

**PEDIATRIC (PRE-PUBERTAL)
FORENSIC MEDICAL EXAMINATION FORM
ACUTE ≤ 72 HOURS**

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:
2. Child Protective Services Notified	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA	
Representative Name (if applicable):				
3. 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
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FORENSIC EXAMINER'S SIGNATURE

E. PATIENT HISTORY

1. Name of Person Providing History:
2. Pertinent Medical History:
3. Any history of developmental delays or related concerns? Yes No
If yes, describe:
4. Is child fully potty-trained? Yes No
If no, please describe current training status:
5. Child is: Pre-menarchal Post-menarchal Age of menarche (if applicable):
6. Last menstrual period (if applicable):
7. Any history of anal or genital injuries, surgeries, diagnostic procedures, or medical treatment that may affect the interpretation of current physical findings? Yes No
If yes, describe:
8. Any other pertinent ano-genital condition(s) that may affect the interpretation of current physical findings (i.e. UTIs, constipation, ano-genital rashes, etc.)? Yes No
If yes, describe:
9. Any known current/recent physical injuries present upon child which are NOT related to the current assault/abuse allegations? Yes No
If yes, describe:
10. Any known history of prior sexual abuse? Yes No
If yes, describe:
11. Any history of child engaging in problematic sexual behaviors? Yes No
If yes, describe:
12. Any history of bleeding or clotting disorders? Yes No
If yes, describe:

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

14. Assault Related History:					
a.	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
b.	Non-genital injury, pain and/or bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No		If yes, describe:
c.	Anal or genital injury, pain and/or bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No		If yes, describe:
d.	Additional Information:				

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:	
3.	Pertinent Physical Surroundings of Assault(s):			

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

4. **Contact of patient's vagina by:**

Penis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> NA
Finger	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> NA
Mouth/Tongue	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> NA
Vagina	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> NA
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> NA

If yes to any, describe:

5. **Contact of patient's penis by:**

Penis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> NA
Finger	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> NA
Mouth/Tongue	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> NA
Vagina	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> NA
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> NA

If yes to any, describe:

6. **Contact of patient's anus by:**

Penis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> NA
Finger	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> NA
Mouth/Tongue	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> NA
Vagina	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> NA
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> NA

If yes to any, describe:

7. **Contact of patient's mouth:**

Penis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> NA
Finger	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> NA
Mouth/Tongue	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> NA
Vagina	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> NA
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure	<input type="checkbox"/> Penetration Reported	<input type="checkbox"/> NA

If yes to any, describe:

8. **Contraceptive or lubricant products used:**

Contraceptive or lubricant products used:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
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If yes, describe (condom, lubrication, lotion, saliva, etc.)

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

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

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

12. Describe any other details noted about assailant:					
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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. PATIENT HISTORY OF ASSAULT

Patient Declined

Non-Verbal Child

Other Communication Barrier

Child's description of assault:

Other pertinent witnessed or relayed description of assault and source of information:

Additional pages included: Yes No

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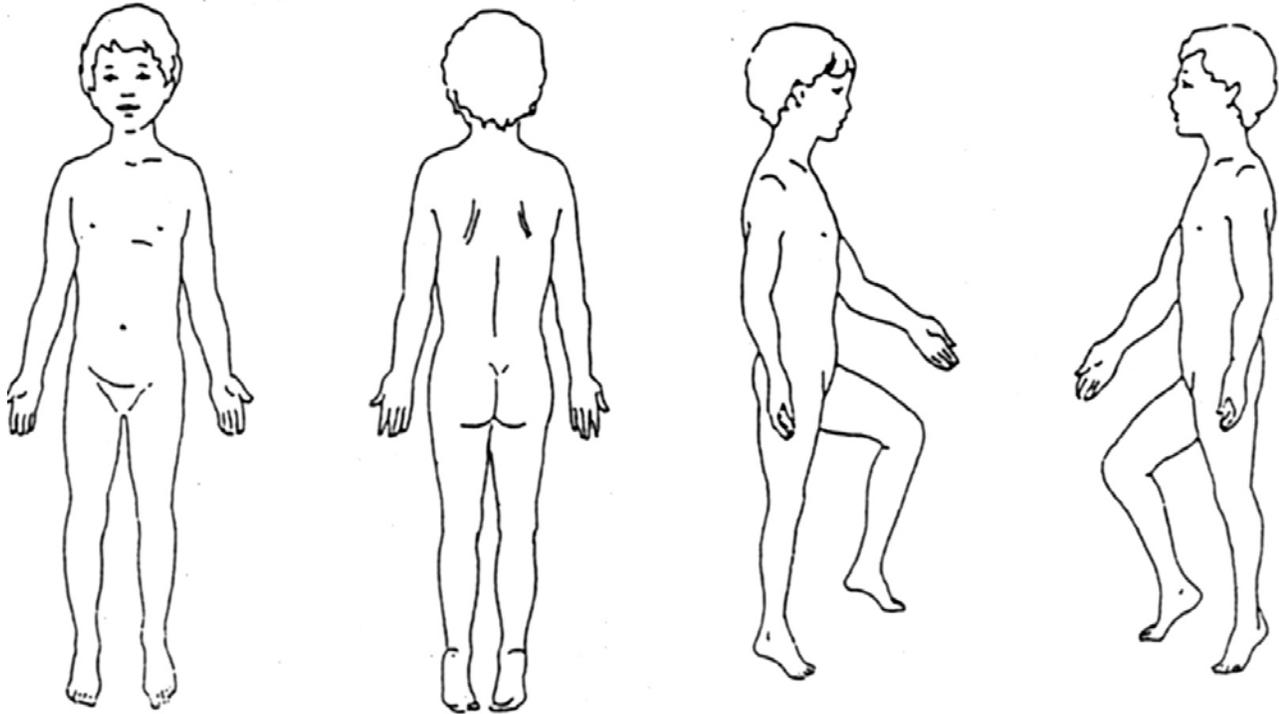
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J. BODY DIAGRAM

