ADOLESCENT/ADULT
FORENSIC MEDICAL EXAMINATION
FORM ACUTE ≤ 120 HOURS

DISTRIBUTION ☐ 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, CONSENT FOR RELEASE OF EVIDENCE, PHOTO DOCUMENTATION AND RECORDS WAIVER OF MEDICAL PRIVILEGE

D. PATIENT CONSENT

☐ YES	☐ NO	I have been informed that victims of crime may be eligible to submit crime victim compensation claims to the Nebraska Crime Victims Compensation fund for out of pocket medical expenses, psychological counseling and wage loss.
☐ 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, including, but 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.
☐ YES	☐ NO	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.

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

PLACE PATIENT IDENTIFICATION STICKER HERE

_____
FORENSIC EXAMINER'S SIGNATURE

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:

7. Pertinent Pre- and Post-Assault Related History:

a.	Other intercourse within past 5 days	☐ Yes	☐ No	☐ NA	If yes, when:
b.	Anal (within past 5 days)	☐ Yes	☐ No	☐ NA	If yes, when:
c.	Vaginal (within past 5 days)	☐ Yes	☐ No	☐ NA	If yes, when:
d.	Oral (within past 24 hours)	☐ Yes	☐ No	☐ NA	If yes, when:
e.	If yes, did ejaculation occur	☐ Yes	☐ No	☐ NA	If yes, where:
f.	If yes, was a condom used	☐ Yes	☐ No	☐ NA	
g.	Any alcohol use within 12 hours prior to assault	☐ Yes	☐ No	If yes or loss of memory, toxicology samples are recommended.	
h.	Any drug use within 96 hours prior to assault	☐ Yes	☐ No	If yes or loss of memory, toxicology samples are recommended.	
i.	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.	

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8.	**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:

9.	**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 ☐ Acute incident of abuse/assault with history of chronic abuse by same assailant ☐ 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

1.	Gonorrhea	☐ Yes	☐ No	☐ NA	
2.	Chlamydia	☐ Yes	☐ No	☐ NA	
3.	Trichomoniasis	☐ Yes	☐ No	☐ NA	
4.	HIV (Rapid)	☐ Yes	☐ No	☐ NA	
5.	Hepatitis Panel	☐ Yes	☐ No	☐ NA	
6.	Pregnancy	☐ Yes	☐ No	☐ NA	
7.	Radiology	☐ Yes	☐ No	☐ NA	Description:
8.	Other	☐ Yes	☐ No	☐ NA	Description:

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H. PATIENT HISTORY OF ASSAULT

☐ Patient Declined

Description of assault:

Additional pages included: ☐ Yes ☐ No

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FORENSIC EXAMINER'S SIGNATURE

