# ADOLESCENT/ADULT
# FORENSIC MEDICAL EXAMINATION
# FORM ACUTE ≤ 120 HOURS

DISTRIBUTION ☐ Full Report to Law Enforcement ☐ Partial Report to Law Enforcement or ☐ Anonymous Report

Initial to indicate copies are made and distributed.

| | | |
|---|---|---|
| ____________ | COPY | Crime Lab (place in kit) |
| ____________ | COPY | Law Enforcement (place in envelope on back of kit) |
| ____________ | ORIGINAL | Hospital or CAC |

**CONFIDENTIAL DOCUMENT**

## A. GENERAL INFORMATION (print)

1. Name of Patient:

2.

| Address: | City: | State: | Zip: | Telephone: |
|---|---|---|---|---|
| | | | | |

3.

| Age: | DOB: | Gender: ☐ M ☐ F | Ethnicity: | Arrival Date: | Discharge Date: | Discharge Time: |
|---|---|---|---|---|---|---|
| | | | | | | |

## B. AGENCY INFORMATION

1. Notification of Advocacy Center: ☐ Yes ☐ No ☐ NA — If no, explain:

   Name of Advocate (if applicable):

2. Adult Protective Services Notified: ☐ Yes ☐ No ☐ NA

   Representative Name (if applicable):

3. Child Protective Services Notified: ☐ Yes ☐ No ☐ NA

   Representative Name (if applicable):

4. Interpreter Used: ☐ Yes ☐ No ☐ NA

   Representative Name:

## C. JURSDICTION

1. Responding Officer (if applicable): ____________________ Agency: ____________________
2. Responding Detective (if applicable): ____________________ Agency: ____________________

PLACE PATIENT IDENTIFICATION STICKER HERE

____________________
FORENSIC EXAMINER'S SIGNATURE

# CONSENT FOR FORENSIC EXAMINATION, RELEASE OF EVIDENCE, PHOTO DOCUMENTATION AND RECORDS, WAIVER OF MEDICAL PRIVILEGE

## D. PATIENT CONSENT

☐ YES ☐ NO I have been informed that my medical provider may seek reimbursement from the Nebraska Crime Victims Compensation Fund for any medical expenses that would otherwise be paid out-of-pocket by me only with my permission.

☐ YES ☐ NO I have been informed that a Forensic Nurse Examiner, also known as a Sexual Assault Nurse Examiner (SANE) nurse or a physician will conduct a forensic examination for the evaluation and documentation of injuries and collection of evidence. I understand that I may withdraw consent at any time for any portion of the examination.

☐ YES ☐ NO I understand that this consent and waiver authorizes a complete forensic examination to be performed, which may include, but is not limited to an evidence collection of Sexual Assault Evidence Collection kit, blood and urine samples, HIV testing, HIV and/or sexually transmitted disease prophylaxis.

☐ YES ☐ NO I understand that collection of evidence may include forensic photography of injuries and these photographs may include the genital area.

**Choose Option 1 OR Option 2**

### OPTION 1

Please utilize the following consent/waiver for all mandatory reports to law enforcement. Reporting to law enforcement is mandatory by law if the patient is under the age of 18 or the patient has suffered serious bodily injury, regardless of age.

☐ I understand that this consent and waiver also authorizes the release of medical and forensic records, evidence and photographs to the appropriate law enforcement, child protection and prosecuting agencies.

### OPTION 2

If the patient is 18 or older and has not suffered serious bodily injury please utilize the following consent and waiver.
I understand that this consent and waiver allows me to choose one of the following reporting options for my sexual assault exam and the sexual assault kit and evidence collection resulting from the exam. **Choose ONE of the three options below**:

☐ **Full Law Enforcement Report**: This authorizes the release of my sexual assault kit and evidence, records and photographs related to my sexual assault. These will be provided to the appropriate law enforcement and prosecuting agency.

☐ **Partial Report:** This allows my sexual assault kit and evidence to be collected and provided to law enforcement with my name only. I understand that DNA testing will be done on my sexual assault kit.

