

**FORENSIC MEDICAL REPORT: ACUTE (<72 HOURS)
ADULT/ADOLESCENT SEXUAL ASSAULT EXAMINATION**

**STATE OF CALIFORNIA
GOVERNOR'S OFFICE of EMERGENCY SERVICES**

OES 923

Confidential Document

Patient Identification

A. GENERAL INFORMATION (print or type)

Name of Medical Facility:

1. Name of patient

Patient ID number

2. Address

City

County

State

Telephone
(W)
(H)

3. Age

DOB

Gender
M F

Ethnicity

Date/time of arrival

Date/time of discharge

B. REPORTING AND AUTHORIZATION

Jurisdiction (city county other):

1. Telephone report made to law enforcement agency

Name of Officer

Agency

ID Number

Telephone

Reported by:

Name

Date

Time

2. Responding Officer

Agency

ID Number

Telephone

3. I request a forensic medical examination for
suspected sexual assault at public expense.

Law enforcement officer

ID number

Agency

Telephone Authorization

Agency:

Authorizing party:

ID number:

Telephone

Date

Time

Case Number

Date/time:

C. PATIENT INFORMATION

• I understand that hospitals and health care professionals are required by Penal Code Sections 11160-11161 to report to law enforcement authorities cases in which medical care is sought when injuries have been inflicted upon any person in violation of any state penal law. The report must state the name of the injured person, current whereabouts, and the type and extent of injuries. _____ (Initial)

• I have been informed that victims of crime are eligible to submit crime victim compensation claims to the State Victims of Crime (VOC) Restitution Fund for out-of-pocket medical expenses, psychological counseling, loss of wages, and job retraining and rehabilitation. _____ (Initial)

D. PATIENT CONSENT

Minors: Family Code Section 6927 permits minors (12 to 17 years of age) to consent to medical examination, treatment, and evidence collection for sexual assault without parental consent. See instructions for parental notification requirements for minors.

• I understand that a forensic medical examination for evidence of sexual assault at public expense can, with my consent, be conducted by a health care professional to discover and preserve evidence of the assault. If conducted, the report of the examination and any evidence obtained will be released to law enforcement authorities. I understand that the examination may include the collection of reference specimens at the time of the examination or at a later date. I understand that I may withdraw consent at any time for any portion of the examination. _____ (Initial)

• I understand that collection of evidence may include photographing injuries and that these photographs may include the genital area. _____ (Initial)

• I hereby consent to a forensic medical examination for evidence of sexual assault. _____ (Initial)

• I understand that data without patient identity may be collected from this report for health and forensic purposes and provided to health authorities and other qualified persons with a valid educational or scientific interest for demographic and/or epidemiological studies. _____ (Initial)

Signature _____

Patient

Parent

Guardian

DISTRIBUTION OF OES 923

Original - Law Enforcement

Copy within evidence kit - Crime Lab

Copy - Child Protective Services
(if patient is a minor)

Copy - Medical Facility Records

E. PATIENT HISTORY

1. Name of person providing history: _____ Relationship to patient: _____

2. Pertinent medical history:

- Last menstrual period _____
- Any recent (60 days) anal-genital injuries, surgeries, diagnostic procedures, or medical treatment that may affect the interpretation of current physical findings? No Yes
If yes, describe: _____
- Any other pertinent medical condition(s) that may affect the interpretation of current physical findings? No Yes
If yes, describe: _____
- Any pre-existing physical injuries? No Yes
If yes, describe: _____

3. Pertinent pre- and post-assault related history:

	No	Yes	Unsure
Other intercourse within past 5 days? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unsure			
If yes,			
anal (within past 5 days)? When _____	<input type="checkbox"/>	<input type="checkbox"/>	
vaginal (within past 5 days)? When _____	<input type="checkbox"/>	<input type="checkbox"/>	
oral (within past 24 hours)? When _____	<input type="checkbox"/>	<input type="checkbox"/>	
If yes, did ejaculation occur? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unsure			
If yes, where? _____			
If yes, was a condom used? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unsure			
Any voluntary alcohol use within 12 hours prior to assault? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unsure			
Any voluntary drug use within 96 hours prior assault? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unsure			
Any voluntary drug or alcohol use between the time of the assault and the forensic exam? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unsure			

