State of West Virginia
Pediatric/Adolescent Sexual Assault Information Form
Medical Forensic Examination Confidential Document

Patient Identification Label

Kit Tracking Number

STEP 1: WEST VIRGINIA SEXUAL ASSAULT INFORMATION FORMS

A. PEDIATRIC PATIENT INFORMATION (Print Legibly)

Name of Patient			Date of Birth		Medical Facility		
Patient Address			Sex at Birth M F	Gender Identity	Pronouns		
Date/Time of Arrival	Date/Time of Discharge		Date of Exam	Time Exam Started	Time Exam Completed		
City/County/State of Assault				Date of Assault	Time of Assault		
Name of: ☐ Parent ☐ Legal Guardian ☐ Other (Specify)			Address/City/State/Zip:		Phone: ☐ Home ☐ Cell		
Name of: ☐ Parent ☐ Legal Guardian ☐ Other (Specify)			Address/City/State/Zip:		Phone: ☐ Home ☐ Cell		
Name(s) of Sibling:	Gender	Age	DOB	Name(s) of Sibling:	Gender	Age	DOB
Name(s) of Sibling:	Gender	Age	DOB	Name(s) of Sibling:	Gender	Age	DOB

B. LAW ENFORCEMENT INFORMATION (REQUIRED FOR PEDIATRIC PATIENTS)

A legible copy of the forms MUST be given to the responding law enforcement officer. SAECKs reported to law enforcement must be mailed to the WVSP Forensic Lab using the FedEx label in the kit.

Law Enforcement Agency/Detachment Contacted	Name of Responding Officer	Officer's Phone Number
Person Reporting to Law Enforcement		

C. CONSENT FOR MEDICAL FORENSIC EXAMINATION – PEDIATRIC PATIENT-UNDER 14 YEARS OF AGE

Informed consent for all procedures, evidence collection, and treatment must be obtained for patients of any age. If the patient is unable to provide consent due to age or mental status, consent may be obtained from a parent, guardian or healthcare surrogate.

- I hereby authorize this medical facility to collect any forensic evidence found and to examine and treat me for disease or injury sustained as a result of this assault. I also authorize this hospital to perform any and all medical tests that may be necessary or helpful for treatment or for legal evidence. _____ *(Initial)*
- I understand that this is a medical forensic exam to evaluate healthcare needs and to preserve and collect evidence and to document the medical forensic exam. The healthcare provider conducting the exam will not be held responsible for identifying, diagnosing, or treating any other existing medical problems I may have, not related to the sexual assault. _____ *(Initial)*
- I understand that this waiver authorizes a complete medical forensic examination to be conducted, and authorizes the release of the records of that examination to the appropriate law enforcement agencies or the prosecutor's office. _____ *(Initial)*
- I understand that photographs of injuries may be taken as part of the medical forensic exam. Photographs may include pictures of the genital and/or anal area and that these photographs may be shared with individuals involved in the investigation or judicial progress. _____ *(Initial)*
- I authorize this hospital to release all collected forensic evidence and all of the information contained in the medical forensic forms concerning this medical forensic examination and treatment to the law enforcement agencies that may be involved in investigating this sexual assault or in prosecuting the assailant. I hereby waive all medical privilege in connection with this examination, treatment, and collected evidence. _____ *(Initial)*
- I consent for the information to be used in a confidential peer review process or for training purposes. _____ *(Initial)*
- I herewith release and hold harmless the hospital and its agents from any and all liability and claims of injury whatsoever which may result from the authorized release of such information. _____ *(Initial)*

_____ _____
Signature of Parent/Guardian/Healthcare Surrogate *(Date)*

_____ _____
Relationship to Patient *(Date)*

_____ _____
Examiner's Signature *(Date)*

HOSPITAL RECORDS *(WHITE COPY)* | LAB/ENVELOPE ON BACK OF KIT *(YELLOW COPY)* | LAW ENFORCEMENT *(PINK COPY)*

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WV400C:PED-1.2 7/24

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D. PATIENT MEDICAL HISTORY

Person Providing History: Name: _____ Relationship to patient: _____

Medical History	Yes	No	Unknown	Describe
Hospitalization(s)	☐	☐	☐	
Surgery	☐	☐	☐	
Significant illness/injury including fractures/burns	☐	☐	☐	
Other pertinent med hx (birth, etc.)	☐	☐	☐	
Allergies (drugs, latex, other)	☐	☐	☐	
Medications	☐	☐	☐	
Immunizations up to date	☐	☐	☐	
Disabilities	☐	☐	☐	
Normal growth and development	☐	☐	☐	
Menstrual periods	☐	☐	☐	Age of menarche:_____ LMP:_____
Contraception	☐	☐	☐	
Medical conditions or prior treatments, procedures or surgeries that may affect interpretation of findings	☐	☐	☐	

