Sexual Assault Forensic/Medical Exam Documentation Revised 2023 -TRACK-KIT

This file contains the following forms:

- **Consent form** – 2 Pages – Maintained as part of the Medical Record
- **Medical History/ Initial Assessment form** – 6 Pages - Maintained as part of the Medical Record – DO NOT COPY or Forward to Law Enforcement or other disciplines
- **Forensic Examination form** – 11 Pages – Make 2 copies - Copy 1 to Law Enforcement, Copy 2 Inside the Kit Envelope
- **Chain of Custody form** - 1 page - Make 1 copy - Copy to Law Enforcement. DOES NOT need to be placed in kit.

PLEASE COMPLETE ELECTRONICALLY OR PRINT LEGIBLY

Start the kit tracking by entering the barcoded kit # at https://fl.track-kit.us/login

Give the tracking database access card to the victim/ patient.

Attach the extra barcode stickers to Pg-1 of the Consent form, Pg-1 of the Medical History form and Pg-1 of the Forensic Examination form.

Affix kit barcode sticker here

Sexual Assault Medical/Forensic Exam Consent Form

Patient Name	Date & Time	Case #

I, ________________________, freely consent to a forensic medical examination conducted by a medical professional in order to collect and preserve any potential evidence of the described assault. This procedure has been fully explained to me and I understand that I may refuse any portion of the examination at any time. If I decide to report, a copy of the forensic exam paperwork and any potential evidence obtained will be released to the law enforcement agency and the State Attorney's Office for the appropriate jurisdiction. Collection of other specimens and/or samples for laboratory analysis may be conducted per the events reported.

Patient Information

- I understand that healthcare facilities and their personnel must report certain crimes to law enforcement authorities in cases that a patient seeks medical care.
- I have been informed that Florida law provides that a victim of sexual offense shall not be charged for the costs of a forensic evidentiary exam.
- I understand that I do not need to report to law enforcement to receive this service. I understand that I have the option to have the examination performed and report at a later time if I choose to do so.
- I consent to the following (please initial by each item checked):

________Head to toes examination with visual inspection of injuries and possible areas of assault including the mouth, the genitalia and the anus.

________Photographic documentation of any injuries including area of the mouth, genitalia, and anus.

________Photos will become part of the official record of this case and may be used for peer/chart review within the agency. Photos are only released to law enforcement and or state attorney's office with the consent of the patient and/or via a subpoena.

________Photos may be used for educational/training purposes. At no time will a name or any other identifying structure be associated with patient or the case.

________Collection of blood and urine for laboratory testing of possible drug facilitated assault.

________Administration of medication for prevention of infection and/or pregnancy.

________Provide first aid treatment to any superficial injuries.

________Provide information for follow-up testing for the diagnosis of HIV and sexually transmitted infections at the Health Department.

________Provide follow up communications from advocates and/or counselors.

Initials: ______ Date: ______

All Originals – Medical Record

Sexual Assault Medical/Forensic Exam
Consent Form

I consent to the above statements at this time **BUT** would not like to report to law enforcement. I understand that any potential evidence collected will be held for ________months* until/if I decide to report to law enforcement.

At the end of that period:

Would you like to be contacted before the evidence kit is destroyed? Yes ☐ No ☐

If Yes, then how? Letter ____

Telephone ____

Email ____

Text____

Can a message be left at the specified number? Yes ☐ No ☐

*Timeframe determined by community service providers or law enforcement agency storing the kit.

______________________________ ______________________________
Patient- Print Name Patient- Signature

____
Date/Time

______________________________ ______________________________
SANE/Forensic Examiner – Print Name SANE/Forensic Examiner- Signature

____
Date/Time

Affix kit barcode sticker here

Patient Name

DOB

Case #

 ADULT / ADOLESCENT Medical History / Initial Assessment **Initials: _______**

RAPE CRISIS CENTER / FACILITY NAME____

DATE OF EXAM ____

DEMOGRAPHIC INFORMATION:

Gender: ☐ Male ☐ Female **Preferred Pronoun** ☐ She/Her ☐ He/Him ☐ They/Them

Transitioning: ☐ Male to Female ☐ Female to Male ☐ Other ______________________________

Reported Race: ☐ White ☐ Black ☐ White/Hispanic ☐ Non-White Hispanic ☐ Other: _______________

Preferred language: ☐ English ☐ Spanish ☐ Creole ☐ Sign Language ☐ Other:____________________

Does patient require impairment-related accommodations? ☐ No ☐ Yes, explain ________________

Mandated Report? ☐ No ☐ *If yes, please indicate case number of report and name/ID of hotline staff*

____

GENERAL HEALTH HISTORY

Vital Signs: BP:_______/_________ P: __________ R: _________ T: _________

Height (stated): _________________ **Weight** (stated): ______________________

Allergies: ☐ NKA ☐ Yes, describe allergen and response-

____

Latex Allergy: ☐ No ☐ Yes ☐ Unsure **Dye Allergy:** ☐ No ☐ Yes ☐ Unsure

Past Medical History (include pre-existing injuries): ☐ **No history of health concerns reported**