☐ **Anonymous Report:** This allows me to remain completely anonymous so my name and identifying information will not be provided to law enforcement. My sexual assault kit will be turned over to law enforcement for storage with only the kit number. My sexual assault kit and evidence will not be tested unless I change my report at a later time to a Full or Partial Report.

I would like to be contacted for follow-up upon the completion of this exam by the checked box(es) below:

☐ Phone Call Phone Number: ______________________

☐ Text Message Cell Phone Number: ______________________

☐ E-mail E-mail Address: ______________________

______________________________ ______________________________
SIGNATURE OF PATIENT/PARENT/GUARDIAN Date Time

______________________________ ______________________________
RELATIONSHIP: SELF/PARENT/GUARDIAN FORENSIC NURSE/PHYSICIAN/NP/PA

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## E. PATIENT HISTORY

1. Name of Person Providing History:

2. Pertinent Medical History:

3. Last menstrual period (if applicable):

4. Any recent (60 days) anal or genital injuries, surgeries, diagnostic procedures, or medical treatment that may affect the interpretation of current physical findings? ☐ Yes ☐ No

5. Any other pertinent medical condition(s) that may affect the interpretation of current physical findings? ☐ Yes ☐ No

   If yes, describe:

6. Any pre-existing physical injuries? ☐ Yes ☐ No

   If yes, describe:

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## 7. Patient History of Assault

☐ Patient Declined

Description of assault:

Additional pages included: ☐ Yes ☐ No

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| 8. | Pertinent Pre- and Post-Assault Related History: | | | | |
|---|---|---|---|---|---|
| a. | Any consensual sex acts within past 5 days | ☐ Yes | ☐ No | ☐ NA | If yes, when: |
| b. | Name of partner(s) | | | | |
| c. | Anal (within past 5 days) | ☐ Yes | ☐ No | ☐ NA | If yes, when: |
| d. | Vaginal (within past 5 days) | ☐ Yes | ☐ No | ☐ NA | If yes, when: |
| e. | Oral (within past 24 hours) | ☐ Yes | ☐ No | ☐ NA | If yes, when: |
| f. | If yes, did ejaculation occur | ☐ Yes | ☐ No | ☐ NA | If yes, where: |
| g. | If yes, was a condom used | ☐ Yes | ☐ No | ☐ NA | |
| h. | Any alcohol use within 12 hours prior to assault | ☐ Yes | ☐ No | If yes or loss of memory, toxicology samples are recommended. | |
| i. | Any drug use within 96 hours prior to assault | ☐ Yes | ☐ No | If yes or loss of memory, toxicology samples are recommended. | |
| j. | Any drug or alcohol use between the time of the assault and forensic exam | ☐ Yes | ☐ No | If yes or loss of memory, toxicology samples are recommended. | |

| 9. | Post-Assault Hygiene/Activity: | | | |
|---|---|---|---|---|
| a. | Urinated | ☐ Yes | ☐ No | |
| b. | Defecated | ☐ Yes | ☐ No | |
| c. | Genital or body wipes | ☐ Yes | ☐ No | If yes, with what: |
| d. | Douched | ☐ Yes | ☐ No | If yes, with what: |
| e. | Removed or inserted tampon | ☐ Yes | ☐ No | |
| f. | Removed or inserted diaphragm | ☐ Yes | ☐ No | |
| g. | Oral rinse | ☐ Yes | ☐ No | |
| h. | Bath/shower/wash | ☐ Yes | ☐ No | |
| i. | Brushed teeth/floss | ☐ Yes | ☐ No | |
| j. | Ate or drank | ☐ Yes | ☐ No | |
| k. | Changed clothing | ☐ Yes | ☐ No | If yes, describe: |

| 10. | **Assault Related History:** | | | |
|---|---|---|---|---|
| a. | Loss of memory | ☐ Yes | ☐ No | If yes, describe: |
| | | | | If yes, collection of toxicology samples is recommended: ☐ Blood ☐ Urine |
| b. | Lapse of consciousness | ☐ Yes | ☐ No | If yes, describe: |
| | | | | If yes, collection of toxicology samples is recommended: ☐ Blood ☐ Urine |
| c. | Vomited | ☐ Yes | ☐ No | If yes, describe: |
| d. | Non-genital injury, pain and/or bleeding | ☐ Yes | ☐ No | If yes, describe: |
| e. | Anal or genital injury, pain and/or bleeding | ☐ Yes | ☐ No | If yes, describe: |
| f. | Additional Information: | | | |

