



Male Forensic Medical Examination

Adult/Adolescent Sexual Assault 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 a sexual 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
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3. Medical Surgical History:
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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. Bowel History: Diarrhea (Y) (N), Constipation (Y) (N), Hemorrhoids (Y) (N), Last Bowel Movement:
7. Any previous history of sexual assault, rape, and/or domestic violence?  
 \_\_\_\_\_  
 \_\_\_\_\_
8. Up to date on vaccinations: \_\_\_\_\_

**E. Pertinent Pre- and Post-Assault Related History**

Last Consensual Intercourse prior to assault: \_\_\_\_\_ Date and Time: \_\_\_\_\_ Partner: \_\_\_\_\_  
 Greater than 30 days exempt:

Oral	Yes	No	Unsure
Vaginal	Yes	No	Unsure
Anal	Yes	No	Unsure
Oral	Yes	No	Unsure
Did ejaculation occur?	Yes	No	Unsure
Was a condom used?	Yes	No	Unsure

Any consensual intercourse between the sexual assault and time of this exam? (Y) (N)

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

**F. Post-Assault Hygiene/Activities**

Urinated	Yes	No	Bath or Shower	Yes	No
Defecated	Yes	No	Brushed teeth	Yes	No
Vomited	Yes	No	Ate and/or Drank	Yes	No
Used Genital Wipe	Yes	No	Changed clothing	Yes	No
Douched	Yes	No	Removed anything from anus	Yes	No
Oral gargle/rinse	Yes	No	Inserted anything in to anus	Yes	No



**Acts of Assault as Described by Patient**

Any penetration of the vaginal or anal opening, however slight, constitutes the act. Oral copulation requires only contact. If more than one assailant, identify by number.

1. Penetration of anus by:

Penis	Yes	No	Unsure
Finger	Yes	No	Unsure
Object	Yes	No	Unsure

Comments or descriptions from patient:

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2. Oral copulation of genitals:

Of patient by assailant	Yes	No	Unsure
Of assailant by patient	Yes	No	Unsure

3. Oral copulation of anus:

Of patient by assailant	Yes	No	Unsure
Of assailant by patient	Yes	No	Unsure

4. Non-genital act(s):

Licking	Yes	No	Unsure
Kissing	Yes	No	Unsure
Sucking	Yes	No	Unsure
Biting	Yes	No	Unsure
Injury	Yes	No	Unsure
Other	Yes	No	Unsure

Comments, descriptions, or locations from patient:

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5. Did ejaculation occur:

Yes      No      Unsure

Comment, description, location as described by patient:

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6. Contraceptive or Lubricants:

Condom	Yes	No	Unsure
Lubricant/Jelly	Yes	No	Unsure
Foam	Yes	No	Unsure
Saliva	Yes	No	Unsure

Comments or descriptions from patient:

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7. Methods of violence used by Assailant(s):

Weapons	Yes	No	Unsure
Slap	Yes	No	Unsure
Closed fist punch	Yes	No	Unsure
Pinching	Yes	No	Unsure
Grabbing/Holding	Yes	No	Unsure
Physical Restraints	Yes	No	Unsure
Pressure to Neck	Yes	No	Unsure
Burns (chemical/thermal)	Yes	No	Unsure
Threat(s) of harm	Yes	No	Unsure
Other methods	Yes	No	Unsure

Comments or descriptions from patient:

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8. Involuntary ingestion of alcohol?      Yes      No      Unsure  
 9. Involuntary ingestion of drugs?      Yes      No      Unsure  
 10. Any Memory loss experienced?      Yes      No      Unsure

11. Were injuries inflicted upon the assailant(s) during the assault?

Yes      No      Unsure

If yes, describe injuries, location, and how they were inflicted:

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12. Assailant(s) Name	Age	Gender	Ethnicity	Known to Patient	
				Known	Unknown
				Known	Unknown
				Known	Unknown
				Known	Unknown

