

**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  
\_\_\_\_\_ COPY  
\_\_\_\_\_ ORIGINAL

Crime Lab (place in kit)  
Law Enforcement (place in envelope on back of kit)  
Hospital or CAC

**CONFIDENTIAL DOCUMENT**

**A. GENERAL INFORMATION (print)**

1. Name of Patient:						
2. Address:			City:	State:	Zip:	Telephone:
3. Age:	DOB:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Ethnicity:	Arrival Date:	Discharge Date:	Discharge Time:

**B. AGENCY INFORMATION**

1. Notification of Advocacy Center:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	If no, explain:
Name of Advocate (if applicable):		
2. Adult Protective Services Notified:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
Representative Name (if applicable):		
3. Child Protective Services Notified:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
Representative Name (if applicable):		
4. Interpreter Used:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
Representative Name:		

**C. JURSDICTION**

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

PLACE PATIENT IDENTIFICATION  
STICKER HERE

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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.

**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.	<b>Pertinent Pre- and Post-Assault Related History:</b>				
a.	Any consensual sex acts within past 5 days	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA	If yes, when:
b.	Name of partner(s)				
c.	Anal (within past 5 days)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA	If yes, when:
d.	Vaginal (within past 5 days)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA	If yes, when:
e.	Oral (within past 24 hours)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA	If yes, when:
f.	If yes, did ejaculation occur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA	If yes, where:
g.	If yes, was a condom used	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA	
h.	Any alcohol use within 12 hours prior to assault	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes or loss of memory, toxicology samples are recommended.	
i.	Any drug use within 96 hours prior to assault	<input type="checkbox"/> Yes	<input type="checkbox"/> 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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes or loss of memory, toxicology samples are recommended.	

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

10.	<b>Assault Related History:</b>			
a.	Loss of memory	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, describe:
				If yes, collection of toxicology samples is recommended: <input type="checkbox"/> Blood <input type="checkbox"/> Urine
b.	Lapse of consciousness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, describe:
				If yes, collection of toxicology samples is recommended: <input type="checkbox"/> Blood <input type="checkbox"/> Urine
c.	Vomited	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, describe:
d.	Non-genital injury, pain and/or bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, describe:
e.	Anal or genital injury, pain and/or bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> 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: <input type="checkbox"/> M <input type="checkbox"/> F	Assailant Ethnicity:
d.	Reported history of STI:	Reported use of drugs involving needles:	
e.	<input type="checkbox"/> Isolated incident of abuse/assault <input type="checkbox"/> Acute incident of abuse/assault with history of chronic abuse by same assailant <input type="checkbox"/> NA		

2.	Date of Assault(s):	Time of Assault(s) If known:
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3.	Pertinent Physical Surroundings of Assault(s):
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**NOTE: If more than one assailant, identify by number.**

4.	<b>Penetration of vagina by:</b>	If yes to any, describe:			
	Penis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Attempted	<input type="checkbox"/> Unsure
	Finger	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Attempted	<input type="checkbox"/> Unsure
	Object	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Attempted	<input type="checkbox"/> Unsure

5.	<b>Penetration of anus by:</b>	If yes to any, describe:			
	Penis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Attempted	<input type="checkbox"/> Unsure
	Finger	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Attempted	<input type="checkbox"/> Unsure
	Object	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Attempted	<input type="checkbox"/> Unsure

6.	<b>Penetration of oral cavity by:</b>	If yes to any, describe:			
	Penis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Attempted	<input type="checkbox"/> Unsure
	Finger	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Attempted	<input type="checkbox"/> Unsure
	Object	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Attempted	<input type="checkbox"/> Unsure

7.	<b>Contraceptive or lubricant products:</b>				
	Foam used	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Attempted	<input type="checkbox"/> Unsure
	Jelly used	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Attempted	<input type="checkbox"/> Unsure
	Lubricant used	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Attempted	<input type="checkbox"/> Unsure
	Condom used	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Attempted	<input type="checkbox"/> Unsure
	Location of condom (if applicable):				<input type="checkbox"/> Unsure
		Describe type/brand if known:			