*If yes, collection of toxicology samples is recommended according to local policy. Blood Urine

4. Post-assault hygiene/activity: Not applicable if over 72 hours

	No	Yes
Urinated <input type="checkbox"/> No <input type="checkbox"/> Yes		
Defecated <input type="checkbox"/> No <input type="checkbox"/> Yes		
Genital or body wipes <input type="checkbox"/> No <input type="checkbox"/> Yes		
If yes, describe: _____		
Douched <input type="checkbox"/> No <input type="checkbox"/> Yes		
If yes, with what _____		
Removed/inserted tampon <input type="checkbox"/> diaphragm <input type="checkbox"/> <input type="checkbox"/> No <input type="checkbox"/> Yes		
Oral gargle/rinse <input type="checkbox"/> No <input type="checkbox"/> Yes		
Bath/shower/wash <input type="checkbox"/> No <input type="checkbox"/> Yes		
Brushed teeth <input type="checkbox"/> No <input type="checkbox"/> Yes		
Ate or drank <input type="checkbox"/> No <input type="checkbox"/> Yes		
Changed clothing <input type="checkbox"/> No <input type="checkbox"/> Yes		
If yes, describe: _____		

5. Assault-related history:

	No	Yes
Loss of memory? If yes, describe: <input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/> *
Lapse of consciousness? If yes, describe: <input type="checkbox"/> _____	<input type="checkbox"/>	<input type="checkbox"/> *

*If yes, collection of toxicology samples is recommended according to local policy. Blood Urine

Vomited? If yes, describe: No Yes

Non-genital injury, pain and/or bleeding? No Yes
If yes, describe: _____

Anal-genital injury, pain, and/or bleeding? No Yes
If yes, describe: _____

F. ASSAULT HISTORY

1. Date of assault(s): _____ Patient Identification # of assault(s): _____

2. Pertinent physical surroundings of assault(s): _____

3. Alleged assailant(s) name(s)	Age	Gender	Ethnicity	Relationship to patient	
				Known	Unknown
#1.		M F			
#2.		M F			
#3.		M F			
#4.		M F			

4. Methods employed by assailant(s):

	No	Yes	If yes, describe:
Weapons <input type="checkbox"/> No <input type="checkbox"/> Yes			_____
Threatened? <input type="checkbox"/> No <input type="checkbox"/> Yes			_____
Injuries inflicted? <input type="checkbox"/> No <input type="checkbox"/> Yes			_____
Type(s) of weapons? _____			
Physical blows <input type="checkbox"/> No <input type="checkbox"/> Yes			_____
Grabbing/holding/pinching <input type="checkbox"/> No <input type="checkbox"/> Yes			_____
Physical restraints <input type="checkbox"/> No <input type="checkbox"/> Yes			_____
Choking/strangulation <input type="checkbox"/> No <input type="checkbox"/> Yes			_____
Burns (thermal and/or chemical) <input type="checkbox"/> No <input type="checkbox"/> Yes			_____
Threat(s) of harm <input type="checkbox"/> No <input type="checkbox"/> Yes			_____
Target(s) of threat(s) <input type="checkbox"/> No <input type="checkbox"/> Yes			_____
Other methods <input type="checkbox"/> No <input type="checkbox"/> Yes			_____
Involuntary ingestion of alcohol/drugs <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unsure			
If yes, <input type="checkbox"/> Alcohol <input type="checkbox"/> Drugs			
If yes, <input type="checkbox"/> Forced <input type="checkbox"/> Coerced <input type="checkbox"/> Suspected			
If yes, toxicology samples collected: <input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> None			

5. Injuries inflicted upon the assailant(s) during assault? No Yes
If yes, describe injuries, possible locations on the body, and how they were inflicted.