____

Past Surgical History: ☐ **No surgical history reported** ☐ **Yes, describe**

____

____

Current prescription and OTC medications: ☐ **None** ☐ **Yes, list medication and date/time of last dose:**

Patient Name
DOB
Case #

 ADULT / ADOLESCENT Medical History / Initial Assessment **Initials: _______**

Neurological/Coordination:

Level of Consciousness:

☐ Alert ☐ Somnolent but arousable ☐ Unconscious

Oriented to ☐ Person ☐ Place ☐ Time ☐ Situation

Gait: ☐ Steady ☐ Abnormal, describe _________________

Cognition: ☐ No deficits noted ☐ Distracted ☐ Slow ☐ Confused

Mood / Affect: ☐ Tearful ☐ Distracted ☐ Slow ☐ Confused

☐ Avoids eye contact ☐ Fidgety ☐ Other__________________________

Comments:

Glasgow Coma Score:
E: ________ V:________ M:_________ Total: _________

Best eye response (E)	**Best verbal response (V)**	**Best Motor response (M)**
Spontaneous opening - 4	Oriented- 5	Obeys commands for movement- 6
Opens to command – 3	Confused conversation but answers -4	Purposeful movement to painful stimulus-5
Opens to pain – 2	Inappropriate responses-3	Withdraws from pain-4
None - 1	In comprehensible speech – 2	Abnormal flexion, decorticate posture - 3
	None – 1	Extensor response, de-cerebrate posture- 2
		None – 1

Reproductive Health – Select Appropriate Stage

Female: Tanner Stage 1 (pre-pubertal no pubic hair - PH), Stage 2 (breast buds, minimal PH), Stage 3 (elevation of breast, dark coarse, curly PH), Stage 4 (areola forms, PH adult quality), Stage 5 (adult breast adult PH distribution)

Male: Tanner Stage 1 (pre-pubertal no pubic hair - PH), Stage 2 (enlargement of scrotum and testes), Stage 3 (enlargement of penis, further growth of testes), Stage 4 (increased size of penis, testes and scrotum larger, scrotum skin darker), Stage 5 (adult genitalia)

Gynecological History

Age of Menarche: __________ Last Menstrual Period: ___________________ Length: ___________________

Average number of days between periods: _________ ☐ Regular ☐ Irregular

Birth Control: ☐ None ☐ Yes, method: _____________________________ For how long? _______________

Hysterectomy?: ☐ No ☐ Yes Cervix removed? ☐ No ☐ Yes Unsure

Original Copy – Medical Records

DO NOT COPY/FORWARD MEDICAL RECORD TO LAW ENFORCEMENT OR OTHER DISCIPLINES

Patient Name

DOB

Case #

 ADULT / ADOLESCENT Medical History / Initial Assessment **Initials: _______**

Obstetric History

Currently Pregnant? ☐ No ☐ Yes, EDC _______________________ ☐ Unsure

Pregnancy History: ☐ No History of pregnancy

# of Pregnancies _________ # C-section: _____________ #Vaginal Births: _________

Comments:

PRE-ASSAULT HISTORY

Are there any known medical conditions (bleeding or clotting Disorders, etc.) or current/recent physical injuries that may affect the interpretation of current findings? ☐ No ☐ Yes (describe)

Is there any history of anal or genital injuries, surgeries, diagnostic procedure, or medical treatment that may affect the interpretation of current physical findings? ☐ No ☐ Yes (describe)

Is there any history of anal or genital conditions(s) that may affect the interpretation of current physical findings? (e.g. UTI, constipation, ano-genital rashes, antibiotic use, etc.) ☐ No ☐ Yes (describe)

DID PATIENT EXPERIENCE ANY PAIN OR BLEEDING?

		1 (least) & 10 (worst)	BLEEDING
☐ **N/A**	Before assault	Pain Scale:	☐ None ☐ Light ☐ Moderate ☐ Heavy
☐ **N/A**	During assault	Pain Scale:	☐ None ☐ Light ☐ Moderate ☐ Heavy
☐ **N/A**	After assault	Pain Scale:	☐ None ☐ Light ☐ Moderate ☐ Heavy
☐ **N/A**	Currently	Pain Scale:	☐ None ☐ Light ☐ Moderate ☐ Heavy

Describe location of pain / bleeding:

Before assault:____

During assault:____

After assault:____

Currently: ____

Original Copy – Medical Records

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Patient Name

DOB

Case #

 ADULT / ADOLESCENT Medical History / Initial Assessment **Initials: ________**

Psychosocial

Suicidal Ideations: ☐ No ☐ Yes (If yes, when and document actions / referrals)

History of Self-harm: ☐ No ☐ Yes (If yes, when and document actions / referrals)

History of substance use: ☐ No ☐ Yes (If yes, when and document actions / referrals)