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8.	Did ejaculation occur?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Attempted	<input type="checkbox"/> Unsure
If yes, note location(s) below:					
	Mouth	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Attempted	<input type="checkbox"/> Unsure
	Vagina	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Attempted	<input type="checkbox"/> Unsure
	Anus/rectum	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Attempted	<input type="checkbox"/> Unsure
	Body surface	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Attempted	<input type="checkbox"/> Unsure
	On bedding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Attempted	<input type="checkbox"/> Unsure
	On clothing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Attempted	<input type="checkbox"/> Unsure
	Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Attempted	<input type="checkbox"/> Unsure

9.	Oral copulation of genitals:				If yes to any, describe:	
	Of patient by assailant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Attempted		<input type="checkbox"/> Unsure
	Of assailant by patient	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Attempted		<input type="checkbox"/> Unsure

10.	Non-genital act(s):				Describe where on body and by whom:	
	Licking	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Attempted		<input type="checkbox"/> Unsure
	Kissing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Attempted		<input type="checkbox"/> Unsure
	Suction injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Attempted		<input type="checkbox"/> Unsure
	Biting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Attempted		<input type="checkbox"/> Unsure

11.	Other act(s):				If yes to any, describe:	
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Attempted		<input type="checkbox"/> Unsure
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Attempted		<input type="checkbox"/> Unsure
		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Attempted		<input type="checkbox"/> Unsure

12.	Describe any other details noted about assailant:

## G. TESTS PERFORMED

1.	Gonorrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA	
2.	Chlamydia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA	
3.	Trichomoniasis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA	
4.	HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA	
5.	Hepatitis Panel	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA	
6.	Syphilis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA	
7.	Pregnancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA	
8.	Radiology	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA	Description:
9.	Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA	Description:

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## 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	

[illegible]

Additional photo log included: ☐ Yes ☐ No

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

<input type="checkbox"/> Colposcope	<input type="checkbox"/> Video	<input type="checkbox"/> Still Photos
<input type="checkbox"/> Camera	<input type="checkbox"/> Video	<input type="checkbox"/> Still Photos
Total # of pictures taken:		