Pre-Existing Medical Conditions
☐ **Negative, if not indicated below.**

DERM: ☐ Eczema ☐ Warts ☐ Lesions ☐ Scars ☐ Easy bleeding/bruising ☐ Other:_____

GI: ☐ Constipation ☐ Diarrhea ☐ Vomiting ☐ Incontinence ☐ Bleeding (rectal) ☐ Abdominal pain
☐ Itching (rectal) ☐ Other: _____

GU: ☐ Genital or anal itching ☐ Discharge ☐ Pain ☐ Bleeding ☐ UTI ☐ Symptoms of previous injury
☐ Bed wetting/wetting pants ☐ History of STI ☐ Other:_____

Mental Health: ☐ Self harm ☐ Sexualized behavior ☐ Other behavioral changes: _____

Previous Abuse History: ☐ Yes ☐ No ☐ Unknown _____

Other Medical Conditions: _____

Pertinent Family Medical History	Yes	No	Unsure
Human Papillomavirus (HPV)	☐	☐	☐
Herpes Simplex Virus (HSV)	☐	☐	☐
Human Immonodeficiency Virus (HIV)	☐	☐	☐

Other: _____

Recent Medical Conditions
Has the child has any recent (60 days) injuries, surgeries, diagnostic procedures or medical treatments that may affect physical findings? ☐ Yes ☐ No

If yes, describe: _____

_____

_____

_____

E. ASSAULT HISTORY

Pre-Assault History (Prior to the Assault) Document any recent (5 days) sexual activity prior to the assault.

Consensual intercourse within the last 5 days? ☐ Yes ☐ No
Vaginal intercourse (within last 5 days)? ☐ Yes ☐ No If Yes, When (date/time)_____
Anal intercourse (within last 5 days)? ☐ Yes ☐ No If Yes, When (date/time)_____
Oral intercourse (within last 5 days)? ☐ Yes ☐ No If Yes, When (date/time)_____
Was a condom used? ☐ Yes ☐ No
Did ejaculation occur? ☐ Yes ☐ No ☐ Uncertain If Yes, Where on the body?_____
Any contact with the assailant, prior to the assault, within the last 5 days? ☐ None ☐ Non-Sexual Contact ☐ Sexual Contact

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E. ASSAULT HISTORY (CONTINUED)

Post-Assault History

Information provided by: ☐ Parent/Guardian/Healthcare Surrogate ☐ Patient

Did the patient do any of the following after the assault, but before the medical forensic exam? (***Mark all that apply.***)

Urinate	☐ Yes ☐ No	Vomit	☐ Yes ☐ No	Bath/Shower/Wash	☐ Yes ☐ No
Bowel Movement	☐ Yes ☐ No	Remove/Insert Tampon	☐ Yes ☐ No	Douche	☐ Yes ☐ No
Eat or Drink	☐ Yes ☐ No	Remove/Insert Diaphragm	☐ Yes ☐ No	Change Outer Clothing	☐ Yes ☐ No
Use Genital or Body Wipes	☐ Yes ☐ No	Brush Teeth	☐ Yes ☐ No	Other:_____	
Change Underwear	☐ Yes ☐ No	Oral Gargle/Rinse	☐ Yes ☐ No		

Suspected Assailant(s)	Gender	Age	Race	Relationship to Patient: If Known (Describe) If Unknown (N/A)

Time Between Assault and Forensic Examination

☐ 0 to 24 hours (Same Day) ☐ 24 to 48 hours (2nd Day) ☐ 48 to 72 hours (3rd Day) ☐ 72 to 96 hours (4th Day)
☐ Greater than 96 Hours ☐ Uncertain of when assault occurred

Location/Place of Assault:_____ County/City_____

Pertinent Physical Surroundings:_____

_____

Method of Assault by Assailant(s)

Use of Weapons	☐ Yes	☐ No	☐ Uncertain
If Yes, Type of Weapon (e.g. gun, knife, etc.)			
Felt Threatened	☐ Yes	☐ No	☐ Uncertain
Threats of Harm	☐ Yes	☐ No	☐ Uncertain
Received Injuries	☐ Yes	☐ No	☐ Uncertain
Fear of Death/Dying	☐ Yes	☐ No	☐ Uncertain
Received Physical Blows	☐ Yes	☐ No	☐ Uncertain
Burns (Thermal/Chemical)	☐ Yes	☐ No	☐ Uncertain
Grabbing/Holding	☐ Yes	☐ No	☐ Uncertain
Pinching	☐ Yes	☐ No	☐ Uncertain
Physically Restrained	☐ Yes	☐ No	☐ Uncertain