G. ACTS DESCRIBED BY PATIENT

- Any penetration of the genital or anal opening, however slight, constitutes the act.
- Oral copulation requires only contact
- If more than one assailant, identify by number.

Patient Identification**1. Penetration of vagina by:**

Describe:

	No	Yes	Attempted	Unsure
Penis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Finger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Object	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, describe the object:

2. Penetration of anus by:

Describe:

	No	Yes	Attempted	Unsure
Penis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Finger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Object	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, describe the object:

3. Oral copulation of genitals:

Describe:

	No	Yes	Attempted	Unsure
Of patient by assailant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Of assailant by patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Oral copulation of anus:

Describe:

	No	Yes	Attempted	Unsure
Of patient by assailant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Of assailant by patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Non-genital act(s):

	No	Yes	Attempted	Unsure
Licking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kissing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suction injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Biting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Describe:

6. Other act(s):

	No	Yes	Attempted	Unsure
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Describe:

7. Did ejaculation occur?

	No	Yes	Unsure
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Describe:

If yes, note location(s):

- Mouth
- Vagina
- Anus/Rectum
- Body surface
- On clothing
- On bedding
- Other

8. Contraceptive or lubricant products:

Describe type/brand, if known:

	No	Yes	Unsure
Foam used?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jelly used?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lubricant used?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Condom used?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

H. GENERAL PHYSICAL EXAMINATION

Record all findings using diagrams, legend, and a consecutive numbering system.

1. Blood Pressure	Pulse	Resp	Temp	2. Date/time examination	
				Started	Completed
3. Describe general physical appearance				4. Describe general demeanor	

Patient Identification

5. Describe condition of clothing upon arrival.

6. Collect outer and underclothing if indicated. Not indicated
7. Conduct a physical examination. Findings No Findings
8. Collect dried and moist secretions, stains, and foreign materials from the body. Scan the entire body with a Wood's Lamp.
 Findings No Findings
9. Collect fingernail scrapings or cuttings according to local policy.

Diagram A

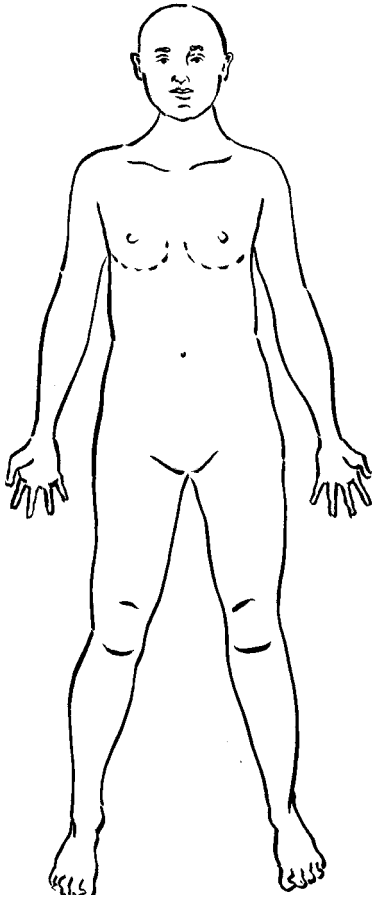
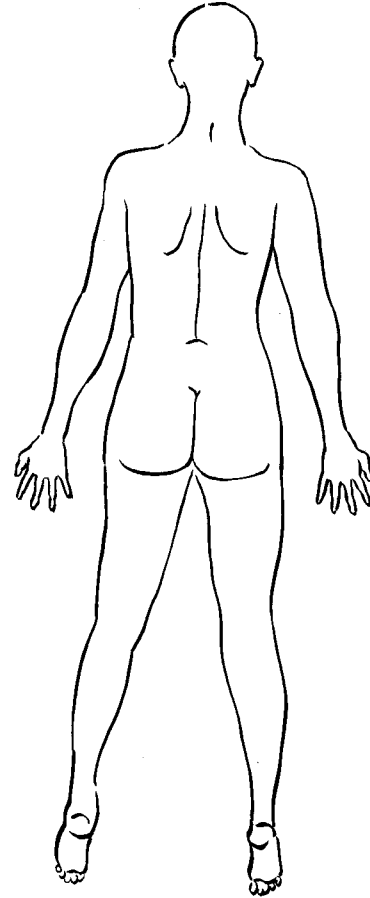