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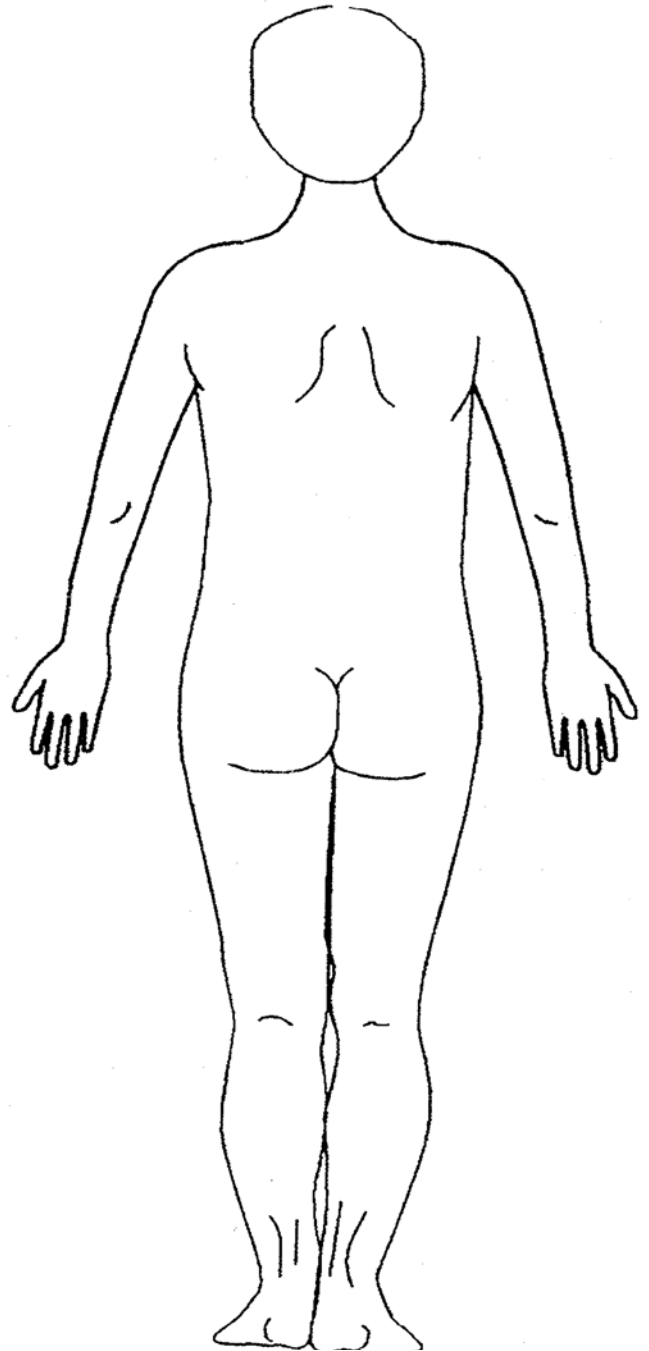
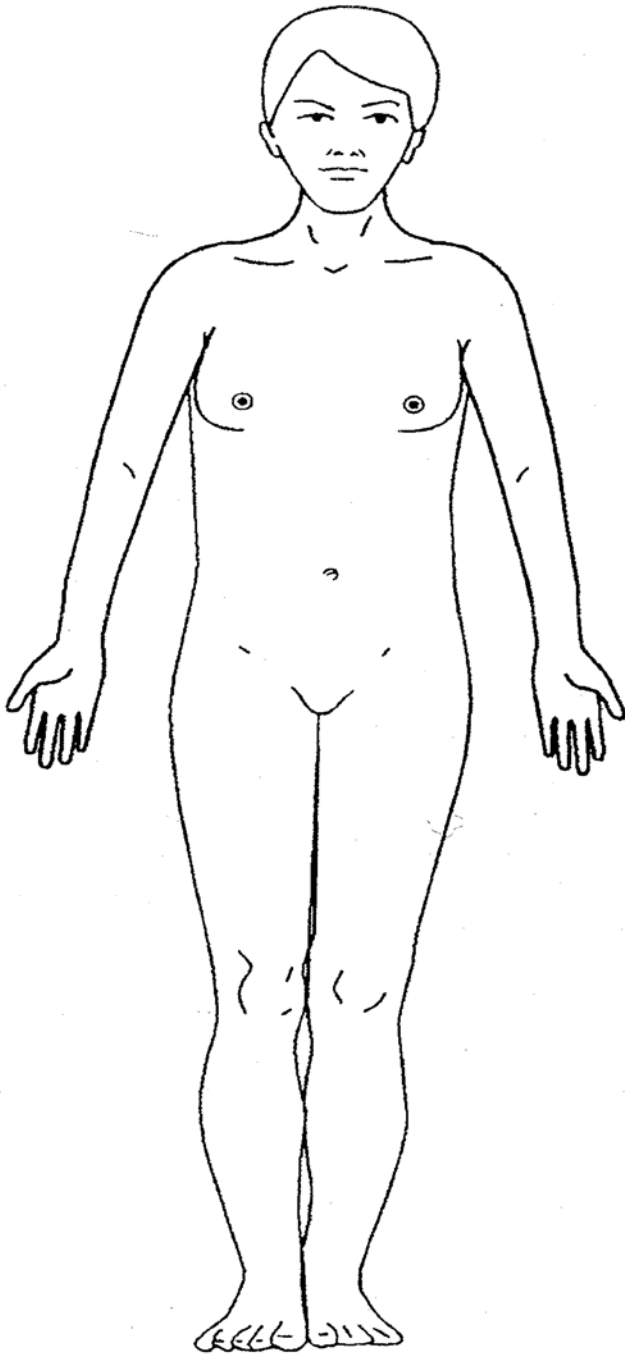
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## I. BODY DIAGRAM

### Legend: Types of Findings

A-Abrasions	DF-Deformity	FB-Foreign Body	MS-Moist Secretion	PE-Petechiae	S-Swelling
BI-Bite	DS-Dry Secretion	IN-Induration	OF-Other Foreign	PS-Potential Saliva	TE-Tenderness
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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	