Strangulation

Was any pressure applied to your neck and/or chest?	☐ Yes	☐ No	☐ Uncertain
If yes,			
Are you or did you have difficulty breathing?	☐ Yes	☐ No	☐ Uncertain
Did you lose or nearly lose consciousness?	☐ Yes	☐ No	☐ Uncertain
Do you have a cough or change in your voice since the time of the incident?	☐ Yes	☐ No	☐ Uncertain
Did you experience loss of bladder control?	☐ Yes	☐ No	☐ Uncertain
Did you experience loss of bowel control?	☐ Yes	☐ No	☐ Uncertain

Yes to any of these questions requires notification of a physician.

For additional assessment instructions, refer to page (insert number) of the kit instruction paperwork.

Drugs/Alcohol Use

Information provided by: ☐ Parent/Guardian/Healthcare Surrogate ☐ Patient

The information below is required by the WVSP Forensic Laboratory to properly interpret toxicology findings.

Any alcohol use within 12 hours prior to the assault? ☐ Yes ☐ No If yes, date/time of last drink _____
Any drug(s) use within 96 hours prior to the assault? ☐ Yes ☐ No
If yes, list prescription drug(s), OTC, and recreational drug(s) used: _____
Any drug(s) or alcohol use between the time of the assault and the medical forensic exam? ☐ Yes ☐ No
It yes, list prescription drug(s), OTC, and recreational drug(s) used: _____
Suspected ingestion of drug(s) by patient? ☐ Yes ☐ No ☐ Uncertain If yes: ☐ Alcohol ☐ Drug(s)
Suspected Drug Facilitated Sexual Assault (DFSA)? ☐ Yes ☐ No ☐ Uncertain If yes: ☐ Forced ☐ Coerced
If yes, what drug(s) is suspected? _____

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Drugs/Alcohol Use (Continued)

If the patient's history or symptoms marked below indicate the possibility that drugs/alcohol were used within 96 hours, collect evidence using the WV Blood/Urine Collection Kit. Step 10 for Toxicology Specimen Collection instructions.

Check all symptoms observed or reported by the patient or the parent/guardian making the report

☐ Loss of Consciousness	☐ Dizziness	☐ Stupor	☐ Aggressive Behavior
☐ Memory Loss	☐ Weakness	☐ "Black out"	☐ Slurred speech
☐ Vomiting	☐ Drowsiness	☐ Paralysis	☐ Other:
☐ Hallucinations	☐ Sedation	☐ Excitable	

Injuries Inflicted Upon Assailant

Was the assailant injured by the patient? (e.g., scratching, biting, etc.) ☐ Yes ☐ No ☐ Uncertain

If yes, describe: _____

If reported that the assailant was scratched, collect fingernail swabs.

Patient's Name for Body Parts:
Information provided by: ☐ Parent/Guardian/Healthcare Surrogate ☐ Patient

Breast: _____ Female Genitalia: _____ Male Genitals: _____ Anus: _____

Parent/Guardian/Healthcare Surrogate's Account of Abuse/Assault

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Parent/Guardian/Healthcare Surrogate's Account of Abuse/Assault (Continued)

Child's Spontaneous Remarks Regarding Abuse/Assault
Use this section **ONLY** if a child makes spontaneous remarks about the abuse/assault.
Medical providers should document the child's exact words using quotes. Specific questions and detailed information about the incident should be asked by a Forensic Interviewer at a Child Advocacy Center. If patient is less than 14 years of age, avoid leading or yes/no questions. For example: ask the child "Why are you here today?"

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E. ASSAULT HISTORY (CONTINUED)
Document all acts described. Any penetration of the genital or anal opening, however slight, constitutes an act.

If patient answers yes to the questions below, collect two simultaneous swabs from each area of oral contact, penetration, or ejaculation. Moisten the swabs with sterile water if the area is dry. Label the swab boxes with the location of collection. Note if patient declines specimen collection.

