

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

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

**ADOLESCENTS AGES 12-17 < 120 HOURS
CHILDREN UNDER AGE 12: FOLLOW
LOCAL SART GUIDELINES**

CAL OES 2-930

July 2020



For copies of this form or assistance in completing
the Cal OES 2-930, please contact

California Clinical Forensic Medical Training Center
www.ccfmtc.org

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

STATE OF CALIFORNIA Governor's Office of Emergency Services

Cal OES 2-930

Confidential Document

Patient Identification

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

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

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

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 2-930

- Original – Law Enforcement Copy – Child Protective Services Copy Within Evidence Kit – Crime Lab Copy – Medical Records

D. PATIENT HISTORY

1. Most recent incident(s)	Date(s)	Time/time frame
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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
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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		Unknown	
	No	Yes	No	Yes		
Abdominal/pelvic pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pain on urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genital discomfort or pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genital itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genital discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genital bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genital rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anal discomfort or pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anal itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Enuresis (bed or daytime wetting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fecal soiling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____						_____
If yes to any of the above, describe onset, duration, and intensity: _____						

10. Post-assault hygiene activity Not applicable if over 120 hours

10. Post-assault hygiene activity	By patient		By historian		Unknown	
	No	Yes	No	Yes		
Urinated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Defecated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genital or body wipes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
If yes to any of the above, describe: _____						
Removed/inserted <input type="checkbox"/> tampon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/> panty liner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oral gargle/rinse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bath/shower/wash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brushed teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ate or drank	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Changed clothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

H. GENERAL PHYSICAL EXAMINATION								
1. BP	Pulse	Resp.	Temp.	Height	%	Weight	%	BMI
2. Record who is with child during exam. <input type="checkbox"/> N/A								
3. Sexual Maturity Rating/Female Tanner Stage - Breast <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5								
4. Describe general physical appearance.						Patient Identification		
6. Record relevant statements made during exam. <input type="checkbox"/> See addendum <input type="checkbox"/> N/A						5. Describe general demeanor.		
7. Describe condition of clothing on arrival. <input type="checkbox"/> Collect outer and underclothing if indicated.						Clothing brought in by:		
8. Conduct a general physical examination. <input type="checkbox"/> Findings <input type="checkbox"/> No findings						General exam within normal limits? <input type="checkbox"/> Yes <input type="checkbox"/> No		
9. Scan entire body with an ALS (Alternate Light Source). <input type="checkbox"/> Findings <input type="checkbox"/> No findings								
10. Collect dried and moist secretions, stains, foreign materials. <input type="checkbox"/> Findings <input type="checkbox"/> No findings						11. Collect fingernail swabbings (2 microtipped swabs). <input type="checkbox"/> N/A		
12. Collect 2 swabs from right breast/nipple and 2 swabs from left breast/nipple. Consider swabs from umbilicus and each side of inner thighs <input type="checkbox"/> N/A								

Diagram A

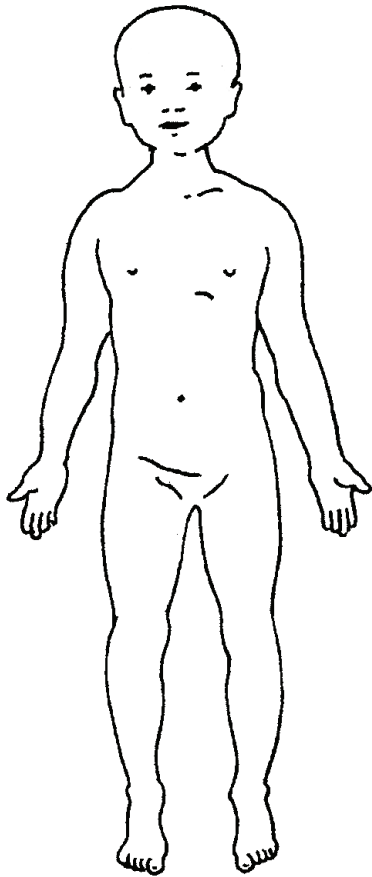
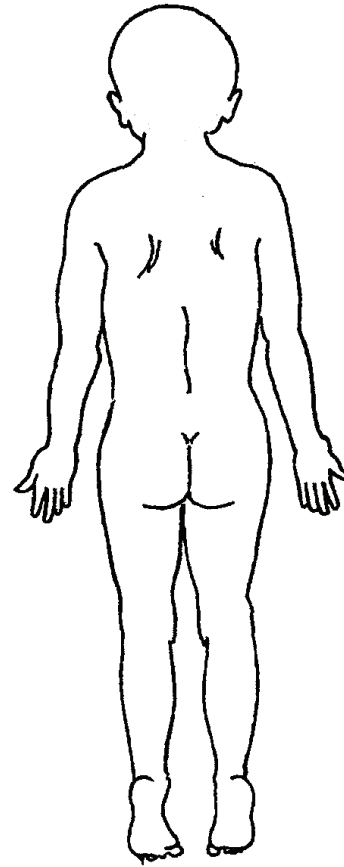