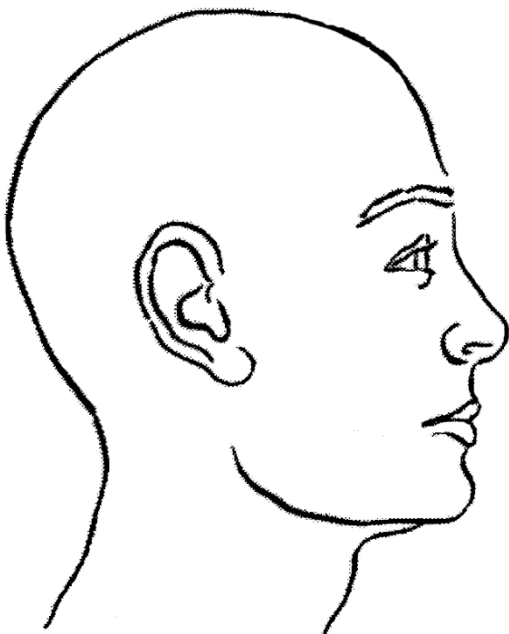
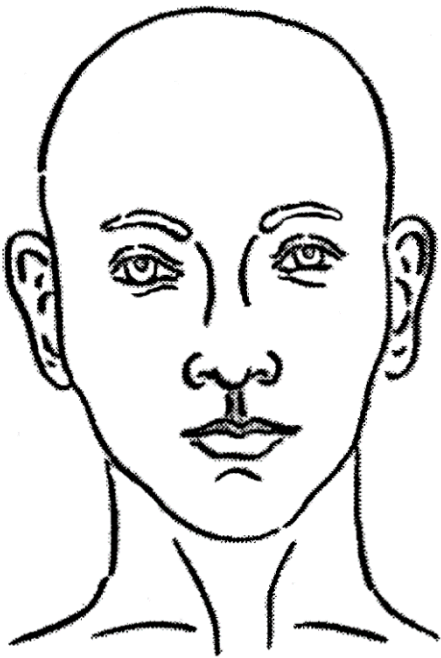


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### Legend: Types of Findings

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	

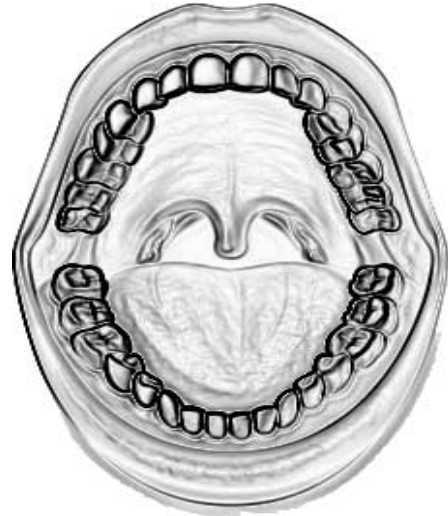
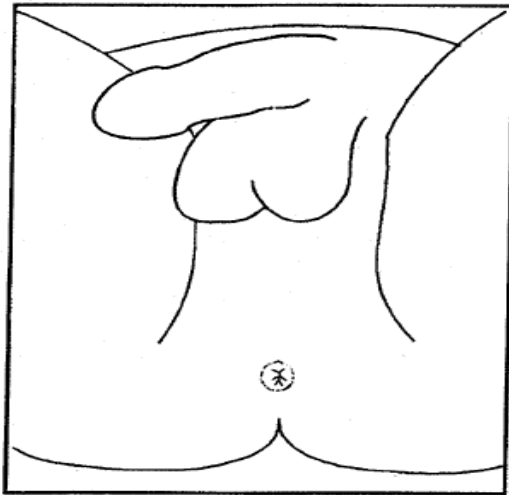
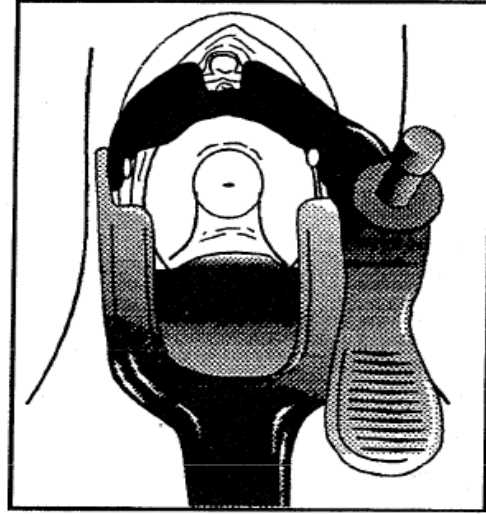
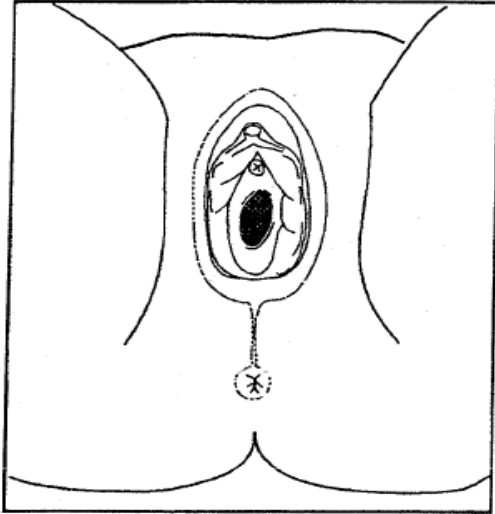