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## F. ABUSE/ASSAULT HISTORY

1. **Assailant Information**

| | |
|---|---|
| a. | Assailant Name: |
| b. | Relationship to Patient: |
| c. | Assailant Age: \| Assailant Gender: ☐ M ☐ F \| Assailant Ethnicity: |
| d. | Reported history of STI: \| Reported use of drugs involving needles: |
| e. | ☐ Isolated incident of abuse/assault<br>☐ Acute incident of abuse/assault with history of chronic abuse by same assailant<br>☐ NA |

2. Date of Assault(s): | Time of Assault(s) If known:

3. Pertinent Physical Surroundings of Assault(s):

**NOTE: If more than one assailant, identify by number.**

4.

| Penetration of vagina by: | | | | | If yes to any, describe: |
|---|---|---|---|---|---|
| Penis | ☐ Yes | ☐ No | ☐ Attempted | ☐ Unsure | |
| Finger | ☐ Yes | ☐ No | ☐ Attempted | ☐ Unsure | |
| Object | ☐ Yes | ☐ No | ☐ Attempted | ☐ Unsure | |

5.

| Penetration of anus by: | | | | | If yes to any, describe: |
|---|---|---|---|---|---|
| Penis | ☐ Yes | ☐ No | ☐ Attempted | ☐ Unsure | |
| Finger | ☐ Yes | ☐ No | ☐ Attempted | ☐ Unsure | |
| Object | ☐ Yes | ☐ No | ☐ Attempted | ☐ Unsure | |

6.

| Penetration of oral cavity by: | | | | | If yes to any, describe: |
|---|---|---|---|---|---|
| Penis | ☐ Yes | ☐ No | ☐ Attempted | ☐ Unsure | |
| Finger | ☐ Yes | ☐ No | ☐ Attempted | ☐ Unsure | |
| Object | ☐ Yes | ☐ No | ☐ Attempted | ☐ Unsure | |

7.

| Contraceptive or lubricant products: | | | | | |
|---|---|---|---|---|---|
| Foam used | ☐ Yes | ☐ No | ☐ Attempted | ☐ Unsure | |
| Jelly used | ☐ Yes | ☐ No | ☐ Attempted | ☐ Unsure | |
| Lubricant used | ☐ Yes | ☐ No | ☐ Attempted | ☐ Unsure | |
| Condom used | ☐ Yes | ☐ No | ☐ Attempted | ☐ Unsure | Describe type/brand if known: |
| Location of condom (if applicable): | | | | ☐ Unsure | |

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| 8. | Did ejaculation occur? | ☐ Yes | ☐ No | ☐ Attempted | ☐ Unsure |
|---|---|---|---|---|---|
| | **If yes, note location(s) below:** | | | | |
| | Mouth | ☐ Yes | ☐ No | ☐ Attempted | ☐ Unsure |
| | Vagina | ☐ Yes | ☐ No | ☐ Attempted | ☐ Unsure |
| | Anus/rectum | ☐ Yes | ☐ No | ☐ Attempted | ☐ Unsure |
| | Body surface | ☐ Yes | ☐ No | ☐ Attempted | ☐ Unsure |
| | On bedding | ☐ Yes | ☐ No | ☐ Attempted | ☐ Unsure |
| | On clothing | ☐ Yes | ☐ No | ☐ Attempted | ☐ Unsure |
| | Other | ☐ Yes | ☐ No | ☐ Attempted | ☐ Unsure |

| 9. | **Oral copulation of genitals:** | | | | | If yes to any, describe: |
|---|---|---|---|---|---|---|
| | Of patient by assailant | ☐ Yes | ☐ No | ☐ Attempted | ☐ Unsure | |
| | Of assailant by patient | ☐ Yes | ☐ No | ☐ Attempted | ☐ Unsure | |