Diagram B



LEGEND: Types of Findings

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

Locator #	Type	Description	Locator #	Type	Description

RECORD ALL CLOTHING AND SPECIMENS COLLECTED ON PAGE 8

I. HEAD, NECK, AND ORAL EXAMINATION

Record all findings using diagrams, legend, and a consecutive numbering system.

1. Examine the face, head, hair, scalp, and neck for injury and foreign materials. Findings No Findings
2. Collect dried and moist secretions, stains, and foreign materials from the face, head, hair, scalp, and neck. Findings No Findings
3. Examine the oral cavity for injury and foreign materials (if indicated by assault history). Collect foreign materials.
Exam done: Not applicable Yes Findings No Findings
4. Collect 2 swabs from the oral cavity up to 12 hours post assault and

Diagram C

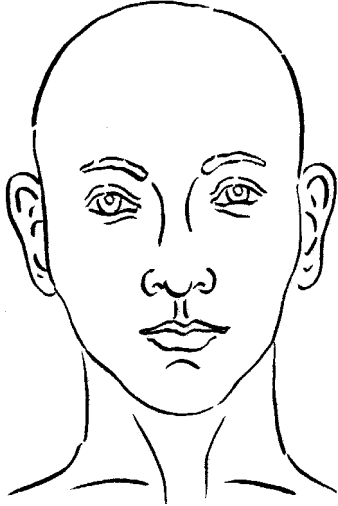


Diagram D

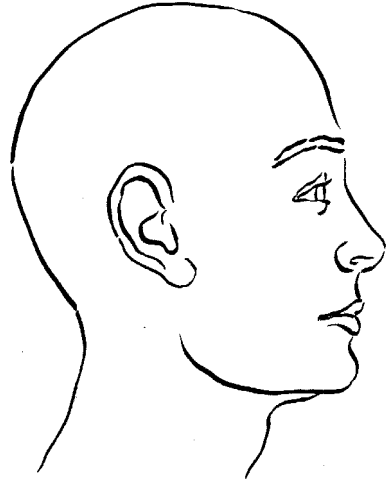


Diagram E

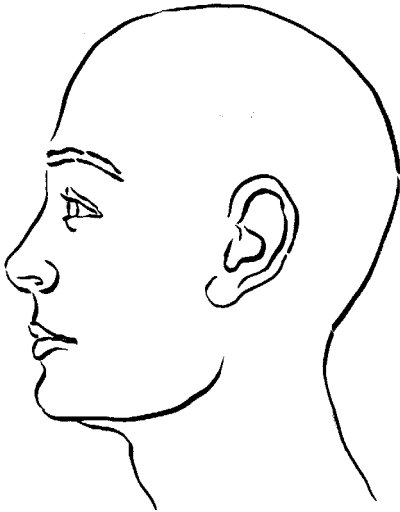


Diagram F



LEGEND: Types of Findings

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

Locator #	Type	Description	Locator #	Type	Description

RECORD ALL SPECIMENS COLLECTED ON PAGE 8

L. EVIDENCE COLLECTED AND SUBMITTED TO CRIME LAB

1. Clothing placed in evidence kit	Other clothing placed in bags

2. Foreign materials collected

	No	Yes	Collected by:
Swabs/suspected blood	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dried secretions	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fiber/loose hairs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vegetation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Soil/debris	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swabs/suspected semen	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swabs/suspected saliva	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swabs/Wood's Lamp® area(s)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Control swabs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fingernail scrapings/cuttings	<input type="checkbox"/>	<input type="checkbox"/>	_____
Matted hair cuttings	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pubic hair combings/brushings	<input type="checkbox"/>	<input type="checkbox"/>	_____
Intravaginal foreign body	<input type="checkbox"/>	<input type="checkbox"/>	_____
If yes, describe: _____			
Other types	<input type="checkbox"/>	<input type="checkbox"/>	_____
If yes, describe: _____			

3. Oral/genital/anal/rectal samples

	# Swabs	# Slides	Time collected	Collected by:
Oral				
Vaginal				
Cervical				
Anal				
Rectal				
Penile				
Scrotal				
Aspirate/washings (optional) <input type="checkbox"/> No <input type="checkbox"/> Yes				