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### Legend: Types of Findings

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DE-Debris	F/H-Fiber/Hair	BL-Blood	(describe)	T-Tears	



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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	<input type="checkbox"/> Yes	<input type="checkbox"/> No				<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	Clothing bags (# Collected ____)	<input type="checkbox"/> Yes	<input type="checkbox"/> No				<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.	Underwear (# Collected ____)	<input type="checkbox"/> Yes	<input type="checkbox"/> No				<input type="checkbox"/> Yes	<input type="checkbox"/> No
4.	Oral Swabs	<input type="checkbox"/> Yes	<input type="checkbox"/> No				<input type="checkbox"/> Yes	<input type="checkbox"/> No
5.	Additional Evidence Swabs	<input type="checkbox"/> Yes	<input type="checkbox"/> No				<input type="checkbox"/> Yes	<input type="checkbox"/> No
6.	Alternative Light Source Swabs	<input type="checkbox"/> Yes	<input type="checkbox"/> No				<input type="checkbox"/> Yes	<input type="checkbox"/> No
7.	Fingernail Swabs (Left and Right Hand)	<input type="checkbox"/> Yes	<input type="checkbox"/> No				<input type="checkbox"/> Yes	<input type="checkbox"/> No
8.	Mons Pubis/Combings	<input type="checkbox"/> Yes	<input type="checkbox"/> No				<input type="checkbox"/> Yes	<input type="checkbox"/> No
9.	External Genitalia Swabs	<input type="checkbox"/> Yes	<input type="checkbox"/> No				<input type="checkbox"/> Yes	<input type="checkbox"/> No
10.	Anal/Rectal Swabs	<input type="checkbox"/> Yes	<input type="checkbox"/> No				<input type="checkbox"/> Yes	<input type="checkbox"/> No
11.	Vaginal/Cervical Swabs	<input type="checkbox"/> Yes	<input type="checkbox"/> No				<input type="checkbox"/> Yes	<input type="checkbox"/> No
12.	Patient's Reference DNA Swab	<input type="checkbox"/> Yes	<input type="checkbox"/> No				<input type="checkbox"/> Yes	<input type="checkbox"/> No

Toxicology Samples		Sample Collected		Collected By	Time	Officer Received	
1.	Blood Toxicology	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA		<input type="checkbox"/> Yes	<input type="checkbox"/> No
2.	Urine Toxicology	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA		<input type="checkbox"/> Yes	<input type="checkbox"/> No

Sexual Assault Kit				
1.	Sexual Assault Kit Used:	<input type="checkbox"/> Yes	<input type="checkbox"/> 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		Time:

Received By		
		Case #:
Law Enforcement Officer (PRINTED NAME)		
Signature of Law Enforcement Officer		Time:

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