



Forensic Medical Report

Adult/Adolescent Intimate Partner Violence Examination

A. General Information Date of Exam: _____ Exam Location: _____ Room: _____

Name of Patient Case Number Kit Number

Address City Zip Code County Phone Number

Age Date of Birth Gender (Born as) Gender (Identify with) Ethnicity

B. Jurisdiction

1. Have you reported to law enforcement? Y/N If no, do you want to report? Y/N If No: Jane Doe

If Reporting: Agency Name of Officer or Detective

C. Patient Consent

I have been informed that victims of crime are eligible to submit Crime Victims Compensation Claims to the State Victims of Crime (VOC) Restitution fund for out-of-pocket medical expenses, psychological counseling, loss of wages, and job retraining and rehabilitation. _____

I understand that forensic medical examination for evidence of personal assault can, with my consent, be conducted by health care professional to discover and preserve evidence of the assault. If conducted the report of the examination and any evidence will be released to law enforcement authorities. I understand that the examination may include the collection of a reference specimen. _____

I understand that I may withdraw consent at any time for any portion of the examination. _____

I understand the collection of evidence may include photographing injuries and that these photographs may include genital areas. Photographs may be released to law enforcement authorities or prosecution upon request. _____

I understand that patient identification may be collected from this report for health and forensic purposes and provided to health authorities and to other persons with a valid interest for demographic, epidemiological, and/or educational studies. _____

I hereby consent to a forensic medical examination with possible evidence collection. _____

Signature Date

Witness Date

*I was informed of the discharge instructions and was given a copy of them. _____

D. Patient General History

1. Name of Person Providing History: _____ Relationship to Patient: _____
2. Allergies: No Known Drug Allergies Medications Does not take any medications
- | | |
|--|----------------------|
| | |
| | |
| | Contraceptive: _____ |
3. Medical Surgical History:
- | |
|--|
| |
| |
| |
| |
| |
4. Any recent (60 days) anal-genital injuries, surgeries, diagnostic procedures, or medical treatments that may affect the interpretation of current physical findings?

5. Any pre-existing physical injuries? _____
6. Last menstrual period: _____
7. OB History
 Number of Pregnancies: _____ Living Births: _____ Abortions: _____
8. Bowel History: Diarrhea (Y) (N), Constipation (Y) (N), Hemorrhoids (Y) (N), Last Bowel Movement: _____
9. Any previous history of sexual assault, rape, and/or domestic violence?

10. Up to date on vaccinations: _____

E. Pertinent Pre- and Post-Assault Related History

Any voluntary alcohol use within 12 hours prior to the assault?	Yes	No	Unsure
Any voluntary drug use within 96 hours prior to the assault?	Yes	No	Unsure
Any voluntary alcohol or drug use between the time of the assault and the forensic exam?	Yes	No	Unsure