Diagram B



AB Abrasion AHT Absent Hymenal Tissue AL Anal Laxity ALS Alternate Light Source BI Bite BU Burn	CV Congenital Variation DE Debris DF Deformity DI Discharge DS Dry Secretion EC Ecchymosis (bruise)	ER Erythema (redness) F/H Fiber/Hair FB Foreign Body IN Induration IW Incised Wound LA Laceration	LHX Limited History Swab M/H Micro-hemorrhage/ Micro-hematoma MS Moist Secretion OF Other Foreign Materials (describe) OI Other Injury (describe)	OSC Other Skin Condition PCD Potential Contact DNA PE Petechiae PGW Possible Genital Wart PHN/C Possible Hymenal Notch/Cleft PHT Possible Hymenal Transection	PI Pre-Existing Injury PPW Possible Perianal Wart PS Potential Saliva PSH Potential Semen Per History PSI Potential Suction Injury SPH Sample Per History	SW Swelling TB Toluidine Blue ⊕ TE Tenderness V/S Vegetation/Soil/Sand VL Vesicular Lesion
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Locator #	Type	Description	Locator #	Type	Description

I. HEAD, NECK, AND ORAL EXAMINATION	
1. Examine the face, head, hair, scalp, and neck for injury and foreign materials.	<input type="checkbox"/> Findings <input type="checkbox"/> No findings
2. Scan areas with Alternate Light Source (ALS). Indicate ALS⊕ if there are findings.	<input type="checkbox"/> Findings <input type="checkbox"/> No findings
3. Collect dried and moist secretions, stains, and foreign materials.	<input type="checkbox"/> Findings <input type="checkbox"/> No findings

Patient Identification

4. Examine the oral cavity for injury and foreign materials. Collect foreign materials. Findings No findings
5. Collect 2 swabs from oral cavity up to 24 hours post-assault. Separately swab the perioral area and collect 2 swabs.
6. Collect 2 swabs from the right side of neck and 2 swabs from the left side. 7. Collect head hair reference samples *only if foreign hair is found*. Not applicable

Diagram C - Head (right-side view)

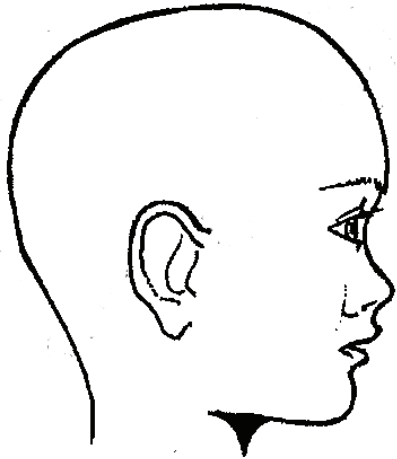


Diagram D - Head (left-side view)

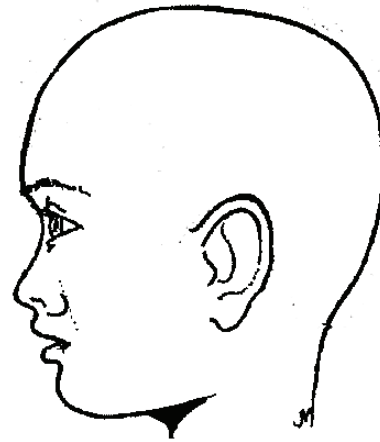


Diagram E - Head (front view)

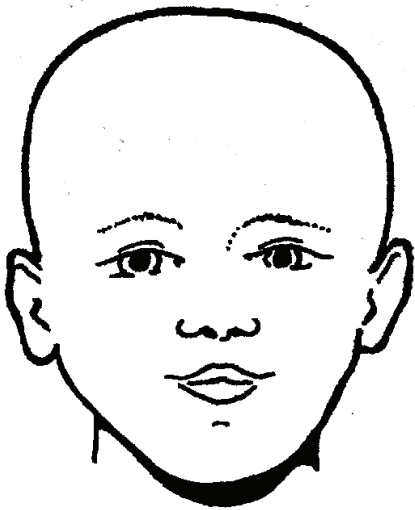
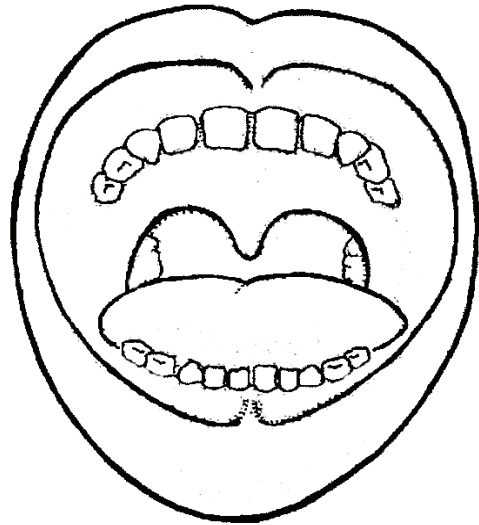