Information provided by: ☐ Parent/Guardian/Healthcare Surrogate ☐ Patient

Penetration of Female Sex Organ (Vulva/Vagina):

	Yes	No	Attempted	Uncertain	If yes or attempted, describe:
Penis	☐	☐	☐	☐	
Finger	☐	☐	☐	☐	
Tongue	☐	☐	☐	☐	
Object	☐	☐	☐	☐	

Penetration of Anus:	Yes	No	Attempted	Uncertain	If yes or attempted, describe:
Penis	☐	☐	☐	☐	
Finger	☐	☐	☐	☐	
Tongue	☐	☐	☐	☐	
Object	☐	☐	☐	☐	

Oral Copulation of Genitals:	Yes	No	Attempted	Uncertain	If yes or attempted, describe:
of patient by assailaint	☐	☐	☐	☐	
of assailaint by patient	☐	☐	☐	☐	
Oral Copulation of Anus:	Yes	No	Attempted	Uncertain	If yes or attempted, describe:
of patient by assailaint	☐	☐	☐	☐	
of assailaint by patient	☐	☐	☐	☐	
Other Acts:	Yes	No	Attempted	Uncertain	If yes or attempted, describe:
Licking	☐	☐	☐	☐	
Kissing	☐	☐	☐	☐	
Suction injury	☐	☐	☐	☐	
Biting	☐	☐	☐	☐	
Grabbing/Holding	☐	☐	☐	☐	
Strangulation	☐	☐	☐	☐	

Ejaculation by Assailant:	Yes	No	Attempted	Uncertain	If yes or attempted, describe:
	☐	☐	☐	☐	

If the assailant ejaculated, note the location:
☐ Vagina ☐ Anus ☐ Mouth ☐ Body Surface: _____
☐ Clothing ☐ Bedding ☐ Floor/Ground ☐ Other: _____
If ejaculation occurred, collect the item or swab the area.

Lubrication/Condom:	Yes	No	Attempted	Uncertain	If yes or attempted, describe:
Saliva used?	☐	☐	☐	☐	
Condom used?	☐	☐	☐	☐	
Foam/Jelly used?	☐	☐	☐	☐	
Other	☐	☐	☐	☐	

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F. EVIDENCE COLLECTION

STEP 2: CLOTHING AND UNDERWEAR COLLECTION

Follow instructions on Steps 2a-2d on paper bags.
Collect underwear, diaper, or clothing in contact with the genital area.

Underwear Collected ☐ Yes ☐ No ☐ N/A
Clothing Collected ☐ Yes ☐ No ☐ N/A
Clothing Collected Worn
☐ At Time of Assault ☐ Following Assault to Hospital

STEP 3: FINGERNAIL SWAB AND DEBRIS COLLECTION

Follow instructions on Steps 3a and 3b envelopes.
Collect fingernail swabs (right/left hand) if the patient scratched the assailant.

Fingernail Swabs Collected ☐ Yes ☐ No ☐ N/A
Debris Collected ☐ Yes ☐ No ☐ N/A
If not collected, Why?_____

STEP 4: ORAL SWAB AND ADDITIONAL SWAB COLLECTION

Follow instructions on Steps 4a and 4b envelopes.
Examine the oral cavity for injury, debris, or foreign material if indicated by assault history.

Collect swabs from oral cavity if oral assault occurred within the last 24 hours or if patient cannot recall the assault.

Collect swabs from body areas that were kissed/licked, suction injuries, dried semen or saliva stains within 96 hours of assault, including external mouth (lips).

Oral Swabs Collected ☐ Yes ☐ No ☐ N/A
Additional Swabs Collected ☐ Yes ☐ No ☐ N/A
Document items collected, If not collected, Why?
_____

STEP 5: PUBIC HAIR COMBING/MONS PUBIS SWAB COLLECTION

Follow instructions on Step 5 envelope.
☐ No Pubic Hair (Swab Mons Pubis)
☐ Pubic Hair (Comb Pubic Hair)

Pubic Hair Combing ☐ Yes ☐ No ☐ N/A
Mons Pubis Swab Collected ☐ Yes ☐ No ☐ N/A
If not collected, Why?_____

STEP 6: VULVA/PENILE SWAB COLLECTION

Follow instructions on Step 6 envelope.
Conduct a genital exam.

Internal vaginal swabs and a speculum exam are NOT to be performed on prepubescent patients.

For female patients, if assault occurred >24 hours but within 96 hours, collect two deep cervical swabs in addition to two internal and two external swabs. Each set of swabs must be placed in separate swabs boxes. Do not package internal, external, and deep cervical swabs together.

External Vulva Swabs Collected ☐ Yes ☐ No ☐ N/A
Internal Vaginal Swabs Collected ☐ Yes ☐ No ☐ N/A
Deep Cervical Swabs Collected ☐ Yes ☐ No ☐ N/A

For male patients, if oral contact occurred, swab the penile shaft, glans and base of the penis, using two swabs simultaneously. Avoid swabbing the urethral meatus. If penile and scrotal swabs are both collected, they **MUST** be placed in separate swab boxes.