Does the patient have a safe place to go upon discharge? ☐ No ☐ Yes

Is there someone that can stay with patient upon D/C? ☐ No ☐ Yes

Tetanus:

Is tetanus vaccine up to date? ☐ Yes ☐ No ☐ Unsure

Hepatitis B Vaccine

Has patient ever received Hepatitis B Vaccine? ☐ Yes ☐ No ☐ Unsure

nPEP:

Risk assessment discussed? ☐ Yes ☐ No

Select the applicable action below:

Referred for nPEP**:** ☐ Yes ☐ No

Declined**:** ☐ Yes ☐ No

nPEP given: ☐ Yes ☐ No (if yes, be sure to complete the CDC 2021 Recommended STI Medications on next page)

Was pregnancy test positive? ☐ Yes ☐ No (if yes, state where referred to)

Patient Name
DOB
Case #

EMERGENCY CONTRACEPTION				
Given?	**Medication**	**Time Given**	**Initials**	**Pharmacy: Name and time called in OR Indicate prescription given**
Yes No	Levonorgestrel 1.5 mg po (e.g. Plan B, My Way)	________am ________pm		
Yes No	Other:	________am ________pm		

CDC 2021 RECOMMENDED STI MEDICATIONS				
Given?	**Medication**	**Time Given**	**Initials**	**Pharmacy: Name and time called in OR Indicate prescription given**
Yes No	**Gonorrhea:** Ceftriaxone (Rocephin) 500mg* IM in a single dose *give 1 gm IM if >330 lbs; if >165 lbs counsel patient, may not be effective	________am ________pm		
Yes No	**Chlamydia:** Doxycycline 100 mg orally 2x a day for 7 days (do not give if pregnant)	________am ________pm		
Yes No	**Trichomonas - females only w/ a vaginal assault** Flagyl (Metronidazole) 500 mg 2x a day for 7 days	________am ________pm		
Yes No	**nPEP** ☐ 28 day starter pack ☐ 3 to 4 day start			
Yes No	OTHER:	________am ________pm		

Referrals made? ☐ Yes ☐ No (If yes, please describe below)

STI Follow up? ☐ **Yes** ☐ **No** (If yes, please describe)

Original Copy – Medical Records

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Patient Name
DOB
Case #

 ADULT / ADOLESCENT Medical History / Initial Assessment **Initials: _______**

DISCHARGE SUMMARY

______________________________________ ______________________________________

Forensic Examiner- Print Name **Signature of Forensic Examiner**

Original Copy – Medical Records

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Affix kit barcode sticker here

Patient Name________________________________

DOB____

Case #______________________________________

 ADULT / ADOLESCENT FORENSIC EXAMINATION

Exam Date:	**Exam Time:**
By birth: ☐ **Female** ☐ **Male**	**Race:** ☐ Black ☐ White ☐ White/Hispanic ☐ Hispanic ☐ Other:
Primary language: ☐ English ☐ Spanish ☐ Creole ☐ Other:	
Patient's address:	**City/State/Zip**
Phone #	**Interpreter used?** ☐ No ☐ Yes, record name and/or ID#
Crisis Center / Agency:	**CASE #**

Patient's Description of Assault, use quotations for direct quotes

Narrative continued on additional pages: ☐ Yes ☐ No

Initials _______Date_________

Patient Name____________________________
DOB_____________________________________
Case #___________________________________

 ADULT / ADOLESCENT FORENSIC EXAMINATION

Has the patient had any consensual sexual relations in the last 5 days? ☐ No ☐ Yes		
Name of consensual partner(s): ______________________________Buccal Swab Obtained? ☐ Yes ☐ No		
If consensual sexual relations in the last 5 days was it: Consensual Partner Gender at Birth: M F		
Vaginal	☐ Yes ☐ No	If Yes, Date(s) & time(s)
Oral	☐ Yes No	If Yes, Date(s) & time(s)
Anal	☐ Yes ☐ No	If Yes, Date(s) & time(s)
Condom use?	☐ Yes ☐ No	If Yes, Date(s) & time(s)
Ejaculation?	☐ Yes ☐ No	If yes, location(s):

ASSAULT HISTORY				
Date/Time of assault(s): Location of Assault: (inside, outside, vehicle, workplace, etc.):				
ASSAILANT INFORMATION # of Assailants: ____________				
Name(s) of Assailant	Gender	Age	Race/Ethnicity	Relationship to Victim
1.				
2.				
3.				
Did patient inflict injury upon assailant(s) during assault? ☐ No ☐ Yes ☐ Unsure *If yes, describe injuries, location(s) on assailant's body & mechanism of injury. Collect swab samples under fingernails. If unsure describe reason:				