Diagram F - Mouth



AB Abrasion	CV Congenital Variation	ER Erythema (redness)	LHX Limited History Swab	OSC Other Skin Condition	PI Pre-Existing Injury	SW Swelling
AHT Absent Hymenal Tissue	DE Debris	F/H Fiber/Hair	M/H Micro-hemorrhage/ Micro-hematoma	PCD Potential Contact DNA	PPW Possible Perianal Wart	TB Toluidine Blue⊕
AL Anal Laxity	DF Deformity	FB Foreign Body	MS Moist Secretion	PE Petechiae	PS Potential Saliva	TE Tenderness
ALS Alternate Light Source	DI Discharge	IN Induration	OF Other Foreign Materials (describe)	PGW Possible Genital Wart	PSH Potential Semen Per History	V/S Vegetation/Soil/Sand
BI Bite	DS Dry Secretion	IW Incised Wound	OI Other Injury (describe)	PHN/C Possible Hymenal Notch/Cleft	PSI Potential Suction Injury	VL Vesicular Lesion
BU Burn	EC Ecchymosis (bruise)	LA Laceration		PHT Possible Hymenal Transection	SPH Sample Per History	

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 Colposcope Other magnification Direct visualization only

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

Exam Technique Catheter Moistened swab Toluidine Blue Dye
 Saline/water Other
 Speculum (only for patients w/ SMR of 4 or 5, and only if tolerated)

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
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"/> Crescentic			_____
<input type="checkbox"/> Imperforate			_____
<input type="checkbox"/> Septate			_____
Fossa navicularis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Posterior fourchette	<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: _____			

5. Scan entire body with an ALS (Alternate Light Source). Collect dried and moist secretions, stains, and foreign materials

Findings No findings

6. Collect swabs.

- Mons pubis** (collect 2 swabs (all patients))
- Prepubertal female** (collect at least 2 vulvar and 2 vestibular swabs)
- Pubertal female**
 - Collect 4 swabs from the vaginal pool
 - Consider collecting 2 cervical swabs (if over 24 hours post-assault)
 - N/A

7. Collect pubic hair brushing N/A

8. Collect pubic hair reference samples only if a foreign hair is found N/A

Patient Identification

Diagram G - Genitals: Vulva, Vestibule, Vagina (Supine View)

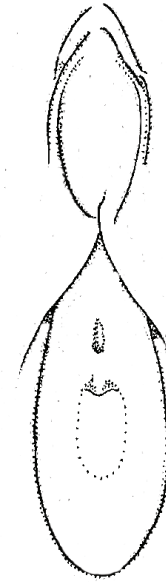
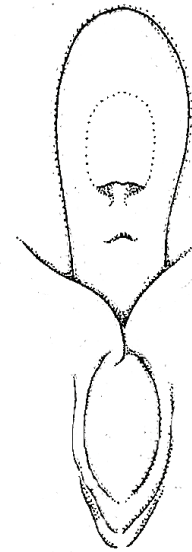


Diagram H - Genitals: Vulva, Vestibule, Vagina (Prone Knee-Chest View)



AB Abrasion	CV Congenital Variation	ER Erythema (redness)	LHX Limited History Swab	OSC Other Skin Condition	PI Pre-Existing Injury	SW Swelling
AHT Absent Hymenal Tissue	DE Debris	F/H Fiber/Hair	M/H Micro-hemorrhage/ Micro-hematoma	PCD Potential Contact DNA	PPW Possible Perianal Wart	TB Toluidine Blue
AL Anal Laxity	DF Deformity	FB Foreign Body	MS Moist Secretion	PE Petechiae	PS Potential Saliva	TE Tenderness
ALS Alternate Light Source	DI Discharge	IN Induration	OF Other Foreign Materials (describe)	PGW Possible Genital Wart	PSH Potential Semen Per History	V/S Vegetation/Soil/Sand
BI Bite	DS Dry Secretion	IW Incised Wound	OI Other Injury (describe)	PHN/C Possible Hymenal Notch/Cleft	PSI Potential Suction Injury	VL Vesicular Lesion
BU Burn	EC Ecchymosis (bruise)	LA Laceration		PHT Possible Hymenal Transection	SPH Sample Per History	

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. Scan the entire body with an Alternate Light Source (ALS).