Penile Swabs Collected ☐ Yes ☐ No ☐ N/A
If not collected, why?_____

STEP 7: ANAL SWAB COLLECTION

Follow instructions on Step 7 envelope.
Examine the buttocks, perianal skin, and the anal folds for injury. Collect any dried and/or moist secretions, stains, debris/foreign materials.

Anal Swabs Collected ☐ Yes ☐ No ☐ N/A
If not collected, Why?_____

STEP 8: KNOWN SALIVA SAMPLE COLLECTION (Patient Saliva)

Follow instructions on Step 8 envelope.
Collect the known saliva (patient) sample. Verify that the patient has had nothing to eat/drink for at least 25 minutes.

STEP 9: KNOWN BLOOD SAMPLE COLLECTION (Patient Blood)

Follow instructions on Step 9 envelope.
Collect a known blood sample from the patient if the assault was oral.
Collect a known blood sample from the patient if oral assault within the last 24 hours or if patient cannot recall the assault.

A known specimen is required in every case. If an oral assault occurred, a known blood specimen should be collected, not a known saliva sample. If oral assault occurred within the last 24 hours or patient cannot recall the assault, a known blood specimen must be collected in place of a known saliva sample.

Indicate which one was collected:
☐ Known Saliva ☐ Known Blood

WV Blood/Urine Kit Collected ☐ Yes ☐ No ☐ N/A
Blood <48 hrs ☐ Yes ☐ No ☐ N/A
Urine < 96 hrs ☐ Yes ☐ No ☐ N/A

STEP 10: TOXICOLOGY SPECIMEN COLLECTION

Follow instructions for Step 10. (Inside the blood/urine collection box)
Collect toxicology samples, if warranted by assault history.

Date/Time of Collection _____ / _____

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G. GENERAL PHYSICAL EXAMINATION

Describe patient's general appearance (e.g. torn clothing, debris, etc.): _____

_____

_____

Describe patient's emotional demeanor (e.g. crying, agitated, lethargic, cooperation, etc.): _____

_____

_____

Vital Signs:

Height: _____ Weight: _____ Temp: _____ Pulse: _____ Blood Pressure: _____

O2 Saturation: _____ Respiration: _____ Head Circumference (Child <2): _____

Pain:

Is the patient having pain? ☐ Yes ☐ No If Yes, current pain level per patient (Use age-appropriate scale) _____

Location of pain: _____ Type of pain: _____

What makes pain worse: _____

What makes pain better: _____

Additional Information: _____

Area	WNL	ABN	Not Examine	See Diagram
Skin	☐	☐	☐	☐
Head	☐	☐	☐	☐
Scalp/Hair	☐	☐	☐	☐
Eyes	☐	☐	☐	☐
Nose & Ears	☐	☐	☐	☐
Mouth, Lips, and Pharynx	☐	☐	☐	☐
Teeth	☐	☐	☐	☐
Neck/Nodes	☐	☐	☐	☐
Lungs	☐	☐	☐	☐
Chest	☐	☐	☐	☐
Heart	☐	☐	☐	☐
Abdomen	☐	☐	☐	☐
Back	☐	☐	☐	☐
Buttocks	☐	☐	☐	☐
Extremities	☐	☐	☐	☐
Neurological	☐	☐	☐	☐
Development	☐	☐	☐	☐

Describe significant findings: _____

Tanner Stages – Female Breast: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Male Genitals: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Pubic Hair: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

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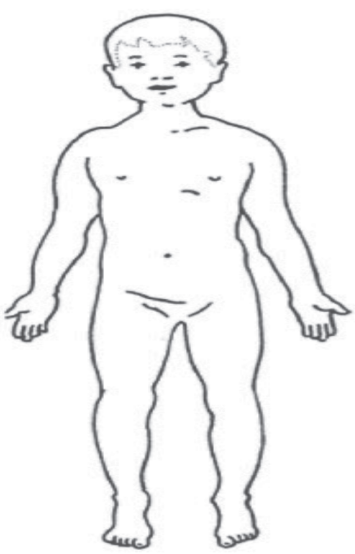
H. PHYSICAL EXAMINATION/FINDINGS

Document all Injuries/Findings ☐ **Injuries/Findings** ☐ **No Injuries/Findings at Time of Examination**

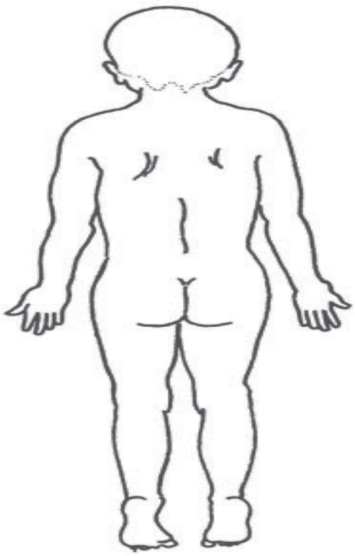
Use the following diagrams, a consecutive numbering system (locator #), and abbreviations to describe the type of injury and findings. Photograph and document measurements (length and width), shape, and color of the injury/finding in the description column in the ledger.