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 IW-	OF-Other Foreign	PS-Potential Saliva	TE-Tenderness
BU-Burn	B-Bruise	Incised Wound	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	WNL-Within Normal Limits

Locator #	Type	Description	Photograph		Number
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	



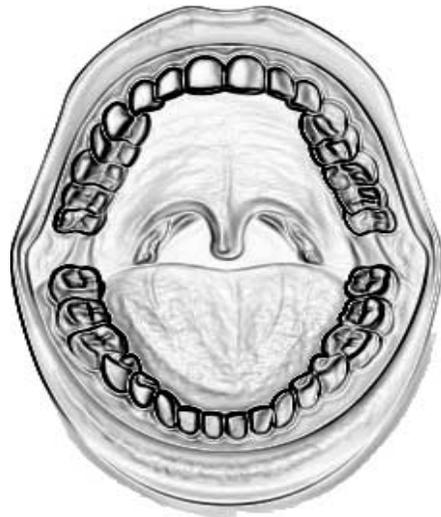
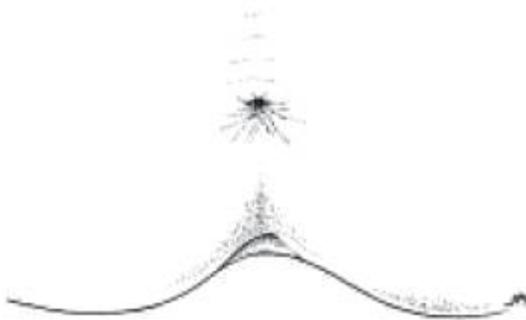
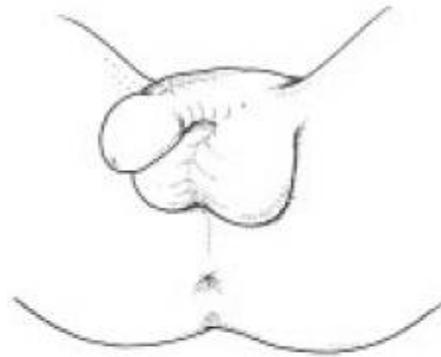
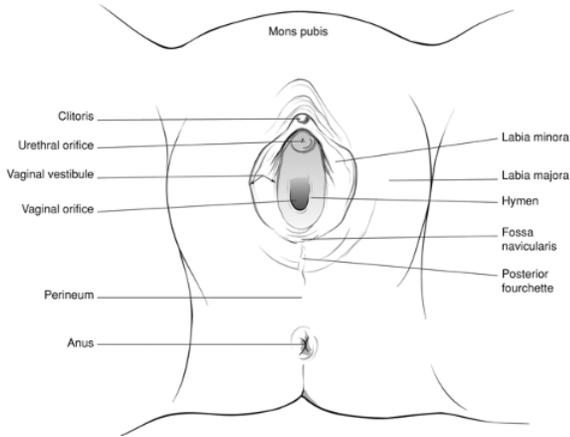
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Legend: Types of Findings

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

Locator #	Type	Description	Photograph		Number
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No	



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K. EVIDENCE COLLECTED AND SUBMITTED TO LAW ENFORCEMENT

					Collected By	Officer Received	
Envelopes	Samples Collected			Notes	First Initial, Last Name		
1. Foreign Material Sheet	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA			<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Clothing bags (# Collected ___)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA			<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Underwear/Diapers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA			<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Oral Swabs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA			<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Additional Evidence Swabs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA			<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Alternative Light Source Swabs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA			<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"/> NA			<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Mons Pubis/Combings	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA			<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. External Genitalia Swabs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA			<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Anal/Rectal Swabs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA			<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. OMIT THIS STEP FOR PRE-PUBERTAL PATIENTS							
12. Patient's Reference DNA Swab	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA			<input type="checkbox"/> Yes	<input type="checkbox"/> No

		Samples 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)			
			Date:
Examiner's Signature		Time:	
Received By			
			Case #:
Law Enforcement Officer (PRINTED NAME)			
			Date:
Signature of Law Enforcement Officer		Time:	

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