4. Vaginal wet mount slide

	No	Yes	Time	Examiner:
Slide prepared	<input type="checkbox"/>	<input type="checkbox"/>		
Motile sperm observed	<input type="checkbox"/>	<input type="checkbox"/>		
Non-motile sperm observed	<input type="checkbox"/>	<input type="checkbox"/>		

M. TOXICOLOGY SAMPLES

	No	Yes	Time	Collected by:
Blood alcohol/toxicology (gray top tube)	<input type="checkbox"/>	<input type="checkbox"/>		
Urine toxicology	<input type="checkbox"/>	<input type="checkbox"/>		

N. REFERENCE SAMPLES

	No	Yes	Collected by:
Blood (lavender top tube)	<input type="checkbox"/>	<input type="checkbox"/>	
Blood (yellow top tube)	<input type="checkbox"/>	<input type="checkbox"/>	
Blood Card (optional)	<input type="checkbox"/>	<input type="checkbox"/>	
Buccal swabs (optional)	<input type="checkbox"/>	<input type="checkbox"/>	
Saliva swabs	<input type="checkbox"/>	<input type="checkbox"/>	
Head hair	<input type="checkbox"/>	<input type="checkbox"/>	
Pubic hair	<input type="checkbox"/>	<input type="checkbox"/>	

O. PHOTO DOCUMENTATION METHODS

	No	Yes	Colposcope/ 35mm	Macrolens/ 35mm	Colposcope/ Videocamera	Other Optics
Body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genitals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Photographed by: _____						

Patient Identification

P. RECORD EXAM METHODS

	No	Yes		No	Yes
Direct visualization only	<input type="checkbox"/>	<input type="checkbox"/>	Toluidine Blue Dye	<input type="checkbox"/>	<input type="checkbox"/>
Colposcopy	<input type="checkbox"/>	<input type="checkbox"/>	Anoscopic exam	<input type="checkbox"/>	<input type="checkbox"/>
Other magnifier	<input type="checkbox"/>	<input type="checkbox"/>	Anal speculum exam	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>			
If yes, describe: _____					

Q. RECORD EXAM FINDINGS

Physical Findings No Physical Findings

R. RECORD ASSESSMENT OF FINDINGS

Exam consistent with history
 Exam inconsistent with history

S. SUMMARIZE FINDINGS

T. PRINT NAMES OF PERSONNEL INVOLVED

History taken by: _____	Telephone: _____
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Exam performed by: _____	
--------------------------	--

Specimens labeled and sealed by: _____	
--	--

Assisted by: <input type="checkbox"/> N/A	
---	--

Signature of examiner _____	License No. _____
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U. EVIDENCE DISTRIBUTION GIVEN TO:

Clothing (item(s) not placed in evidence kit)	
Evidence Kit	
Reference blood samples	
Toxicology samples	

V. SIGNATURE OF OFFICER RECEIVING EVIDENCE

Signature: _____
Print name and ID #: _____
Agency: _____
Date: _____ Phone: _____