| 10. | **Non-genital act(s):** | | | | | Describe where on body and by whom: |
|---|---|---|---|---|---|---|
| | Licking | ☐ Yes | ☐ No | ☐ Attempted | ☐ Unsure | |
| | Kissing | ☐ Yes | ☐ No | ☐ Attempted | ☐ Unsure | |
| | Suction injury | ☐ Yes | ☐ No | ☐ Attempted | ☐ Unsure | |
| | Biting | ☐ Yes | ☐ No | ☐ Attempted | ☐ Unsure | |

| 11. | **Other act(s):** | | | | | If yes to any, describe: |
|---|---|---|---|---|---|---|
| | | ☐ Yes | ☐ No | ☐ Attempted | ☐ Unsure | |
| | | ☐ Yes | ☐ No | ☐ Attempted | ☐ Unsure | |
| | | ☐ Yes | ☐ No | ☐ Attempted | ☐ Unsure | |

12. Describe any other details noted about assailant:

## G. TESTS PERFORMED

| # | Test | | | | |
|---|---|---|---|---|---|
| 1. | Gonorrhea | ☐ Yes | ☐ No | ☐ NA | |
| 2. | Chlamydia | ☐ Yes | ☐ No | ☐ NA | |
| 3. | Trichomoniasis | ☐ Yes | ☐ No | ☐ NA | |
| 4. | HIV | ☐ Yes | ☐ No | ☐ NA | |
| 5. | Hepatitis Panel | ☐ Yes | ☐ No | ☐ NA | |
| 6. | Syphillis | ☐ Yes | ☐ No | ☐ NA | |
| 7. | Pregnancy | ☐ Yes | ☐ No | ☐ NA | |
| 8. | Radiology | ☐ Yes | ☐ No | ☐ NA | Description: |
| 9. | Other | ☐ Yes | ☐ No | ☐ NA | Description: |

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FORENSIC EXAMINER'S SIGNATURE

## H. FORENSIC PHOTOGRAPHY/EXAMINATION

| Legend: Types of Findings | | | | | |
|---|---|---|---|---|---|
| A-Abrasions | DF-Deformity | FB-Foreign Body | MS-Moist Secretion | PE-Petechiae | S-Swelling |
| BI-Bite | DS-Dry Secretion | IN-Induration | OF-Other Foreign | PS-Potential Saliva | TE-Tenderness |
| BU-Burn | B-Bruise | IW-Incised Wood | Materials (describe) | SHX-Sample Per History | V/S-Vegetation/Soil |
| CS-Control Swab | R-Redness | LA-Laceration | OI-Other Injury | SI-Suction Injury | ALS-Alt. Light Source |
| DE-Debris | F/H-Fiber/Hair | BL-Blood | (describe) | T-Tears | |

| | | | Photograph | | |
|---|---|---|---|---|---|
| Body Locator # | Type | Description | | | Number |
| | | | ☐ Yes | ☐ No | |
| | | | ☐ Yes | ☐ No | |
| | | | ☐ Yes | ☐ No | |
| | | | ☐ Yes | ☐ No | |
| | | | ☐ Yes | ☐ No | |
| | | | ☐ Yes | ☐ No | |
| | | | ☐ Yes | ☐ No | |
| | | | ☐ Yes | ☐ No | |
| | | | ☐ Yes | ☐ No | |
| | | | ☐ Yes | ☐ No | |
| | | | ☐ Yes | ☐ No | |
| | | | ☐ Yes | ☐ No | |
| | | | ☐ Yes | ☐ No | |
| | | | ☐ Yes | ☐ No | |
| | | | ☐ Yes | ☐ No | |
| | | | ☐ Yes | ☐ No | |
| | | | ☐ Yes | ☐ No | |
| | | | ☐ Yes | ☐ No | |
| | | | ☐ Yes | ☐ No | |
| | | | ☐ Yes | ☐ No | |
| | | | ☐ Yes | ☐ No | |
| | | | ☐ Yes | ☐ No | |
| | | | ☐ Yes | ☐ No | |
| | | | ☐ Yes | ☐ No | |
| | | | ☐ Yes | ☐ No | |
| | | | ☐ Yes | ☐ No | |
| | | | ☐ Yes | ☐ No | |
| | | | ☐ Yes | ☐ No | |
| | | | ☐ Yes | ☐ No | |
| | | | ☐ Yes | ☐ No | |
| | | | ☐ Yes | ☐ No | |
| | | | ☐ Yes | ☐ No | |