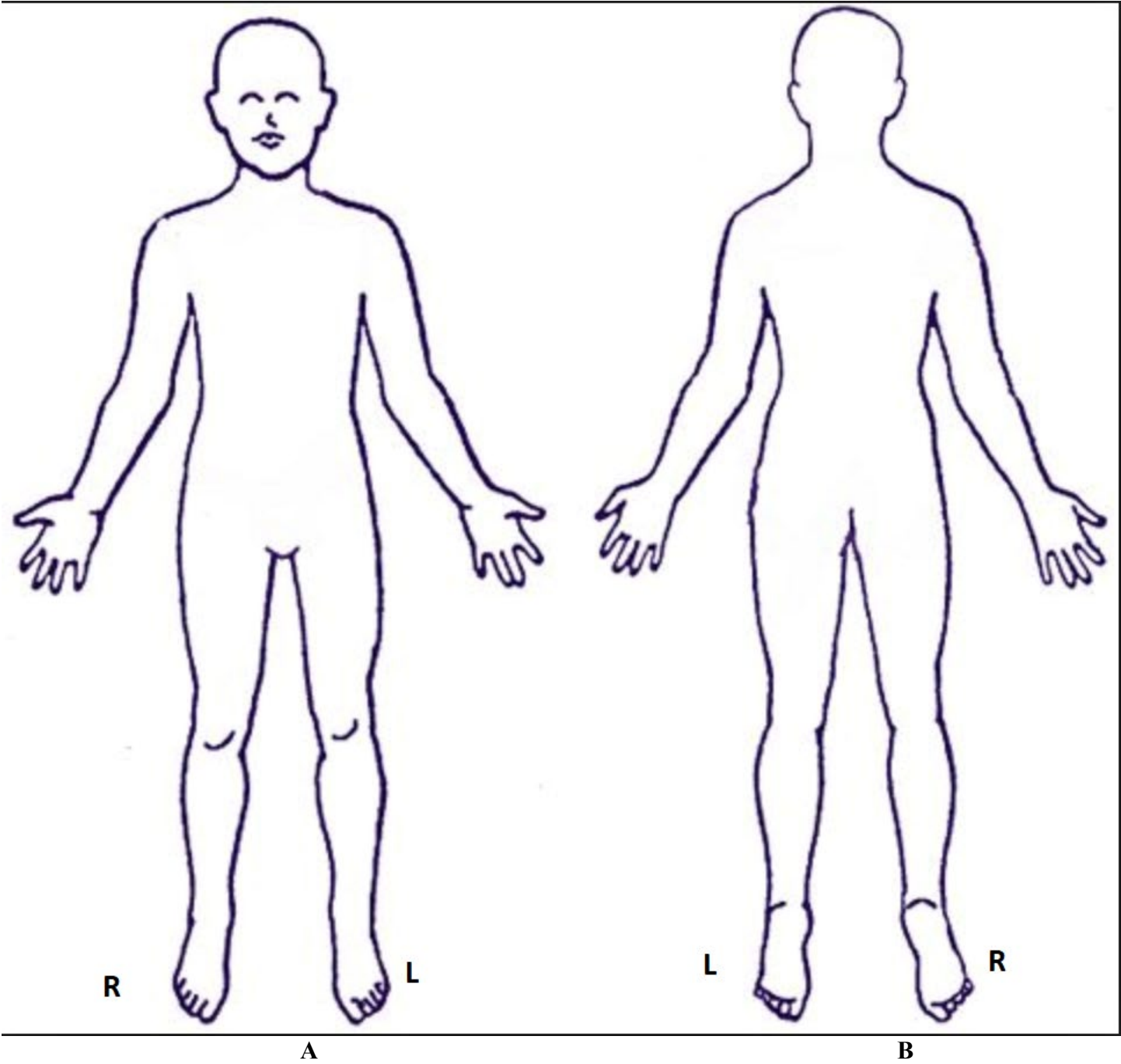
G. General Physical Examination

1. Blood Pressure: _____ Pulse: _____ Respirations: _____ Pulse Ox: _____ Temperature: _____
 2. Stated Height: _____ Stated Weight: _____
 3. Tanner Stage: 1 2 3 4 5
 4. Description of general physical appearance:

5. Description of general demeanor:
- _____
- _____

6. Possible Trauma Response Behaviors Observed

Emotional Reactions:	As Observed by:
<input type="checkbox"/> Fear	
<input type="checkbox"/> Grief	
<input type="checkbox"/> Anger	
<input type="checkbox"/> Guilt	
<input type="checkbox"/> Depressed	
<input type="checkbox"/> Helplessness	
<input type="checkbox"/> Hopelessness	
<input type="checkbox"/> Emotionally Numb	
<input type="checkbox"/> Flat Affect	
<input type="checkbox"/> Overwhelmed	
Cognitive Reactions:	
<input type="checkbox"/> Trouble concentrating	
<input type="checkbox"/> Difficulty remembering things	
<input type="checkbox"/> Confusion	
<input type="checkbox"/> Difficulty making decisions	
<input type="checkbox"/> Preoccupation with the event	
<input type="checkbox"/> Questioning beliefs	
<input type="checkbox"/> Attention span issues	
<input type="checkbox"/> Self-blame	
Physical Reactions:	
<input type="checkbox"/> Tension	
<input type="checkbox"/> Restlessness	
<input type="checkbox"/> Fatigue	
<input type="checkbox"/> Sleep disturbances	
<input type="checkbox"/> Changes in appetite	
<input type="checkbox"/> Racing Heartbeat	
<input type="checkbox"/> Nausea	
<input type="checkbox"/> Headaches	
<input type="checkbox"/> Startle Response	
<input type="checkbox"/> Nervous tendencies	
Interpersonal Reactions:	
<input type="checkbox"/> Distrustful	
<input type="checkbox"/> Irritability	
<input type="checkbox"/> Crying Easily	
<input type="checkbox"/> Withdrawal from others	
<input type="checkbox"/> Feeling rejected or abandoned by others	
<input type="checkbox"/> Guarded interactions with others	
<input type="checkbox"/> Need to control all situations	
<input type="checkbox"/> Poor eye contact	