AB Abrasion
BI Bite
BR Bruise
BU Burn
DE Debris
DF Deformity
DS Dry Secretion
ER Erythema (Redness)
FB Foreign Body
F/H Fiber/Hair
LA Laceration
MS Moist Secretion
OF Other Finding
P Pain (Use appropriate scale)
PE Petechiae
SI Suction Injury
SW Swelling
T Tenderness

Locator #	Type	Description	Photo



FRONT VIEW



REAR VIEW

LEFT SIDE VIEW

RIGHT SIDE VIEW

Notes: _____

_____

_____

_____

Alternative light source used? ☐ **Yes** ☐ **No** **If Yes:** ☐ **Fluoresced** ☐ **No Fluorescence Noted**

HOSPITAL RECORDS *(WHITE COPY)*

LAB/ENVELOPE ON BACK OF KIT *(YELLOW COPY)*

LAW ENFORCEMENT *(PINK COPY)*

_____
EXAMINER INITIALS

Patient Identification Label

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H. PHYSICAL EXAMINATION/FINDINGS

Document all Injuries/Findings ☐ **Injuries/Findings** ☐ **No Injuries/Findings at Time of Examination**

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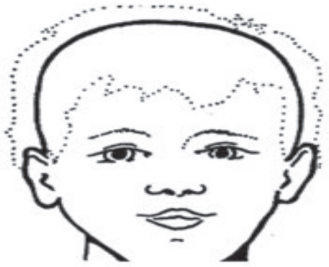
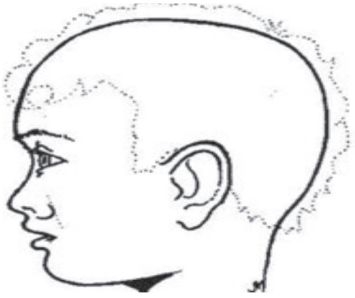
MS Moist Secretion
OF Other Finding
P Pain (Use appropriate scale)
PE Petechiae
SI Suction Injury
SW Swelling
T Tenderness

Locator #	Type	Description	Photo

CHILD FACE, FRONT VIEW



CHILD FACE, LEFT VIEW



CHILD FACE, RIGHT VIEW

CHILD FACE, ORAL AND NASAL VIEW

Notes: _____

_____

_____

_____

Alternative light source used? ☐ **Yes** ☐ **No** **If Yes:** ☐ **Fluoresced** ☐ **No Fluorescence Noted**

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I. GENITAL EXAMINATION-Female Genitalia:

Speculum exam is indicated only in post-menarcheal females, or if the child requires exam under general anesthesia. DO NOT PLACE A SPECULUM in a pre-pubescent child. Avoid touching the hymen in pre-pubescent female children, as it is very sensitive/painful.

Exam Method: ☐ Direct Visualization ☐ Colposcope

Exam Positions:	**Separation**	**Traction**
Supine Knee Chest	☐	☐
Prone Knee Chest	☐	☐
Supine Frog Leg	☐	☐

Exam Adjuncts:

☐ Saline/Water ☐ Moistened Swab ☐ Foley Catheter ☐ Speculum ☐ Other: _____

Assessment	**WNL**	**ABN**	**Describe**
Inner Thighs	☐	☐	_____
Inguinal crease	☐	☐	_____
Labia Majora	☐	☐	_____
Labia Minora	☐	☐	_____
Clitoral Hood	☐	☐	_____
Urethra	☐	☐	_____

Hymen ☐ Annular ☐ Crescentic ☐ Imperforate ☐ Redundant ☐ Septate ☐ Cribiform

Hymenal findings: _____

Fossa Navicularis	☐	☐	_____
Posterior Fourchette	☐	☐	_____
Perineum	☐	☐	_____
Vagina (If visualized)	☐	☐	_____
Cervix (If visualized)	☐	☐	_____
Discharge	☐ Yes	☐ No	If yes, describe: _____

Document all Injuries/Findings ☐ **Injuries/Findings** ☐ **No Injuries/Findings at Time of Examination**