Additional photo log included: ☐ Yes ☐ No

ALS used: ☐ Yes ☐ No
☐ Reactive: Location
☐ Non-reactive:

| ☐ Colposcope | ☐ Video | ☐ Still Photos |
|---|---|---|
| ☐ Camera | ☐ Video | ☐ Still Photos |
| Total # of pictures taken: | | |

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## I. BODY DIAGRAM

| Legend: Types of Findings | | | | | |
|---|---|---|---|---|---|
| A-Abrasions | DF-Deformity | FB-Foreign Body | MS-Moist Secretion | PE-Petechiae | S-Swelling |
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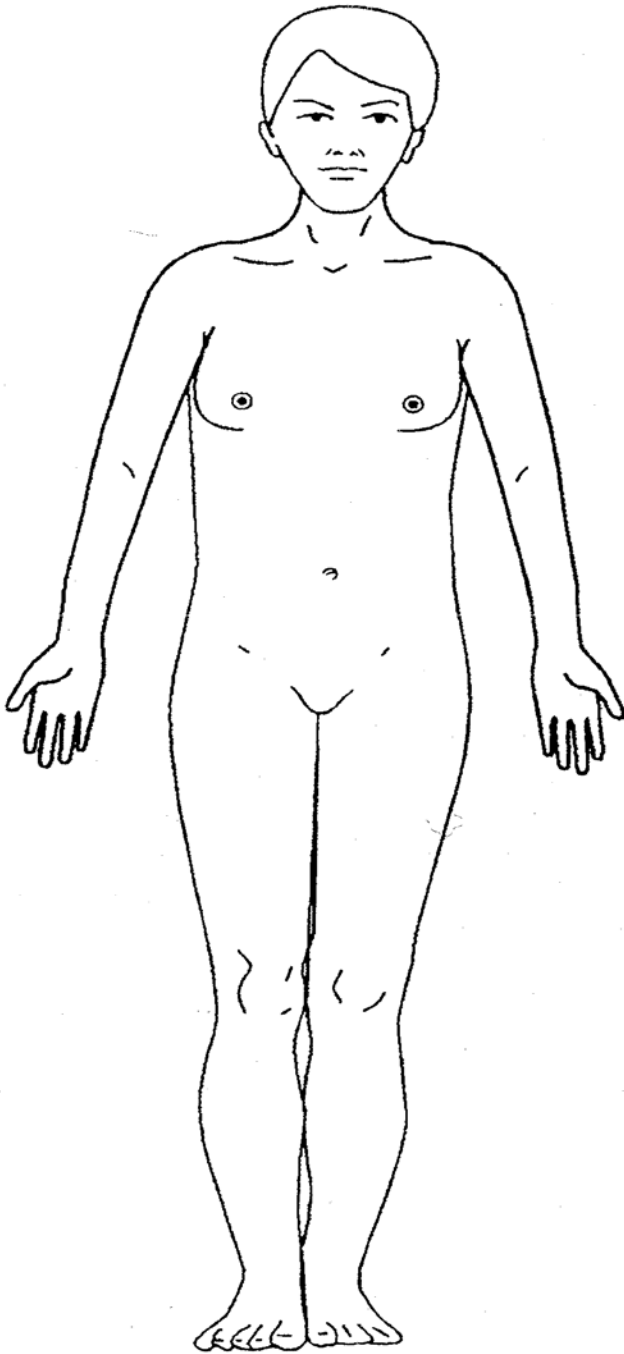
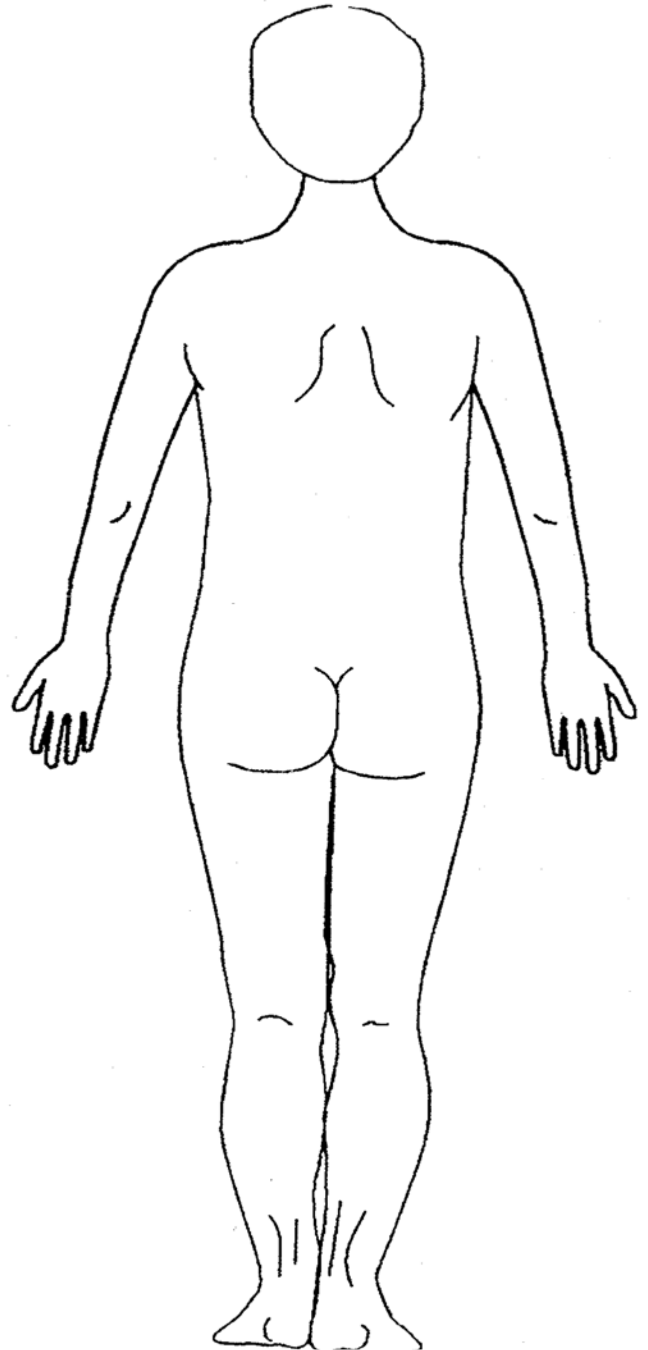
| CS-Control Swab | R-Redness | LA-Laceration | OI-Other Injury | SI-Suction Injury | ALS-Alt. Light Source |
| DE-Debris | F/H-Fiber/Hair | BL-Blood | (describe) | T-Tears | |