Methods of control used by assailant(s)				If yes or unsure describe:
Use of weapons	☐ Yes	☐ No	☐ Unsure	
Physical force: (hit, push, restrain, held down)	☐ Yes	☐ No	☐ Unsure	
Gagging	☐ Yes	☐ No	☐ Unsure	
Threats of Harm	☐ Yes	☐ No	☐ Unsure	
Binding or restraints	☐ Yes	☐ No	☐ Unsure	
Photos/video taken	☐ Yes	☐ No	☐ Unsure	
Other, describe	☐ Yes	☐ No	☐ Unsure	
Strangulation	☐ Yes	☐ No	☐ Unsure	Strangulation assessment done? ☐ Yes ☐ No

Initials _______Date________

Patient Name______________________________
DOB______________________________________
Case #____________________________________

 ADULT / ADOLESCENT FORENSIC EXAMINATION

TOXICOLOGY: ALCOHOL AND DRUGS				
Voluntary/Involuntary ingestion of alcohol/drugs? Circle voluntary or involuntary	☐ Yes	☐ No	☐ Unsure	If, yes or unsure describe
Loss of memory?	☐ Yes	☐ No	☐ Unsure	
Loss of consciousness?	☐ Yes	☐ No	☐ Unsure	

Drug Facilitated Sexual Assault Kit completed? ☐ N/A ☐ Yes, both blood and urine ☐ Blood only ☐ Urine only

If urine only explain or if blood only explain: ____

IF neither blood or urine collected, explain: ☐ N/A ☐ Declined ☐ > 120 hours ☐ Other________________

***DFSA kit is a separate item of evidence** **Expiration date of kit:**

ASSAULT DESCRIPTION

Did the assailant(s) put any of the below body parts or objects in or on patient's vagina?						Comment
Penis	☐ Yes	☐ No	☐ Unsure	☐ Penetration Reported	☐ N/A	
Finger	☐ Yes	☐ No	☐ Unsure	☐ Penetration Reported	☐ N/A	
Mouth/Tongue	☐ Yes	☐ No	☐ Unsure	☐ Penetration Reported	☐ N/A	
Object (describe in comment box)	☐ Yes	☐ No	☐ Unsure	☐ Penetration Reported	☐ N/A	
Other	☐ Yes	☐ No	☐ Unsure	☐ Penetration Reported	☐ N/A	

For MALE Patient: Did the assailant(s) touch patient's penis with any of the below body parts or objects?						Comment
Penis	☐ Yes	☐ No	☐ Unsure	☐ Penetration Reported	☐ N/A	
Finger	☐ Yes	☐ No	☐ Unsure	☐ Penetration Reported	☐ N/A	
Mouth/Tongue	☐ Yes	☐ No	☐ Unsure	☐ Penetration Reported	☐ N/A	
Object (describe in comment box)	☐ Yes	☐ No	☐ Unsure	☐ Penetration Reported	☐ N/A	
Other	☐ Yes	☐ No	☐ Unsure	☐ Penetration Reported	☐ N/A	

Did the assailant(s) put any of the below body parts or objects in or on patient's anus?						Comment
Penis / Vagina circle	☐ Yes	☐ No	☐ Unsure	☐ Penetration Reported	☐ N/A	
Finger	☐ Yes	☐ No	☐ Unsure	☐ Penetration Reported	☐ N/A	
Mouth/Tongue	☐ Yes	☐ No	☐ Unsure	☐ Penetration Reported	☐ N/A	
Object	☐ Yes	☐ No	☐ Unsure	☐ Penetration Reported	☐ N/A	
Other	☐ Yes	☐ No	☐ Unsure	☐ Penetration Reported	☐ N/A	

Initials _______Date_________

Patient Name________________________
DOB________________________
Case #________________________

 ADULT / ADOLESCENT FORENSIC EXAMINATION

Did the assailant(s) put any of the below body parts or objects in or on patient's mouth?						Comments
Penis / Vagina CIRCLE	☐ Yes	☐ No	☐ Unsure	☐ Penetration Reported	☐ N/A	
Finger	☐ Yes	☐ No	☐ Unsure	☐ Penetration Reported	☐ N/A	
Anus	☐ Yes	☐ No	☐ Unsure	☐ Penetration Reported	☐ N/A	
Vagina	☐ Yes	☐ No	☐ Unsure	☐ Penetration Reported	☐ N/A	
Other	☐ Yes	☐ No	☐ Unsure	☐ Penetration Reported	☐ N/A	
Was the patient forced to put his/her mouth on assailant's penis? ☐ Yes ☐ No ☐ Unsure Was the patient forced to put his/her mouth on assailant's anus? ☐ Yes ☐ No ☐ Unsure						

Was ejaculation observed?	☐ **N/A**			
Body surface	☐ Yes	☐ No	☐ Unsure	Comments (i.e. **how many times and where**)
On bedding	☐ Yes	☐ No	☐ Unsure	
On clothing	☐ Yes	☐ No	☐ Unsure	
Other	☐ Yes	☐ No	☐ Unsure	

Non-Genital Acts: Did assailant(s) use his/her mouth to do the following:				**If yes, where on the body?**
Licking	☐ Yes	☐ No	☐ Unsure	
Kissing	☐ Yes	☐ No	☐ Unsure	
Suction injury	☐ Yes	☐ No	☐ Unsure	
Bite(s)	☐ Yes	☐ No	☐ Unsure	
Other acts	☐ Yes	☐ No	☐ Unsure	