**H. General Physical Examination**

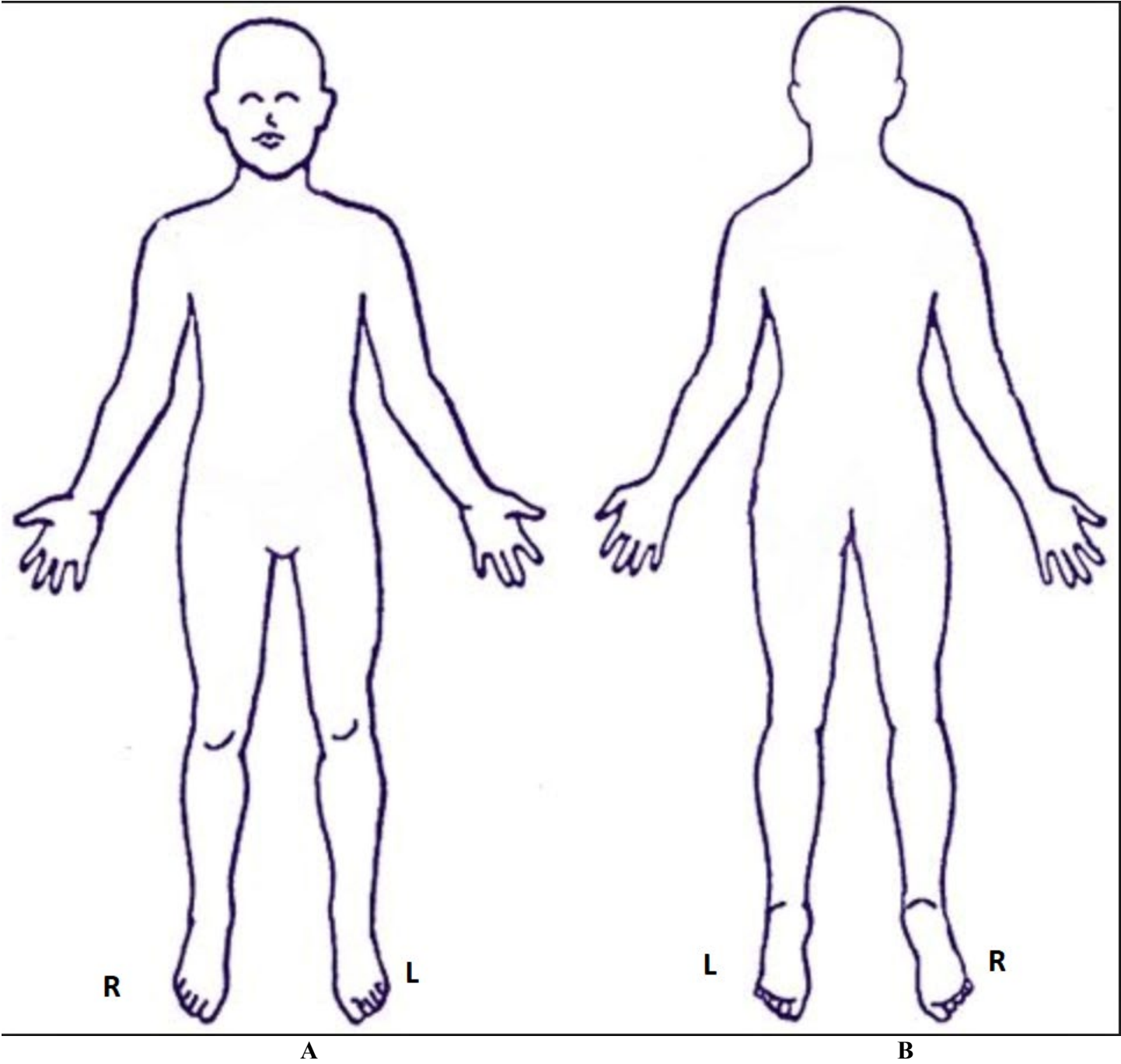
1. Blood Pressure:                      Pulse:                      Respirations:                      Pulse Ox:                      Temperature:  
 2. Stated Height:                      Stated Weight:  
 3. Tanner Stage:                       1                       2                       3     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

\_\_\_\_\_

5. Description of general demeanor:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

6. Possible Trauma Response Behaviors Observed

<b>Emotional Reactions:</b>	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	
<b>Cognitive Reactions:</b>	
<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	
<b>Physical Reactions:</b>	
<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	
<b>Interpersonal Reactions:</b>	
<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	