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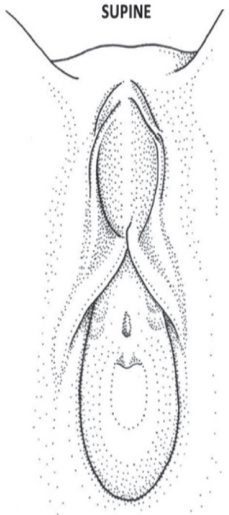
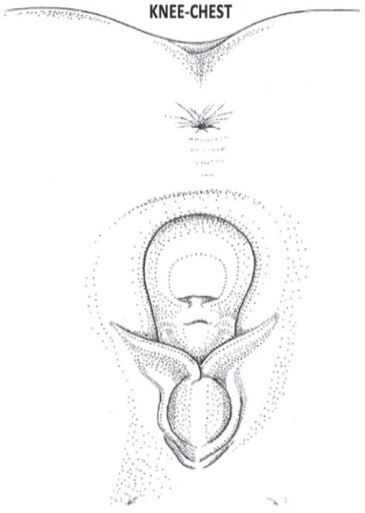
OF Other Finding
P Pain (Use appropriate scale)
PE Petechiae
SI Suction Injury
SW Swelling
T Tenderness

Locator #	Type	Description	Photo





Notes: _____

Alternative light source used? ☐ **Yes** ☐ **No** **If Yes:** ☐ **Fluoresced** ☐ **No Fluorescence Noted**

HOSPITAL RECORDS *(WHITE COPY)*
LAB/ENVELOPE ON BACK OF KIT *(YELLOW COPY)*
LAW ENFORCEMENT *(PINK COPY)*

_____
EXAMINER INITIALS

Patient Identification Label

Kit Tracking Number

I. GENITAL EXAMINATION-Male Genitals

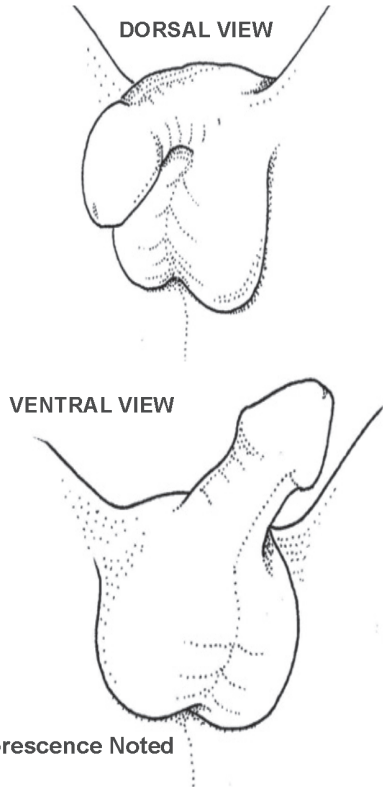
Exam Method: ☐ Direct Visualization ☐ Colposcope
Exam Positions/Methods:
☐ Supine ☐ Prone ☐ Lateral Recumbant ☐ Other: _____

Assessment	WNL	ABN	Describe
Inner Thighs	☐	☐	_____
Inguinal Crease	☐	☐	_____
Perineum	☐	☐	_____
Foreskin	☐	☐	_____
Glans Penis	☐	☐	_____
Penile Shaft	☐	☐	_____
Urethral meatus	☐	☐	_____
Scrotum	☐	☐	_____
Testes	☐	☐	_____
Discharge	☐ Yes	☐ No	If yes, describe: _____
Circumcised	☐ Yes	☐ No	
Foreskin Retracted	☐ Yes	☐ No	

Document all Injuries/Findings ☐ **Injuries/Findings** ☐ **No Injuries/Findings at Time of Examination**
Use the following diagrams, a consecutive numbering system (locator #), and abbreviations to describe the type of injury and findings. Photograph and document measurements (length and width), shape, and color of the injury/finding in the description column in the ledger.