I. 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		(describe)	T-Tears	

			Photograph		
Locator #	Type	Description			Number
			☐ Yes	☐ No	
			☐ Yes	☐ No	
			☐ Yes	☐ No	
			☐ Yes	☐ No	
			☐ Yes	☐ No	
			☐ Yes	☐ No	
			☐ Yes	☐ No	
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			☐ Yes	☐ No	
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			☐ 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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J. 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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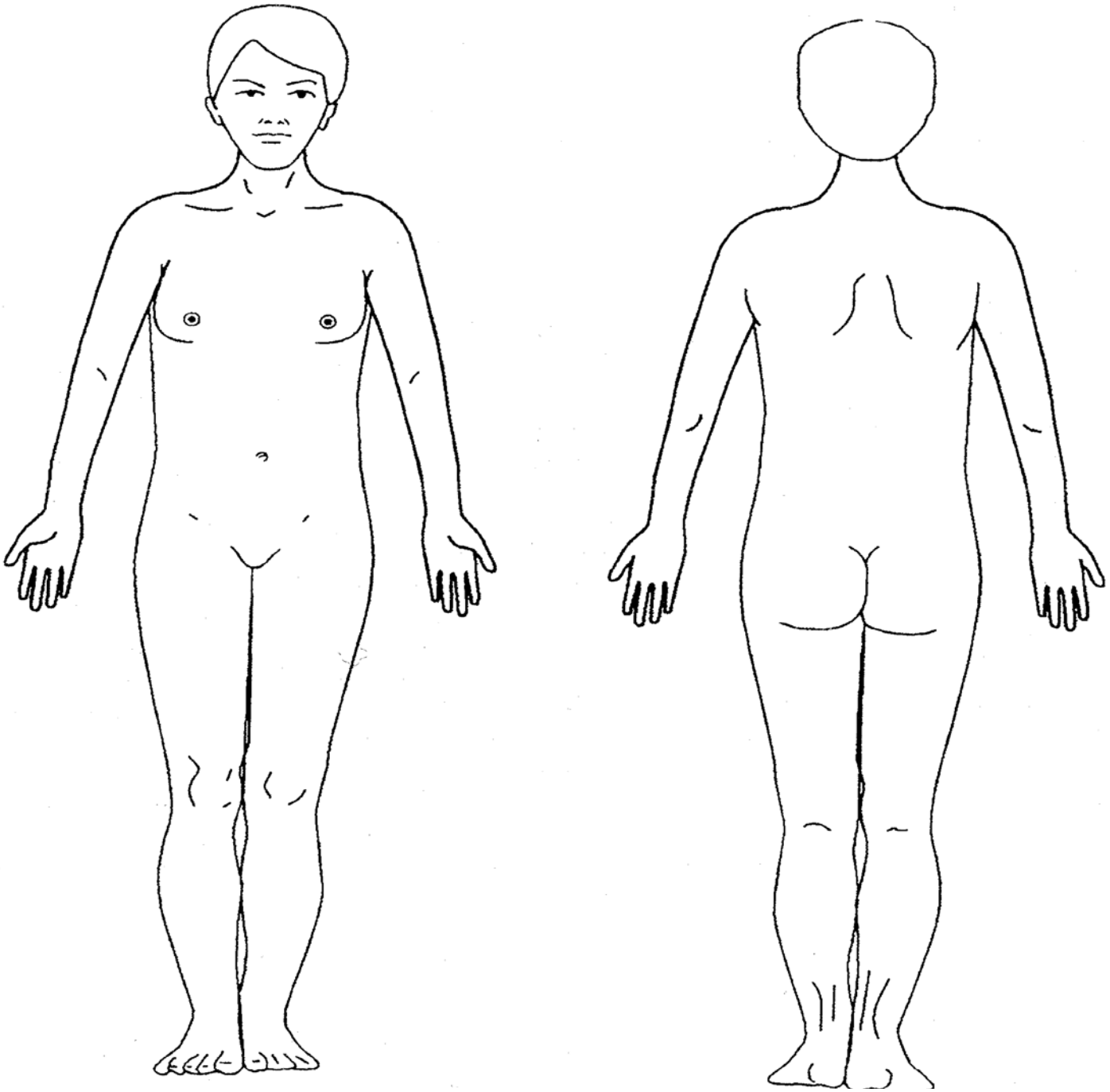
CS-Control Swab	R-Redness	LA-Laceration	OI-Other Injury	SI-Suction Injury	ALS-Alt. Light Source
DE-Debris	F/H-Fiber/Hair		(describe)	T-Tears	



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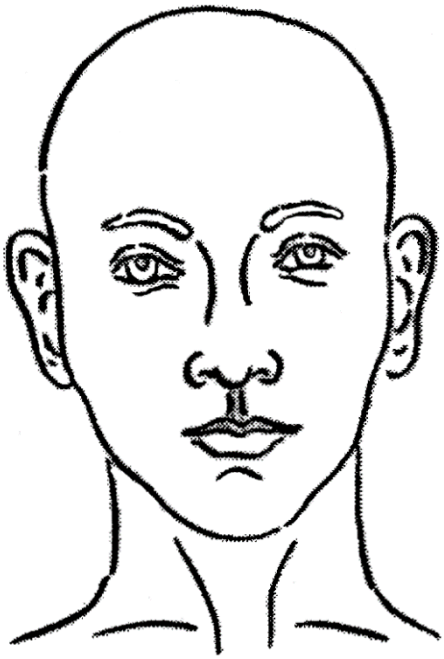