Contraceptive or lubricant products used:				
Lubricant or spermicide used	☐ Yes	☐ No	☐ Unsure	If yes describe (lubrication, lotion, oil, saliva, etc.)
Condom used	☐ Yes	☐ No	☐ Unsure	
Location of condom if known	☐ Yes	☐ No	☐ N/A	

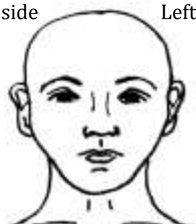
Initials _______Date_________

Patient Name_______________
DOB_______________
Case #_______________

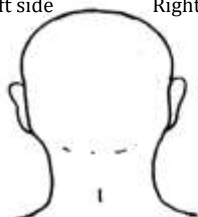
 ADULT / ADOLESCENT FORENSIC EXAMINATION

POST ASSAULT ACTIVITY							
Since assault has patient:			**If yes, please note number of times**	**Since assault has patient:**			**If yes, please note number of times**
Urinated	☐ Yes	☐ No		Brushed teeth	☐ Yes	☐ No	
Bowel movement	☐ Yes	☐ No		Rinsed mouth	☐ Yes	☐ No	
Showered	☐ Yes	☐ No		Ate or drank	☐ Yes	☐ No	
Washed off/ wiped off	☐ Yes	☐ No		Vomited	☐ Yes	☐ No	
Changed clothing	☐ Yes	☐ No		Douched	☐ Yes	☐ No	
Changed underwear	☐ Yes	☐ No		Changed pad/tampon	☐ Yes	☐ No	
Other:				Other:			

Right side Left side



Left side Right side



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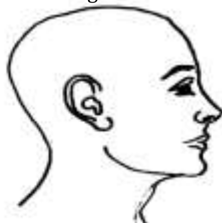
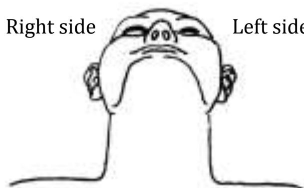


Left side

Right side Left side



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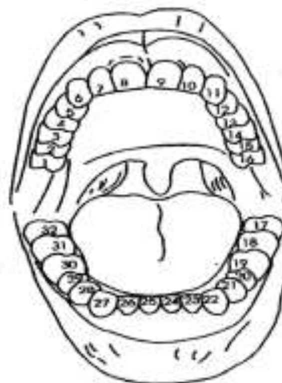


Left side

COMMENTS:

LEGEND: Types of Findings			
AB Abrasion Occurred	**EC** Ecchymosis (bruise)	**MS** Moist Secretion	**SO** Suction
BI Bite **BU** Burn Blue⊕	**ER** Erythema (redness) **F/H** Fiber/Hair	**OF** Other Foreign Materials (describe)	**SW** Swelling **TB** Toluidine
CS Control Swab	**FB** Foreign Body	**OI** Other Injury (describe)	**TE** Tenderness
DE Debris Vegetation/Soil	**IN** Induration	**PE** Petechiae	**V/S**
DF Deformity Lamp⊕	**IW** Incised Wound	**PS** Potential Saliva	**WL** Wood's
DS Dry Secretion	**LA** Laceration	**SHX** Sample Per History	