Indicate ALS⊕ if there are findings. Findings No findings

3. Collect dried and moist secretions, stains, and foreign materials.

Findings No findings

4. Check the ABN box(es) if there are abuse/assault related findings. Describe any abnormal or unusual 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 Yes No If yes: Immediate Delayed

Anal bleeding Yes No If yes, describe: _____

Anal discharge Yes No If yes, describe: _____

Stool present in rectal ampulla Yes No Undetermined

5. Collect 2 perianal swabs.

6. Anal bleeding: Yes No If yes, describe: _____

7. Additional Information:

Patient Identification

Diagram K - Anus (supine view)

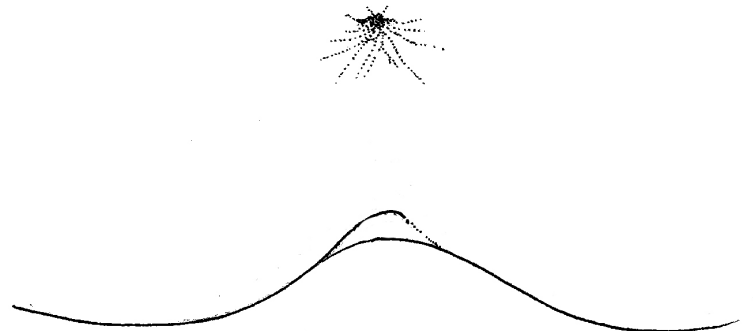
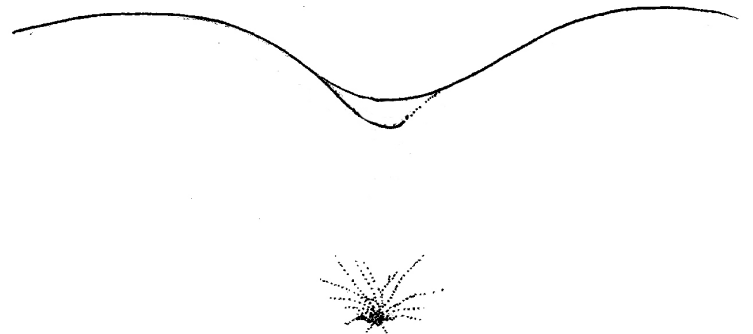


Diagram L - Anus (prone view)



AB Abrasion	CV Congenital Variation	ER Erythema (redness)	LHX Limited History Swab	OSC Other Skin Condition	PI Pre-Existing Injury	SW Swelling
AHT Absent Hymenal Tissue	DE Debris	F/H Fiber/Hair	M/H Micro-hemorrhage/ Micro-hematoma	PCD Potential Contact DNA	PPW Possible Perianal Wart	TB Toluidine Blue ⊕
AL Anal Laxity	DF Deformity	FB Foreign Body	MS Moist Secretion	PE Petechiae	PS Potential Saliva	TE Tenderness
ALS Alternate Light Source	DI Discharge	IN Induration	OF Other Foreign Materials (describe)	PGW Possible Genital Wart	PSH Potential Semen Per History	V/S Vegetation/Soil/Sand
BI Bite	DS Dry Secretion	IW Incised Wound	OI Other Injury (describe)	PHN/C Possible Hymenal Notch/Cleft	PSI Potential Suction Injury	VL Vesicular Lesion
BU Burn	EC Ecchymosis (bruise)	LA Laceration		PHT Possible Hymenal Transection	SPH Sample Per History	

Locator #	Type	Description	Locator #	Type	Description

M. EVIDENCE COLLECTED AND SUBMITTED TO CRIME LABORATORY	
1. Clothing placed in evidence kit	Other clothing placed in bags
_____	_____
_____	_____
<input type="checkbox"/> Clothing brought in	

2. Foreign materials collected	Collected by
Dried secretions <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Fiber/loose hairs <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Fingernail swabbings <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Matted hair cuttings <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Pubic hair brushings <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Soil/debris ⊕ <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Swabs/ALS <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Swabs/suspected blood <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Swabs/suspected saliva <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Swabs/suspected contact DNA <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Swabs/suspected semen <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Vegetation <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Intravaginal foreign body <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Describe: _____	
Other types <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Describe: _____	