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| Legend: Types of Findings | | | | | |
|---|---|---|---|---|---|
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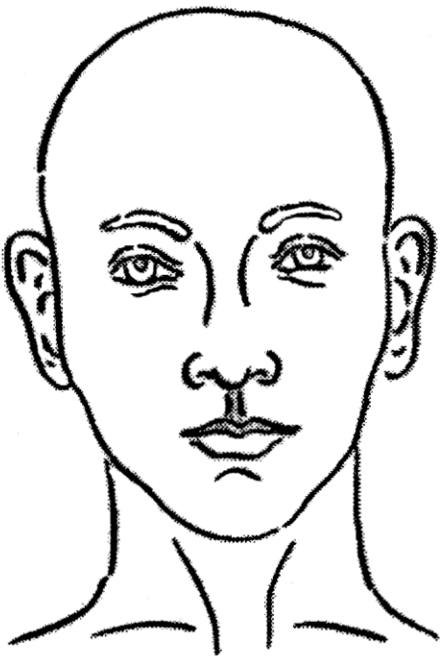

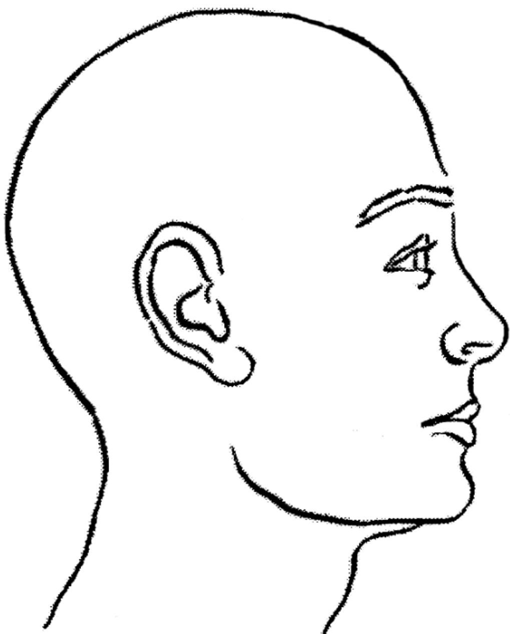

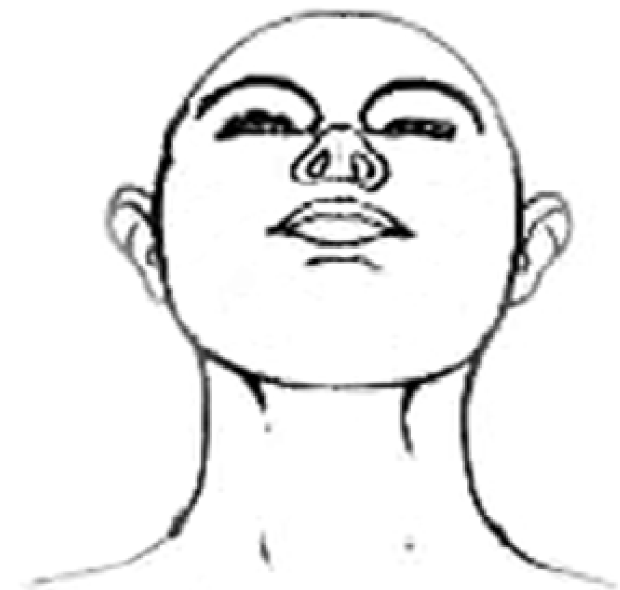

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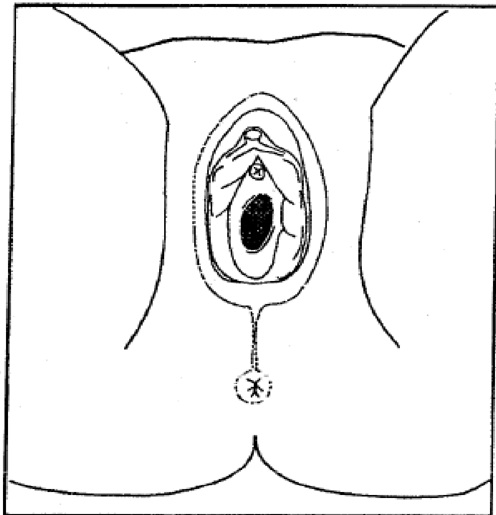