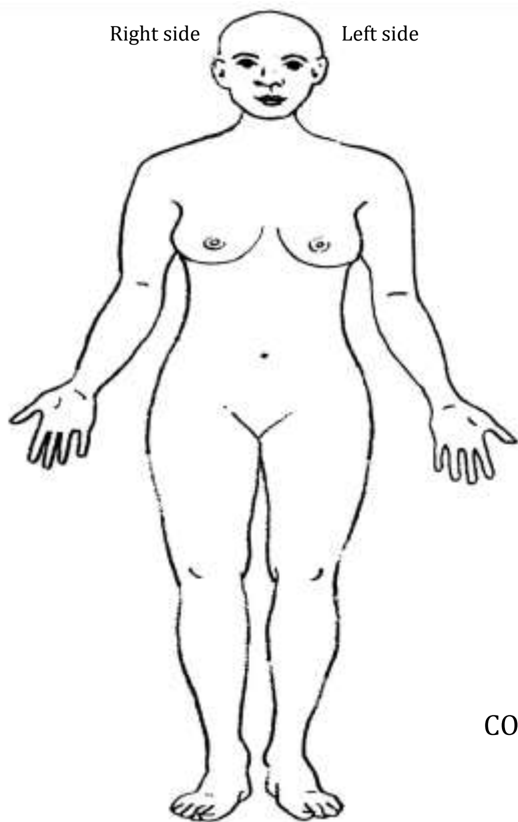
Initials _______Date_________

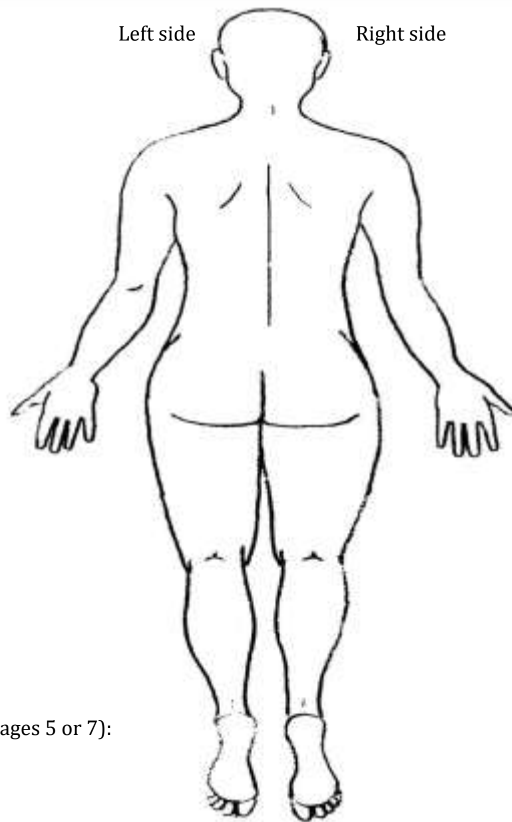
Patient Name______________________________

DOB_______________________________________

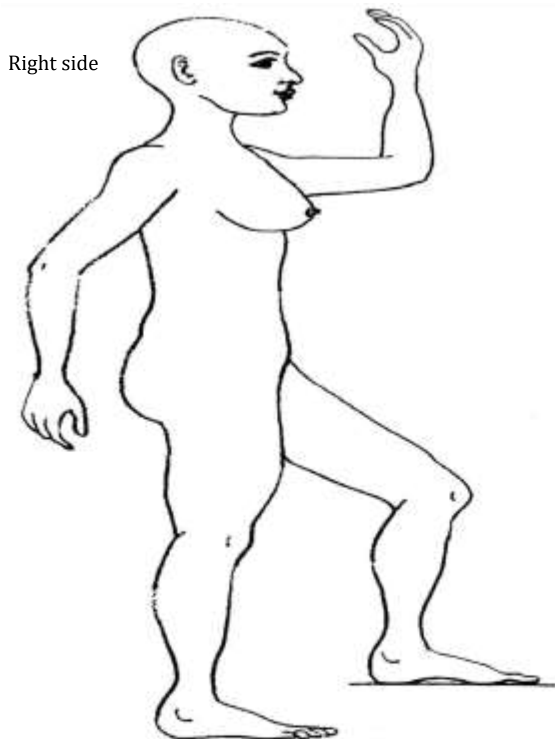
Case #_____________________________________

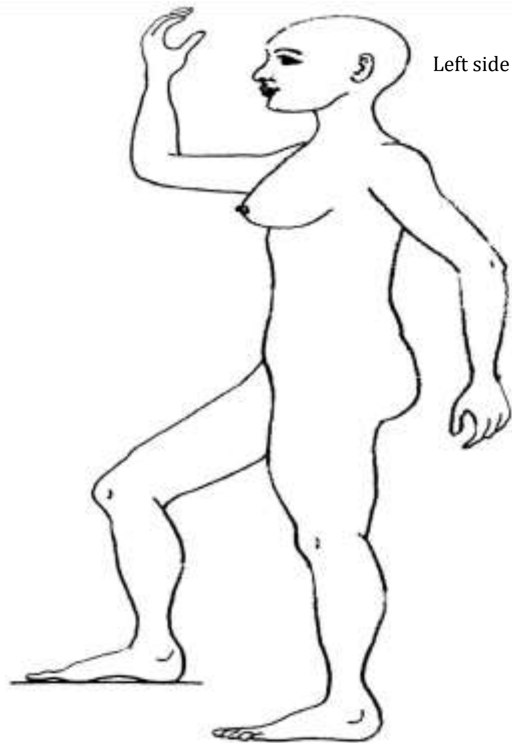
Adult/Adolescent Body Diagram





COMMENTS (see legend pages 5 or 7):





Initials _______Date_________

Patient Name________________________________

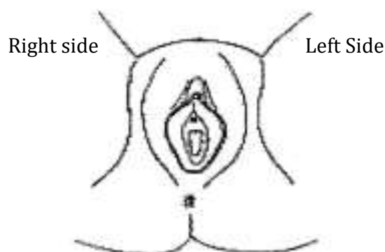
DOB____

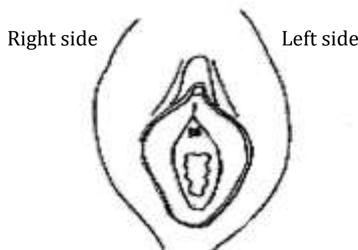
Case #_______________________________________

