

STEP 2A

SEXUAL ASSAULT MEDICAL/FORENSIC REPORT FORM

Please complete in ALL cases regardless of patient's age[CL1].

Kit Number: _____ Date of Birth: _____ Age: _____
Gender Identity: _____ Genetic Sex at Birth: _____
Preferred Pronouns: _____
Patient genitalia at exam (circle): vagina penis testicles
Assault(s) Date: _____ Assault(s) Time: _____
Exam Date: _____ Exam Time: _____

Patient Label (top copy only)

Indicate by checking the appropriate box what the patient has done since the assault (if unsure, please state the reason why):

Bathed/Showered Yes No Unsure _____
Sponge Bath/Wiped Off Yes No Unsure _____
Urinated/Defecated Yes No Unsure _____
Brushed Teeth/ Mouthwash Yes No Unsure _____
Changed Outer Clothing Yes No Unsure _____
Changed Underpants Yes No Unsure _____
Had Food/Drink Yes No Unsure _____
Douched Yes No Unsure _____

At the time of the assault was:

A condom used by offender? Yes No Unsure _____
Patient menstruating? Yes No Unsure _____
Patient wearing a tampon or pad? Yes No Unsure _____
Weapon used/threatened by offender? Yes No Unsure _____
Patient strangled (choked)? Yes No Unsure _____

- was patient able to breathe? Yes No
- what mechanism was used to strangle (choke)? Describe _____

Drug-facilitated assault suspected? Yes No if yes, suspected drug(s)? _____
Voluntary drug/alcohol use? Yes No
If yes, what was used and timeframe of use? _____

At the time of the assault, were any of these symptoms experienced:

Loss of consciousness? Yes No Unsure _____
Impaired memory? Yes No Unsure _____
Nausea/vomiting? Yes No Unsure _____
Drowsiness/Sedation? Yes No Unsure _____
Dizziness? Yes No Unsure _____
Altered motor function? Yes No Unsure _____
Hallucination/paranoia? Yes No Unsure _____
Other? Yes No Describe _____

If blood/urine sample is taken, is the patient taking any prescription drugs? Yes No
If yes, which prescription drugs? _____

Any other witnesses to the incident? Yes No Unsure _____

Date _____ Signature of Examiner _____

STEP 2B

SEXUAL ASSAULT MEDICAL/FORENSIC REPORT FORM

Please complete in ALL cases regardless of patient's age[CL2].

Patient Label (top copy only)

Kit Number: _____

Number of Offenders: _____ Sex of Offender(s): _____

Prior to exam:

Was patient given any medication at the hospital prior to the exam? Yes No

If yes, list medications: _____

At the time of the exam was:

Patient menstruating? Yes No Unsure _____

Patient wearing a tampon or pad? Yes No Unsure _____

Within the past five days has the patient:

Engaged in consensual sexual activity? Yes No If yes, on what date: _____

Was a condom used Yes No

Was the consensual partner also the offender? Yes No

Details of the assault obtained by patient (check all that apply):

Patient was unable to provide history of assault at this time

During the assault, were photos or video taken? Yes No Unknown

Please describe: _____

Penetration performed by offender:

penile/oral penile/genital penile/anal

oral /anal oral/genital digital/genital digital/anal

other (please describe) _____

foreign object (please describe) _____

other oral contact by offender (please describe) _____

other oral contact by patient (please describe) _____

ejaculation deposited on patient's body (please identify location and swab area): _____

Describe the details of the assault specifically related to the samples that have been collected: [P3] _____

Date _____ Signature of Examiner _____

Printed Name of Examiner _____