AB Abrasion
BI Bite
BR Bruise
BU Burn
DE Debris
DF Deformity
DS Dry Secretion
ER Erythema (Redness)
FB Foreign Body
F/H Fiber/Hair
LA Laceration
MS Moist Secretion
OF Other Finding
P Pain (Use appropriate scale)
PE Petechiae
SI Suction Injury
SW Swelling
T Tenderness

Locator #	Type	Description	Photo



Notes: _____

Alternative light source used? ☐ **Yes** ☐ **No** **If Yes:** ☐ **Fluoresced** ☐ **No Fluorescence Noted**

HOSPITAL RECORDS *(WHITE COPY)*
LAB/ENVELOPE ON BACK OF KIT *(YELLOW COPY)*
LAW ENFORCEMENT *(PINK COPY)*

_____
EXAMINER INITIALS

Patient Identification Label

Kit Tracking Number

J. ANUS EXAM

Exam Method: ☐ Direct Visualization ☐ Colposcope ☐ Anoscopy

Exam Positions:	**Observation**	**Observation with Traction**
Supine	☐	☐
Prone	☐	☐
Lateral Recumbant	☐	☐

Assessment	**WNL**	**ABN**	**Describe**
Buttocks	☐	☐	
Perianal skin/folds	☐	☐	
Anal verge	☐	☐	
Anal tone	☐	☐	
Rectum	☐	☐	
Anal dilation	☐ Yes	☐ No	If yes, ☐ Immediate ☐ Delayed ☐ Comments:
Stool present in rectal ampulla	☐ Yes	☐ No	Undetermined

Document all Injuries/Findings ☐ **Injuries/Findings** ☐ **No Injuries/Findings at Time of Examination**

Use the following diagrams, a consecutive numbering system (locator #), and abbreviations to describe the type of injury and findings. Photograph and document measurements (length and width), shape, and color of the injury/finding in the description column in the ledger.

AB Abrasion
BI Bite
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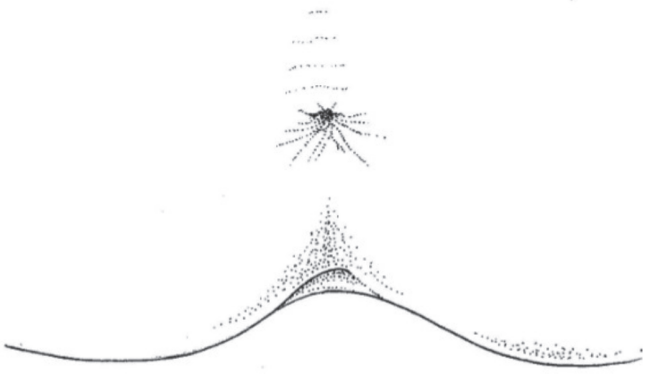
Locator #	Type	Description	Photo



Notes:

Alternative light source used? ☐ **Yes** ☐ **No** **If Yes:** ☐ **Fluoresced** ☐ **No Fluorescence Noted**

Patient Identification Label

Kit Tracking Number

Documentation with Photographs ☐ SD Card ☐ Printed

Photo Storage Location: _____

Body Photos: ☐ Yes ☐ No

Genital Photos: ☐ Yes ☐ No

Photographs taken by: _____

DO NOT send any photographs to the WVSP Forensic Laboratory.

Discharge Information

Patient Discharged to: ☐ Home ☐ Hospital Admit ☐ Other: _____

Home Phone: _____ Other Ways to Contact Patient: _____

Cell Phone: _____

CPS Notified? ☐ Yes ☐ No If yes, reference number: _____

CPS Responded? ☐ Yes ☐ No

Law Enforcement Notified (Required): ☐ Yes ☐ No

Law Enforcement Responded: ☐ Yes ☐ No

Child Advocacy Center referral should be made by CPS or Law Enforcement.

STI/Emergency Contraception (EC)

Prophylactic treatment offered? ☐ Yes ☐ No If Yes, ☐ Oral ☐ Plan B ☐ Other _____

If No, Why? _____

Prophylactic treatment accepted? ☐ Yes ☐ No ☐ N/A

Prophylactic treatment administered on-site ☐ Yes ☐ No ☐ N/A If no, Prescription only? ☐ Yes ☐ No

Tested for STIs ☐ Yes ☐ No

Treated for STIs ☐ Yes ☐ No

Examiner Qualifications

Nurses: ☐ SANE-A ☐ SANE-P ☐ AA SANE ☐ PA SANE ☐ TeleSANE assisted ☐ RN with no SANE designation

Physicians/APRNs/PA-Cs: ☐ Physician ☐ APRN ☐ PA-C ☐ WV SAFE Training

NOTE:

--SANE-A and SANE-P designation is only granted through passing a national certification exam through the IAFN.

--AA SANE and PA SANE designation is granted after completion of 40 hours of SANE didactic coursework and signed documentation of completion of all clinical requirements.

--TeleSANE requires certification as a SANE-A or SANE-P through the IAFN.

_____
Name of person conducting the Medical Screening Examination (Print)

_____
Position

_____
Signature

_____
Name of person conducting the Medical Forensic Examination (Print)

_____
Position

_____
Signature

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EXAMINER INITIALS