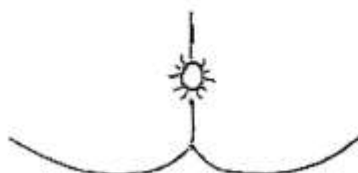
 ADULT / ADOLESCENT FORENSIC EXAMINATION

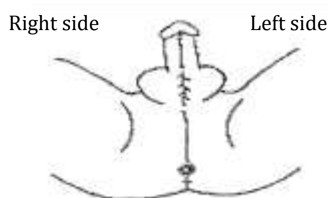
LEGEND: Types of Findings			
AB Abrasion	**EC** Ecchymosis (bruise)	**MS** Moist Secretion	**SO** Suction occurred
BI Bite	**ER** Erythema (redness)	**OF** Other Foreign Materials (describe)	**SW** Swelling
BU Burn	**F/H** Fiber/Hair		**TB** Toluidine Blue⊕
CS Control Swab	**FB** Foreign Body	**OI** Other Injury (describe)	**TE** Tenderness
DE Debris	**IN** Induration	**PE** Petechiae	**V/S** Vegetation/Soil
DF Deformity	**IW** Incised Wound	**PS** Potential Saliva	**WL** Wood's Lamp⊕
DS Dry Secretion	**LA** Laceration	**SHX** Sample Per History	

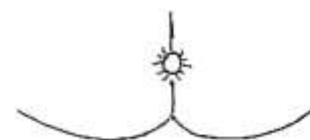
COMMENTS:

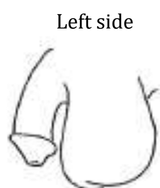


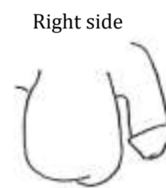












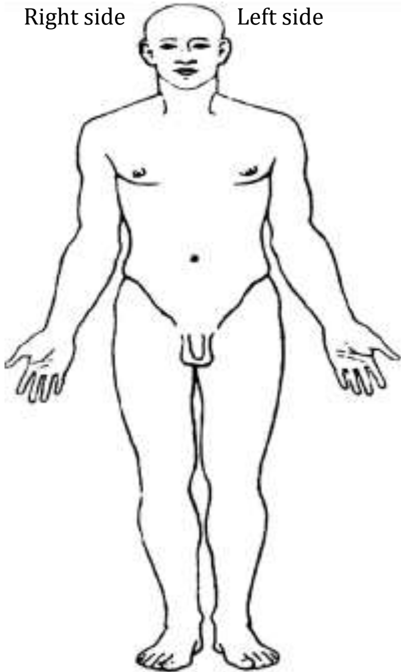
Initials ________Date__________

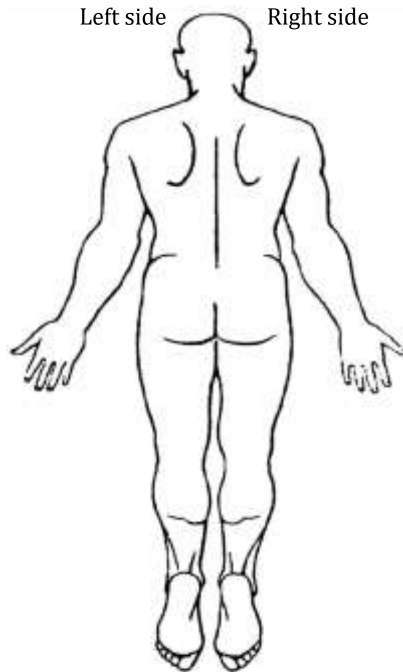
Patient Name________________________

DOB________________________

Case #________________________

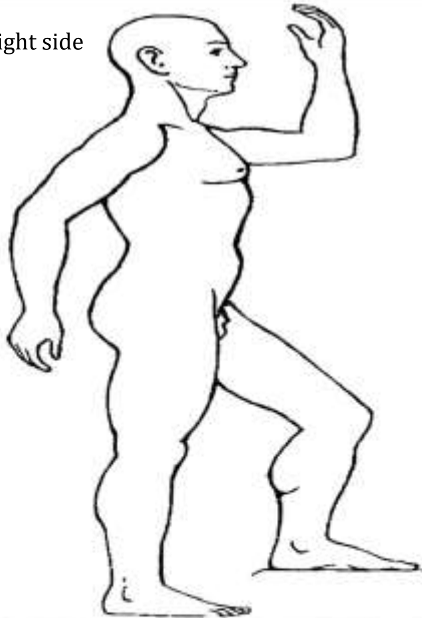
 ADULT / ADOLESCENT FORENSIC EXAMINATION





COMMENTS:

LEGEND: Types of Findings			
AB Abrasion	**EC** Ecchymosis (bruise)	**MS** Moist Secretion	**SO** Suction occurred
BI Bite	**ER** Erythema (redness)	**OF** Other Foreign Materials (describe)	**SW** Swelling
BU Burn	**F/H** Fiber/Hair		**TB** Toluidine Blue⊕
CS Control Swab	**FB** Foreign Body	**OI** Other Injury (describe)	**TE** Tenderness
DE Debris	**IN** Induration	**PE** Petechiae	**V/S** Vegetation/Soil
DF Deformity	**IW** Incised Wound	**PS** Potential Saliva	**WL** Wood's Lamp⊕
DS Dry Secretion	**LA** Laceration	**SHX** Sample Per History	