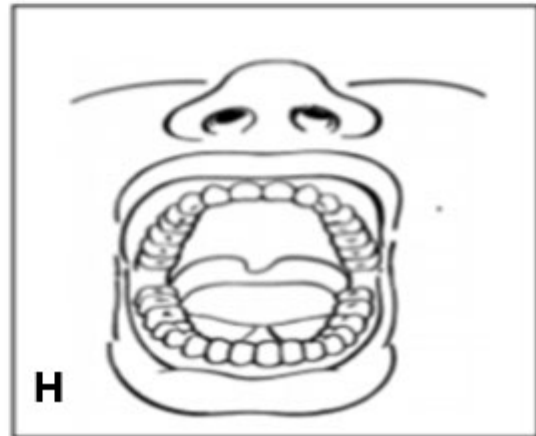
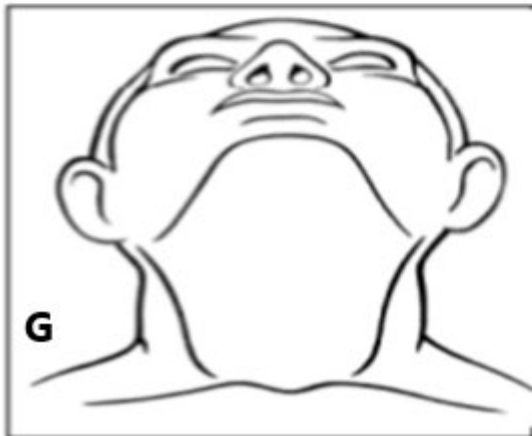
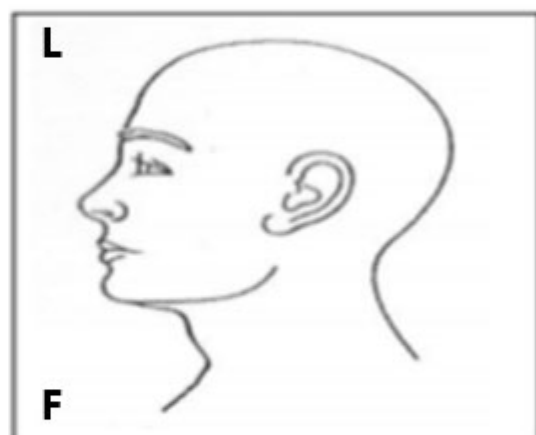
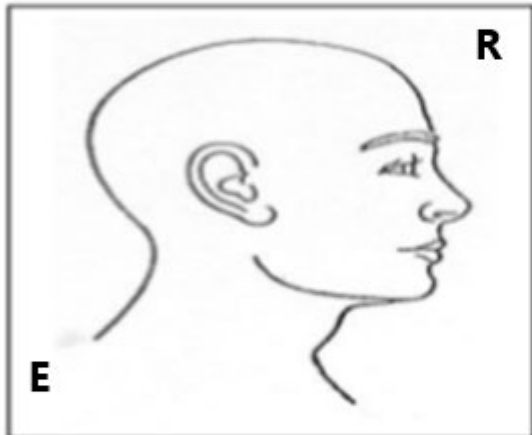
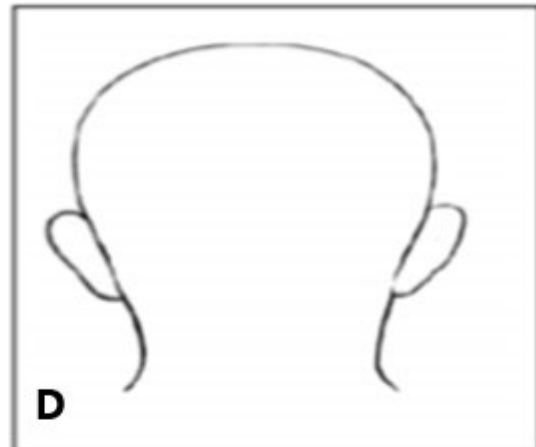
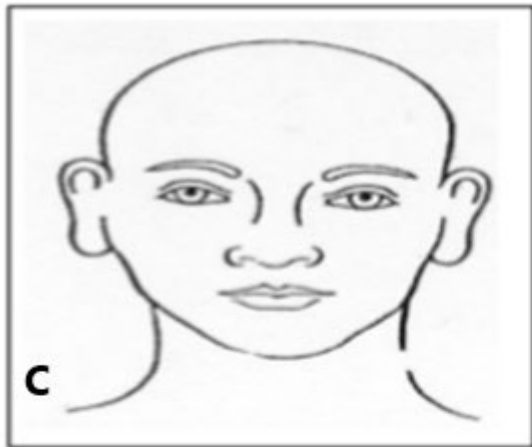


Last Updated: 5/2/2023
Nurse Signature:
Date:

Patient Name:

H. Head, Neck, and Oral Examination

1. Examine the face, head, hair, and neck for injury and foreign materials.
2. Collect dried and moist secretions, stains, and foreign materials from the face, head, hair, scalp, and neck.
3. Examine the oral cavity for injury and foreign materials.