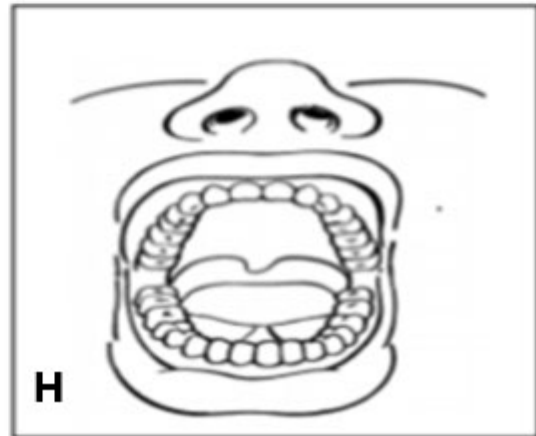
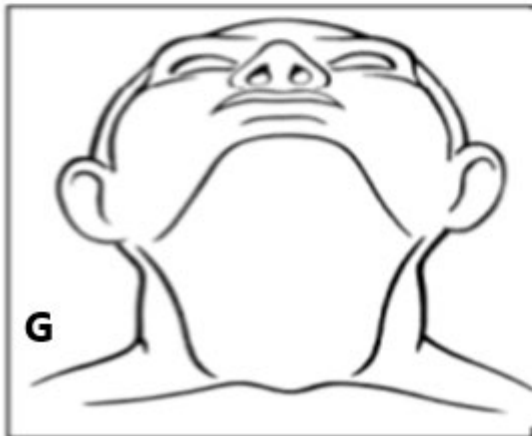
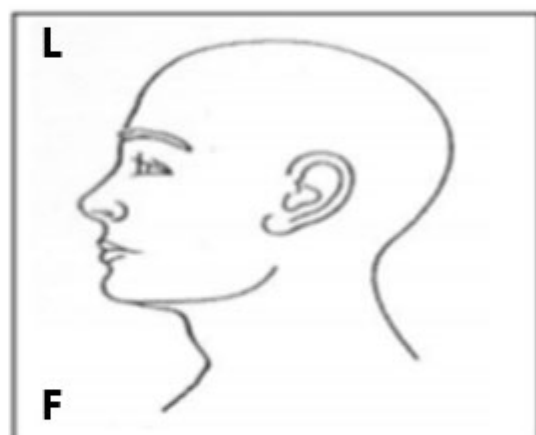
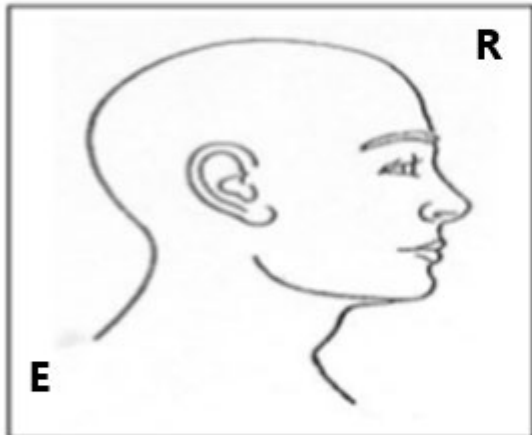
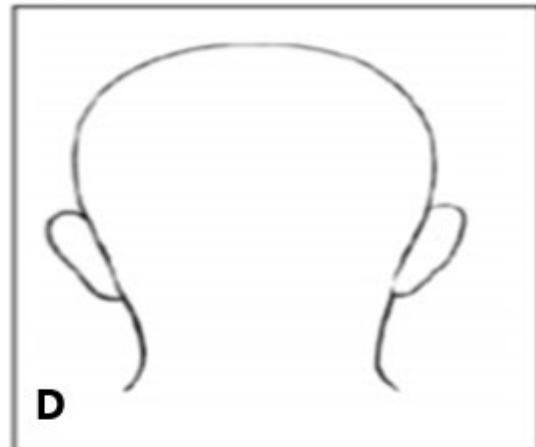
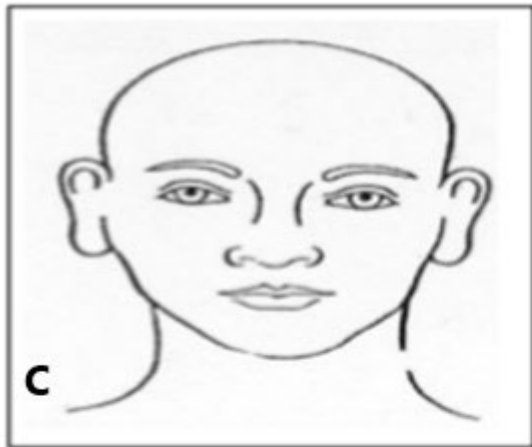
Last Updated: 5/2/2023  
Nurse Signature:  
Date:

Patient Name:

## I. Head, Neck, and Oral Examination

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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.