Initials _______Date_________

Patient Name_______________________________
DOB____
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 ADULT / ADOLESCENT FORENSIC EXAMINATION

PHOTOS TAKEN? ☐ **Yes** ☐ **No** **Total number of photos taken:** _______________

Camera Type: _____________________________________

Injury #	**Photo #**	**Location of Injury/ Photo**	**Type of Photo taken,** e.g. orientation shot, macro with scale, macro without scale
N/A	1	N/A	Patient Label /Case Identification Card / Other (explain)

Photo documentation continued on additional pages: ☐ Yes ☐ No

Initials _______Date_________

Patient Name______________________________

DOB_______________________________________

Case #_____________________________________

 ADULT / ADOLESCENT FORENSIC EXAMINATION

CLOTHING COLLECTED

Item, e.g. shirt, pants, etc.	**When was the item worn?**	**Is the clothing/ item wet?**	**Description** (color, size, brand, condition, location of stains, etc.) **Photo-document any relevant abnormalities.**
1.	☐ **time of assault** ☐ **after assault**	Yes No	
2.	☐ **time of assault** ☐ **after assault**	Yes No	
3.	☐ **time of assault** ☐ **after assault**	Yes No	
4.	☐ **time of assault** ☐ **after assault**	Yes No	
5.	☐ **time of assault** ☐ **after assault**	Yes No	
6.	☐ **time of assault** ☐ **after assault**	Yes No	
7.	☐ **time of assault** ☐ **after assault**	Yes No	
8.	☐ **time of assault** ☐ **after assault**	Yes No	
9.	☐ **time of assault** ☐ **after assault**	Yes No	
10.	☐ **time of assault** ☐ **after assault**	Yes No	

Initials _______Date_________

Patient Name__________________________

DOB________________________________

Case #______________________________

SWABS/SAMPLES COLLECTED

Number of swabs indicated below is the minimum number requested. If additional swabs are collected, note how many swabs taken in the notes section.

EVIDENTIARY SAMPLES COLLECTED – IF MORE SWABS OBTAINED, EXPLAIN IN NOTES	**Swabs collected? Select one**	**# of Swabs collected**	**NOTES**
Oral Swabs (oral assault) (2 dry swabs). After obtained, patient to rinse out mouth; wait 10-15 minutes before obtaining Buccal Swab	Yes No		
Buccal Swab (2 dry swabs) ALWAYS COLLECT	Yes No		
Palms of Hands (1 swab per hand) Swab the entire palmar surface of each hand separately, and then package and label each envelope separately as left palm or right palm	Yes No		
Fingernails (1 swab per hand) Swab the underside of the fingernails with a lightly moistened swab, unless the victim's history (scratching) indicates that nail clippings would yield additional DNA	Yes No		
Pubic Hair Combings w/comb or If no hair, swab the Mons pubis (2 lightly moistened swabs)	Yes No		
External Genitalia (Vaginal Vestibule to include: labia minora, clitoris, hymen, fossa navicularis and posterior fourchette) (2 lightly moistened swabs)	Yes No		
Internal Genitalia – left and right vaginal walls (2 dry swabs)	Yes No		
Internal Genitalia – Cervical, vaginal vault, posterior fornix, cervix/cervical os / if no cervix then swab vaginal cuff (2 dry swabs)	Yes No		
Penis and Scrotum (shaft, glans, under the foreskin & around the corona, and scrotum) (2 lightly moistened swabs) Avoid the urethra	Yes No		
Peri-Anal/Anal Swabs (2 lightly moistened swabs)	Yes No		
Rectal Swabs (2 lightly moistened swabs)	Yes No		
Other (2 swabs)	Yes No		
Other (2 swabs)	Yes No		
Other (2 swabs)	Yes No		
EVIDENTIARY SWABS COLLECTED – IF MORE SWABS OBTAINED, EXPLAIN:			

Initials________Date_________

Patient Name_______________________________
DOB_______________________________________
Case #______________________________________

TRANSFER OF EVIDENCE/CHAIN OF CUSTODY FORM

Evidence Item(s) Received:	Yes	No	Comments: Indicate if Wet/Damp
SAE kit			
DFSA kit			
Photographs:			
CD			
Other:			
Clothing:			
Shirt/top			
Pants/shorts			
Underwear			
Bra			
Jacket/coat			
Shoes			
Other:			
Other:			

Evidence Collected By (print):____

Date/Time:______________________ Signature:____

Evidence Received From:____
(Printed name)

Date/Time: ___________________________ Signature:_____________________________________

Received By: ____
(LEO printed name)

Date/Time:___________________________ Signature:_____________________________________

Original Copy – Medical Chart Copy 2 – Law Enforcement