3. Body surface and cavity evidence swabs collected	# of swabs	Collected by
Oral	_____	_____
Perioral	_____	_____
Neck	_____	_____
Breasts	_____	_____
Umbilicus	_____	_____
Inner thighs	_____	_____
Mons pubis	_____	_____
Vestibular	_____	_____
Vulvar	_____	_____
Vaginal	_____	_____
Cervical	_____	_____
Perianal	_____	_____
Penile	_____	_____
Scrotal	_____	_____

N. TOXICOLOGY SAMPLES	
Blood-alcohol/toxicology (gray top tube) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not indicated <input type="checkbox"/> Patient declined	
Collected by _____	Time _____
Urine toxicology <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not indicated <input type="checkbox"/> Patient declined	
Collected by _____	Time _____

O. DNA AND OTHER REFERENCE SAMPLES	
	Collected by
Buccal swabs (for DNA reference) <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Head hair, if indicated <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Pubic hair, if indicated <input type="checkbox"/> Yes <input type="checkbox"/> No	_____

P. PHOTO DOCUMENTATION METHODS	
<input type="checkbox"/> Colposcope with camera <input type="checkbox"/> Digital camera/macrolens <input type="checkbox"/> Other imaging modality	
Extra-genital	Anal-genital
<input type="checkbox"/> Still images <input type="checkbox"/> Video images	<input type="checkbox"/> Still images <input type="checkbox"/> Video images
Photographed by: _____	

Q. FINDINGS AND INTERPRETATIONS

1. Initial medical findings of injury (acute or previous)	
Perianal/anal <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Limited exam
Body <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Pending further review
Genital <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Pending follow up exam
Oral <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	<input type="checkbox"/> Other
Describe: _____	

2. Interpretations pending final review (check all that apply)	
<input type="checkbox"/> Normal/normal variant exam (does not negate the possibility of abuse)	
<input type="checkbox"/> Other medical conditions present unrelated to injury that could impact the way the exam is interpreted.	
<input type="checkbox"/> Findings with unclear significance with respect to abuse.	
<input type="checkbox"/> Clear evidence of injury.	
<input type="checkbox"/> Findings of unexplained injury and unaccounted for by history (or no history).	
<input type="checkbox"/> Pregnancy confirms sexual contact	
<input type="checkbox"/> Pending formal laboratory results	
<input type="checkbox"/> Presence of sexually transmitted infection	
<input type="checkbox"/> Pending formal laboratory results	

3. <input type="checkbox"/> 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. <input type="checkbox"/> Not applicable	
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R. LAB TESTS PERFORMED	
Oral <input type="checkbox"/> GC <input type="checkbox"/> Chlamydia <input type="checkbox"/> Other Describe: _____	Collected by _____
Genital <input type="checkbox"/> GC <input type="checkbox"/> Chlamydia <input type="checkbox"/> Other Describe: _____	Collected by _____
Anal <input type="checkbox"/> GC <input type="checkbox"/> Chlamydia <input type="checkbox"/> Other Describe: _____	Collected by _____
Urine <input type="checkbox"/> GC <input type="checkbox"/> Chlamydia <input type="checkbox"/> Other Describe: _____	Collected by _____
Serology <input type="checkbox"/> HIV <input type="checkbox"/> Syphilis <input type="checkbox"/> Hepatitis	Collected by _____
Pregnancy test <input type="checkbox"/> Blood <input type="checkbox"/> Urine Results: _____	

S. PRINT NAMES OF PERSONNEL INVOLVED	
History taken by: _____	Phone: _____
Exam performed by: _____	Phone: _____
Specimens labeled & sealed by: _____	Phone: _____
Assisted by: _____ <input type="checkbox"/> N/A	Phone: _____
Signature of Examiner: _____	License # _____

T. EVIDENCE DISTRIBUTION	
Sexual assault evidence kit <input type="checkbox"/> Yes <input type="checkbox"/> No	Given to: _____
Clothing (items not placed in evidence kit) <input type="checkbox"/> Yes <input type="checkbox"/> No	Given to: _____
Reference DNA sample <input type="checkbox"/> Yes <input type="checkbox"/> No	Given to: _____
Urine toxicology/blood-alcohol samples <input type="checkbox"/> Yes <input type="checkbox"/> No	Given to: _____
Rapid turnaround DNA program kit <input type="checkbox"/> Yes <input type="checkbox"/> No	Given to: _____
Wet evidence <input type="checkbox"/> Yes <input type="checkbox"/> No	Given to: _____

U. SIGNATURE OF OFFICER RECEIVING EVIDENCE	
Signature: _____	
Print name and ID: _____	
Agency: _____	
Date: _____	Phone: _____