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Date:

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I. Physical Exam Checklist:

Neck	Thyroid	Normal	Abnormal	
Respiratory	Respiratory Effort	Normal	Abnormal	
	Auscultation of lungs	Normal	Abnormal	
Cardiovascular	Auscultation of heart	Normal	Abnormal	
	Murmurs	Absent	Present	
	Peripheral Vascular	Normal	Abnormal	
Gastrointestinal	Abdomen:	Normal	Abnormal	
Skin	Inspected / Palpated	Normal	Abnormal	
Neurologic	Orientation			
	Time	Place	Person	Comments:
Psychiatric:	Mood and Affect:			
	Normal	Depressed	Anxious	Agitated

J. Examination Method and Tools Used

- Visualization method: Direct Visualization Colposcope Other Magnification: _____
- Tools used during examination: Toluidine Blue Cotton Tipped Applicator
- Examination positions: Supine: Separation Traction Knee Chest
 Prone: Separation Traction Knee Chest
 L or R Side lying: Separation Traction Knee Chest
- Photo Documentation:
 Date and Time on Camera: _____

Camera Used	Number of Images
<input type="checkbox"/> Cortex Flow	
<input type="checkbox"/> DSLR	
<input type="checkbox"/> EVA	
<input type="checkbox"/> Other	

K. Plan of Care

Lab Testing Performed

Patient declined testing

	Chlamydia/Gonorrhea	Urine / Vaginal Swab
	Syphilis	
	HIV	
	Pregnancy	Urine / Blood. + or -

Prophylactic Medications

Patient declined medications

	Azithromycin 1 gm PO	
	Ceftriaxone 500mg IM	Location:
	Metronidazole 2 grams PO	
	Emergency Contraception	
	Promethazine 12.5mg or 25mg	

Testing and medications provided by referring healthcare system. Name of healthcare system: _____

List alternative interventions as applicable or additional education provided:

Recommended labs:

	CBC
	CMP
	UA

Recommended X-Rays or Imaging:

Safety Plan:

Phone number for advocate to call:

L. Evidence Collected and Submitted

1. Clothing: Placed in evidence bags by: No clothing collected

Clothing Collected:	Condition of clothing:

2. Foreign Materials Collected Describe, if needed

Swabs	Yes	No	N/A	
Dried secretions	Yes	No	N/A	
Fibers/loose hairs	Yes	No	N/A	
Vegetation (soil/debris)	Yes	No	N/A	
Fingernail swabbing	Yes	No	N/A	
Matted hair cuttings	Yes	No	N/A	
Pubic hair combings	Yes	No	N/A	
Intra-vaginal foreign body	Yes	No	N/A	
Intra-rectal foreign body	Yes	No	N/A	

3. Swab samples (collection guided by patient history) Kit/Swabs not collected

	# of swabs expected	# of swabs collected	Time Collected	Reason Not Collected
Oral	4			
Peri-Oral (Mouth)	2			
Neck	2			
Bilateral Breasts / Chest	2			
Abdomen	2			

Known Blood Card Collected? Yes No Time Collected: _____ Reason Not Collected: _____

Date and Time when kit repackaging started: _____

4. Toxicology Samples: Yes No Blood: Time collected: _____ Collected by: _____
 Urine: Time collected: _____ Collected by: _____

M. Personnel Involved

History taken by: _____

Exam Performed by: _____

Specimens labeled and sealed by: _____

Signature of Sexual Assault Examiner: _____

Assisted by: _____

N. Evidence Distribution

Evidence picked up by LE

Evidence placed in DVSAC Evidence Locker

**If placed in evidence locker – was LE notified? Yes No How was LE notified? _____ Code for locker: _____

Distribution of Evidence: (Indicate what was provided to LE)

Evidence Kit <input type="checkbox"/> SAECK <input type="checkbox"/> Manual	
Blood/DNA card	
Clothing Bags	# of bags
Urine Toxicology	
Blood Toxicology	
Copy of Chart	

LEO Printed Name	Badge Number	Agency	Date and Time
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LEO Signature