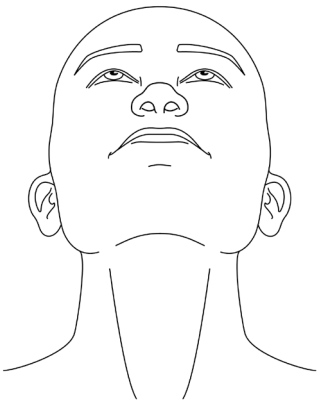


Diagram B

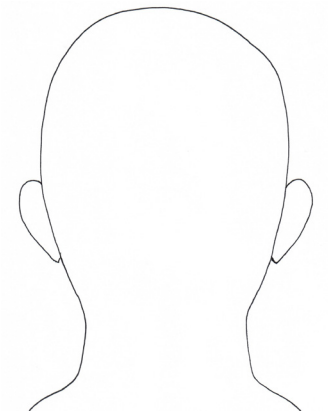
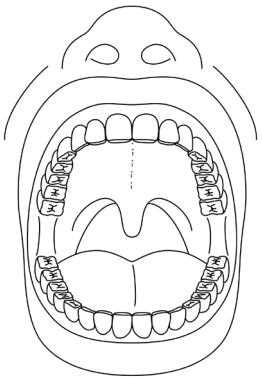


Diagram D



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

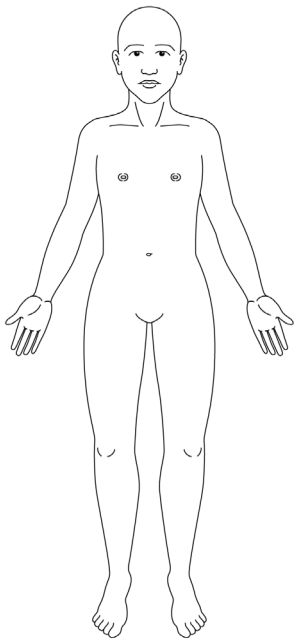
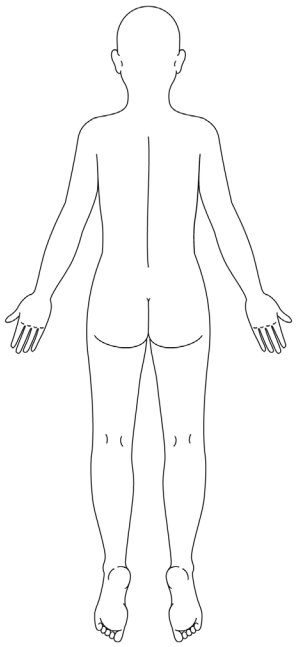


Diagram F



LEGEND: TYPES OF FINDINGS

AB	Abrasion	**DF**	Deformity	**FB**	Foreign Body	**OF**	Other Foreign Materials (describe)	**SI**	Suction Injury
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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: _____

Patient Identification

2. Clothing placed in evidence kit

☐ No ☐ Yes ☐ N/A

Other clothing placed in bags

4. Voice Recording for Strangulation Injuries

☐ No ☐ Yes If Yes, ☐ Audio ☐ Audiovideo

If yes, obtained by: ☐ Examiner ☐ Law Enforcement

3. Foreign Materials	N/A	No	Yes	Collected by:
Swabs/suspected blood	☐	☐	☐	
Dried secretions	☐	☐	☐	
Fibers/loose hairs	☐	☐	☐	
Soil/debris/vegetation	☐	☐	☐	
Swabs/suspected saliva	☐	☐	☐	
Foreign body	☐	☐	☐	
Fingernail scrapings	☐	☐	☐	
Neck swabs	☐	☐	☐	
Other (specify)	☐	☐	☐	

4. Reference Samples ☐ Blood ☐ Saliva ☐ Buccal ☐ N/A

Collected by: _____

M. DISTRIBUTION OF EVIDENCE	☐ N/A	Status
Clothing (items not placed in evidence kit)	☐ N/A	
Evidence kit	☐ N/A	
Reference samples	☐ N/A	
Recording(s) ☐ Audio ☐ 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

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: _____

O. SIGNATURE OF LAW ENFORCEMENT RECEIVING EVIDENCE ☐ N/A

Signature: _____

Print Name: _____ ID#: _____

Agency: _____

Date: _____ Telephone: _____

L. SUMMARY OF KEY FINDINGS

Describe: _____

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)?	☐ No	☐ Yes
If yes, do you remember?	☐ 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. Examples: _____	☐ No	☐ Yes	☐ At time of exam
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

_____

_____

_____

_____

_____

_____

ADDENDUM

Patient Identification