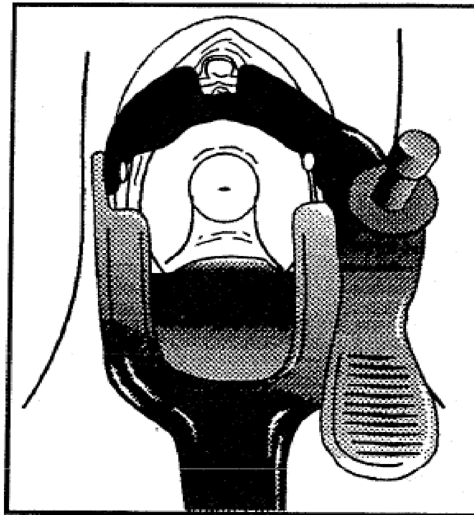

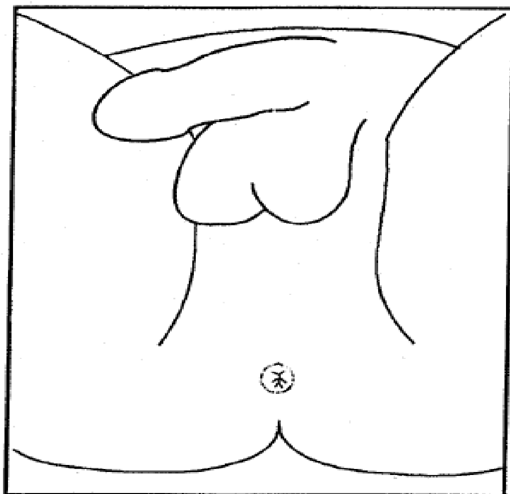

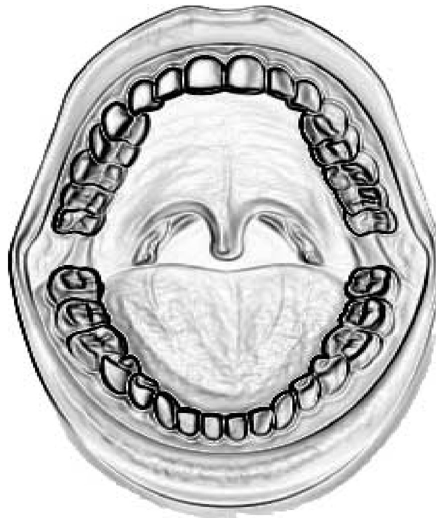

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## J. EVIDENCE COLLECTED AND SUBMITTED TO LAW ENFORCEMENT

| | Envelopes | Sample Collected | | Notes | Collected By First Initial, Last Name | Officer Received | |
|---|---|---|---|---|---|---|---|
| 1. | Foreign Material Sheet | ☐ Yes | ☐ No | | | ☐ Yes | ☐ No |
| 2. | Clothing bags (# Collected ___) | ☐ Yes | ☐ No | | | ☐ Yes | ☐ No |
| 3. | Underwear (# Collected ___) | ☐ Yes | ☐ No | | | ☐ Yes | ☐ No |
| 4. | Oral Swabs | ☐ Yes | ☐ No | | | ☐ Yes | ☐ No |
| 5. | Additional Evidence Swabs | ☐ Yes | ☐ No | | | ☐ Yes | ☐ No |
| 6. | Alternative Light Source Swabs | ☐ Yes | ☐ No | | | ☐ Yes | ☐ No |
| 7. | Fingernail Swabs (Left and Right Hand) | ☐ Yes | ☐ No | | | ☐ Yes | ☐ No |
| 8. | Mons Pubis/Combings | ☐ Yes | ☐ No | | | ☐ Yes | ☐ No |
| 9. | External Genitalia Swabs | ☐ Yes | ☐ No | | | ☐ Yes | ☐ No |
| 10. | Anal/Rectal Swabs | ☐ Yes | ☐ No | | | ☐ Yes | ☐ No |
| 11. | Vaginal/Cervical Swabs | ☐ Yes | ☐ No | | | ☐ Yes | ☐ No |
| 12. | Patient’s Reference DNA Swab | ☐ Yes | ☐ No | | | ☐ Yes | ☐ No |

| | Toxicology Samples | Sample Collected | | | Collected By | Time | Officer Received | |
|---|---|---|---|---|---|---|---|---|
| 1. | Blood Toxicology | ☐ Yes | ☐ No | ☐ NA | | | ☐ Yes | ☐ No |
| 2. | Urine Toxicology | ☐ Yes | ☐ No | ☐ NA | | | ☐ Yes | ☐ No |

| | Sexual Assault Kit | | | |
|---|---|---|---|---|
| 1. | Sexual Assault Kit Used: | ☐ Yes | ☐ No | If Yes, Kit Identification Number: |
| 2. | Note: Please document any necessary deviations/additions to the kit: | | | |

**Collected By**

Examiner’s (PRINTED NAME)

Examiner’s Signature

Date: Time:

**Received By**

Case #:

Law Enforcement Officer (PRINTED NAME)

Signature of Law Enforcement Officer

Date: Time:

PLACE PATIENT IDENTIFICATION STICKER HERE

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