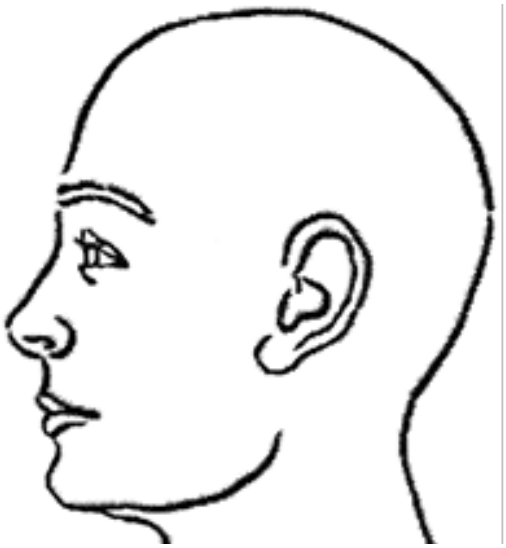

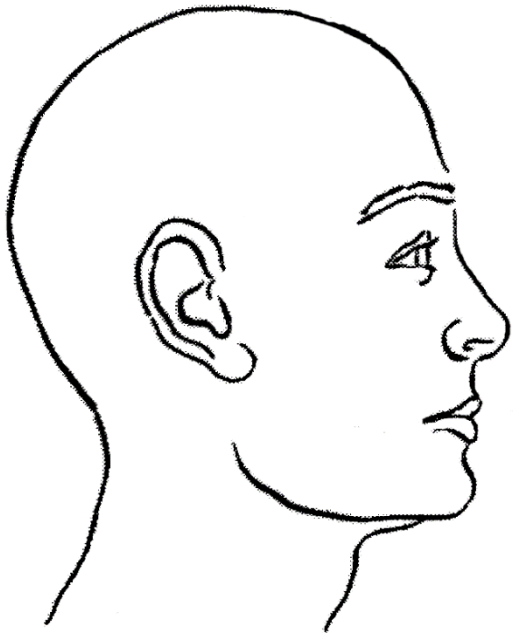

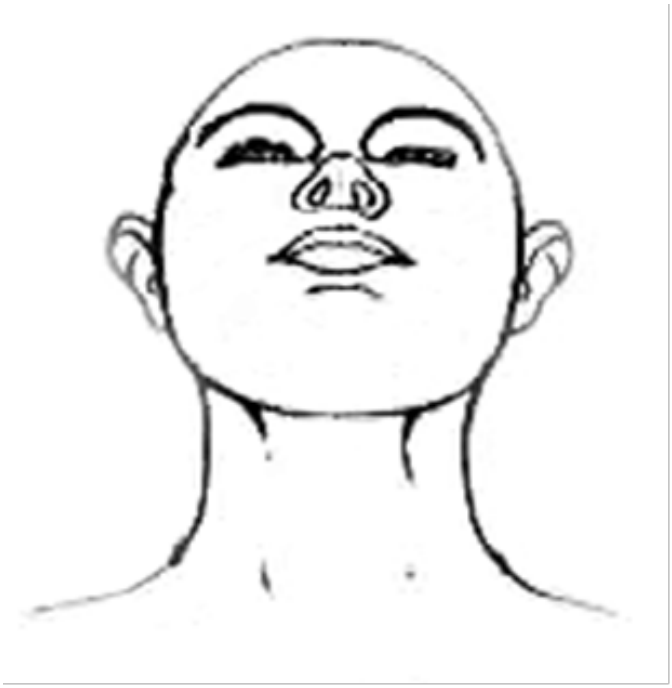

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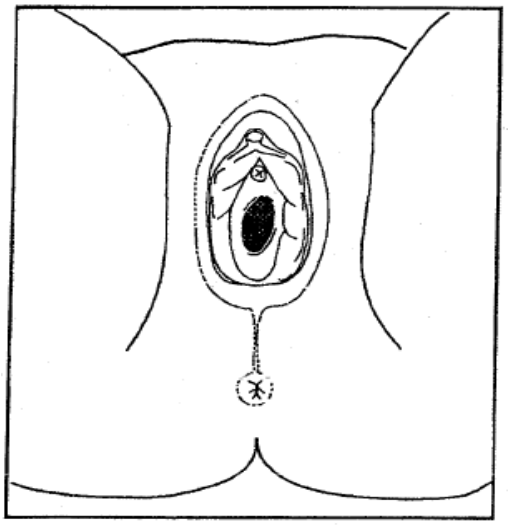

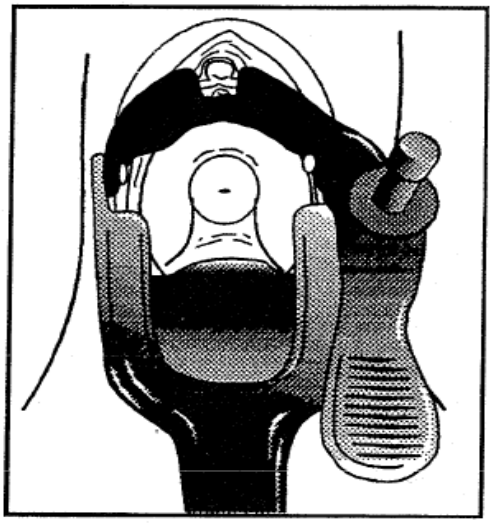

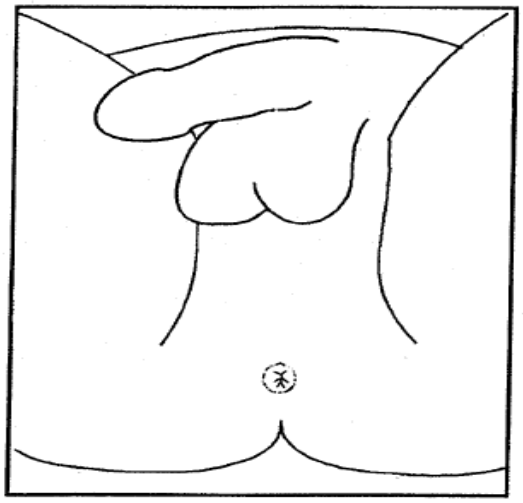

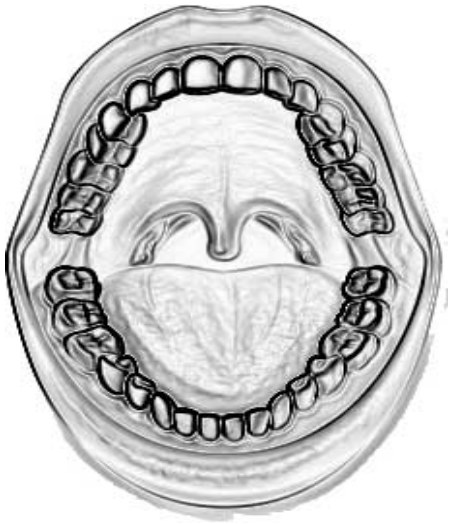

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K. EVIDENCE COLLECTED AND SUBMITTED TO CRME LAB

	Envelopes			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				Collected by	Time	Officer Received	
1.	Blood Toxicology	☐ Yes	☐ No	☐ NA			☐ Yes	☐ No
2.	Urine Toxicology	☐ Yes	☐ No	☐ NA			☐ Yes	☐ No

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:

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