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

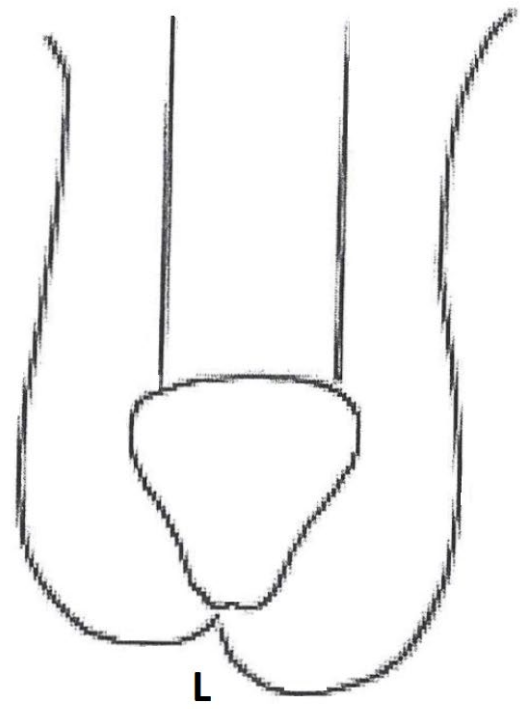
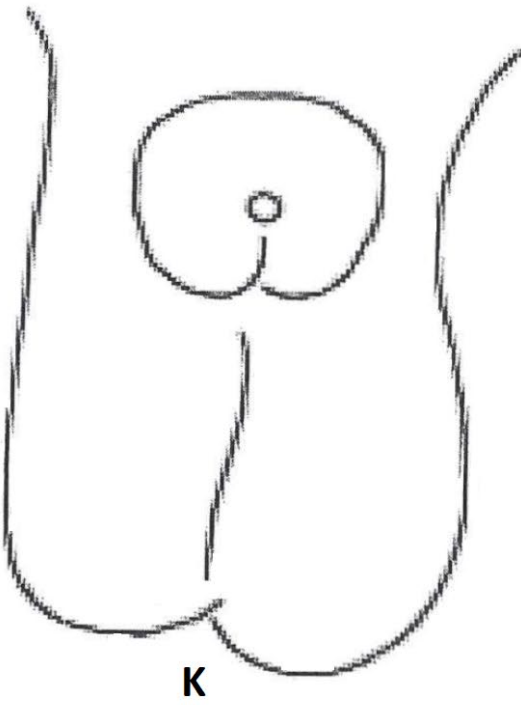
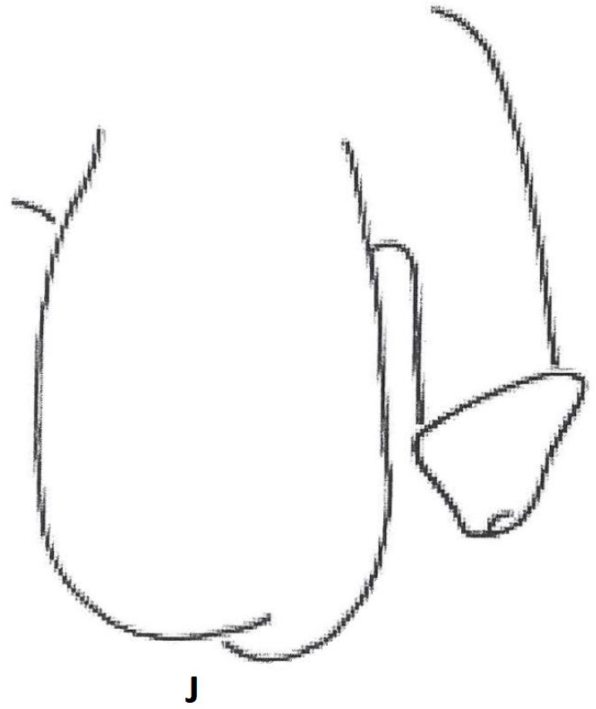
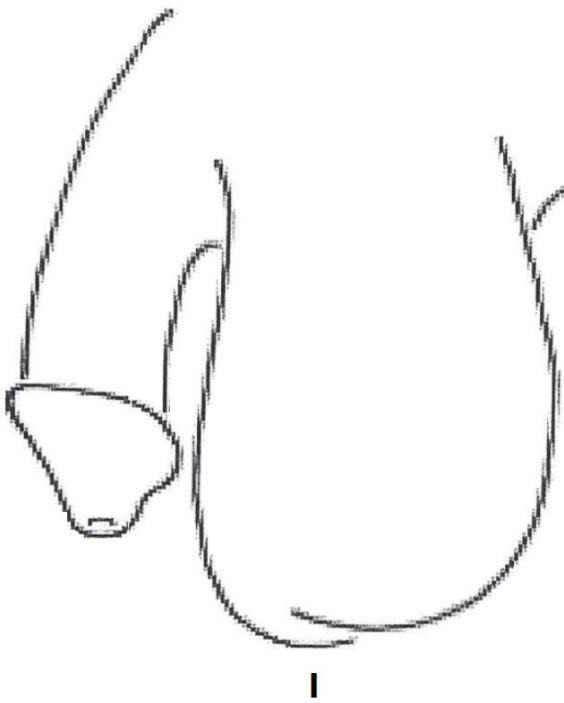
Patient Name:





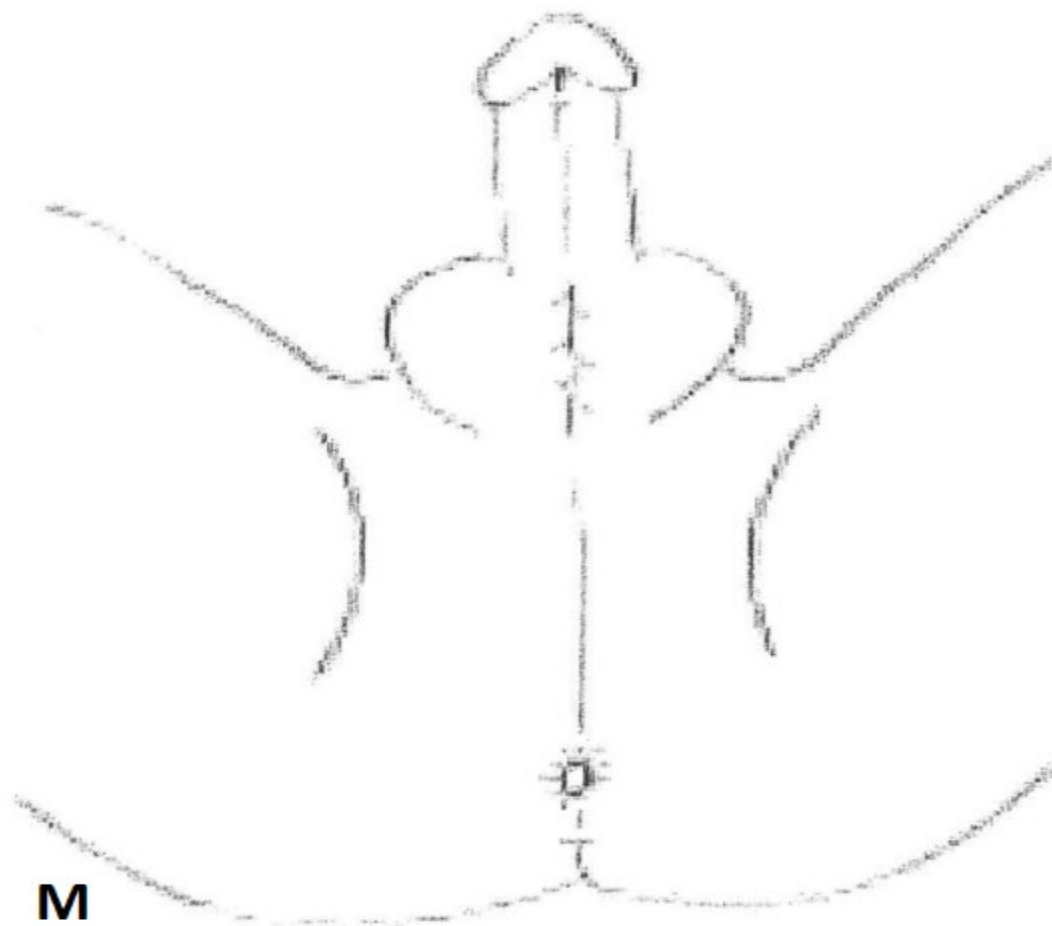
**J. Genital Examination**

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

Patient Name:

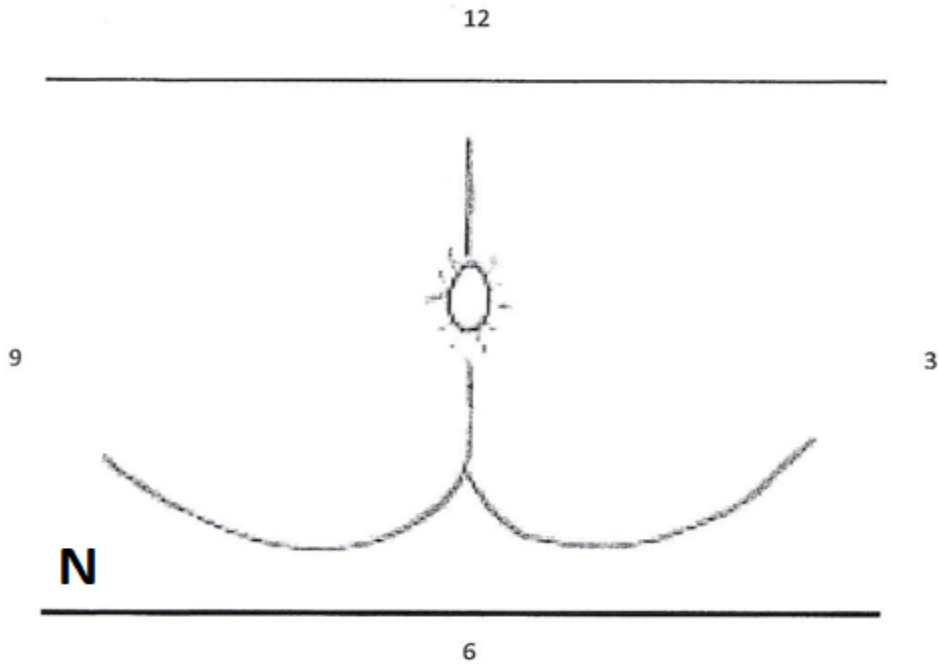


AB: Abrasion	EC: Ecchymosis	LA: Laceration
BI: Bite	ER: Erythema	MS: Moist secretions
BU: Burn	FB: Foreign Body	OI: Other Injury
BR: Bruise	HI: Healed Injury or Scar	PE: Petechiae
DE: Debris	IN: Induration	SW: Swelling
DS: Dry secretion	IW: Incised Wound	TE: Tenderness

Locator Number:	Type:	Description:

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

Patient Name:



AB: Abrasion	EC: Ecchymosis	LA: Laceration
BI: Bite	ER: Erythema	MS: Moist secretions
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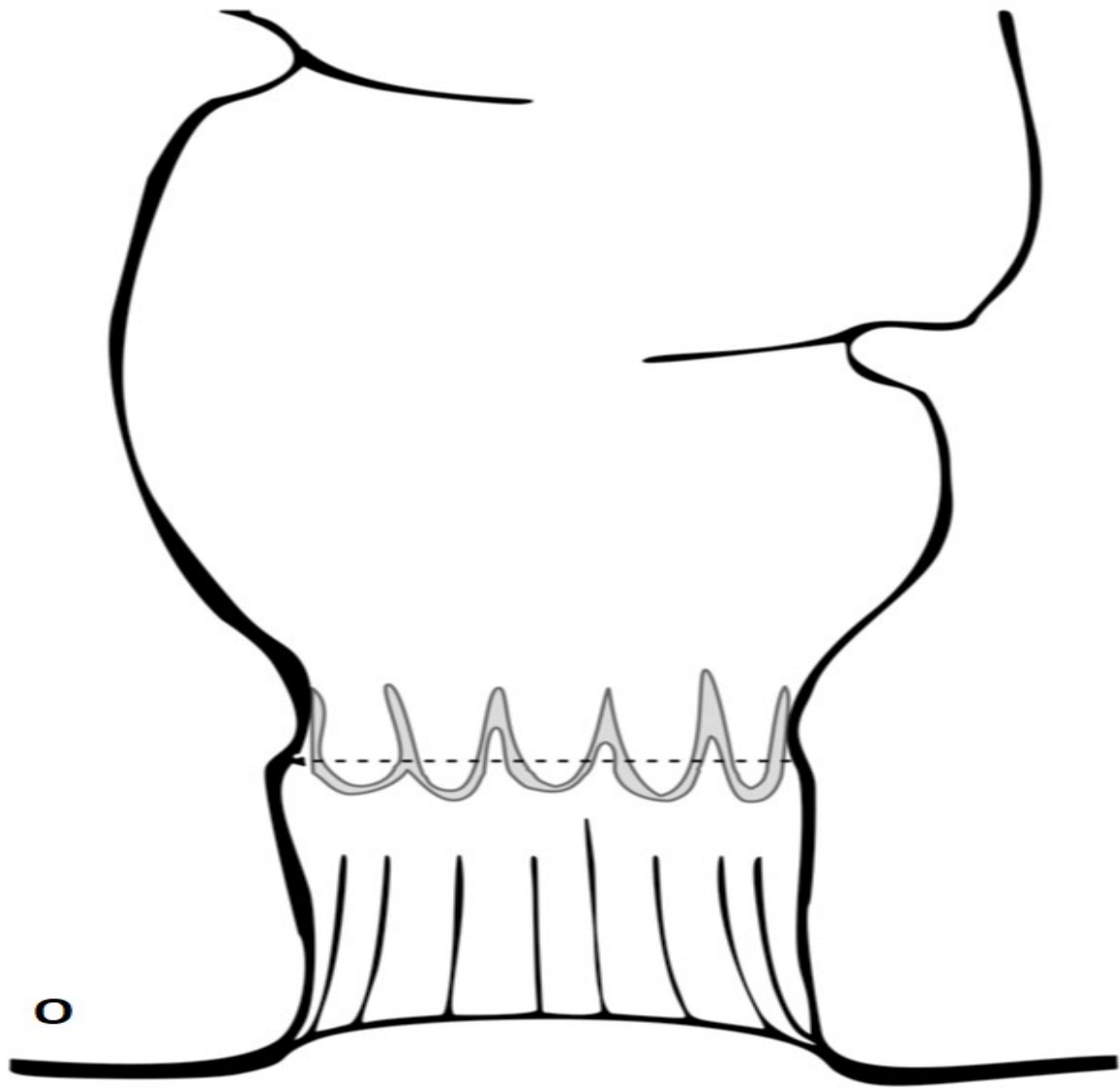
Locator Number:	Type:	Description:

Anal Dilation:  Yes (  Immediate or  Delayed)  No  
 Rectal Bleeding:  Yes  No

Stool in Rectal Vault:  Yes  No

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

Patient Name:



AB: Abrasion	EC: Ecchymosis	LA: Laceration
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BU: Burn	FB: Foreign Body	OI: Other Injury
BR: Bruise	HI: Healed Injury or Scar	PE: Petechiae
DE: Debris	IN: Induration	SW: Swelling
DS: Dry secretion	IW: Incised Wound	TE: Tenderness

Locator Number:	Type:	Description:

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

Patient Name:

**K. Examination Method and Tools Used**

1. Visualization method:    Direct Visualization        Colposcope        Other Magnification: \_\_\_\_\_
2. Tools used during examination: Anoscope    Toluidine Blue    Fox tail swab    Cotton Tipped Applicator
3. Examination positions:    Supine: Knee Chest  
    Prone: Knee Chest  
    L or R Side lying: Knee Chest
4. 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	

**L. Plan of Care**

Lab Testing Performed	<input type="checkbox"/> Patient declined testing
Chlamydia/Gonorrhea	
Syphilis	
HIV	

Prophylactic Medications	<input type="checkbox"/> Patient declined medications
Azithromycin 1 gm PO	
Ceftriaxone 500mg IM	Location:
Metronidazole 2 grams PO	
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:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Safety Plan:

\_\_\_\_\_

\_\_\_\_\_

Phone number for advocate to call:

\_\_\_\_\_

**M. 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-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			
Chest	2			
Abdomen	2			
Penile shaft	2			
Scrotal and perineum	2			
Anal cavity (~first inch)	4			
Rectal cavity (past 2 <sup>nd</sup> sphincter)	4			

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: \_\_\_\_\_

**N. Personnel Involved**

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

Exam Performed by: \_\_\_\_\_

Specimens labeled and sealed by: \_\_\_\_\_

Signature of Sexual Assault Examiner: \_\_\_\_\_

Assisted by: \_\_\_\_\_

**O. Evidence Distribution**

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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	

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LEO Printed Name	Badge Number	Agency	Date and Time
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LEO Signature