FSD-097 (7/2012)
MICHIGAN STATE

AUTHORITY: P.A. 59 of 1935.
COMPLIANCE: Voluntary, but the information contained in this document is confidential and is protected by Federal Health Privacy Regulations.

PATIENT/EXAMINER INFORMATION

Patient Name: [redacted]
Address: [redacted]
Date of Birth: [redacted] Sex:
Date of Examination: [redacted] Time of Examination: [redacted]

MR/Case Number: [redacted]
Phone Number: [redacted]
Contact Number: [redacted]
Contact Instructions: [redacted]
Ethnicity/Race: [redacted]

A. Information for Patient (Health provider review with patient)

- ☒ Patient has signed appropriate consent for treatment provided by the health facility (not included here).
- ☒ The patient has been told that she or he is not required to participate in the criminal justice system or cooperate with law enforcement as a condition of receiving treatment and/or evidence collection. MCL 18.355a(10).
- ☒ Patient understands that receiving an exam, treatment, and/or evidence collection is voluntary and that she/he may stop the exam at any point in time and still receive medical attention if the patient chooses.
- ☒ The patient has received a copy of the booklet "Important Health Information for You" (provided in kit).
- ☒ Information about SAFE Response and examination payment options has been explained to the patient (provided in kit).

MEDICAL HISTORY

B. General treatment hist

Allergies: [redacted]
Current medications (including contraception): [redacted]

General medical history: [redacted] Last tetanus immunization

Disability: ☐No ☐Yes, comments: [redacted]
Recent treatments, including [redacted]
Surgeries, procedure/da[redacted]
Last menstrual period [redacted] Vaginal Deliveries w/in previous 6 months? ☐No ☐Yes Date: [redacted]
Consensual coitus in last 96 hours? ☐No ☐Yes If yes, condom use? ☐No ☐Yes ☐NA

C. History of chief complaint/assault

Date of Assault: [redacted] Time of Assault: [redacted]
Brief history of assault (include loss of memory or lapse of consciousness and/or alcohol/drug use):

Patient Name: _____

Patient alcohol and/or drug use at time of assault:

Multiple Assailants: ☐Unknown ☐No ☐Yes #:

Assailant(s) Gender (number if known): ___Unknown

Relationship of Assailant(s):

Assailant(s) Details (include name(s), if known):

Weapon(s) used/threatened/present:

Location of Assault:

Patient Position During Assault (Check all that apply): ☐Prone ☐Supine ☐Kneeling ☐Unknown ☐Other

D. Acts described by patient

Acts described by patient	Yes	No	Unknown	Attempted		Patient statement:
Fondling						
Licking/Kissing/Suction						
Biting						
Restraint / Force						
Strangulation (see pg. 3)						
Vulvar penetration/contact						
Penis						
Digital						
Foreign object use						
Anal penetration/contact						
Penis						
Digital						
Foreign object use						
Ejaculation					Where:	
Oral contact to genitals						
Patient on assailant						
Assailant on patient						
Oral contact to anal area						
Patient on assailant						
Assailant on patient						
Lubricant used						
Condom used						
Patient clothing removed during assault						
Patient clothing items missing						
Injury to assailant (scratching)						

Patient Name: _____

E. Symptoms since assault

Physical pain/psychological/emotional/ ADL impairment/other: _____

F. Post assault activity/hygiene

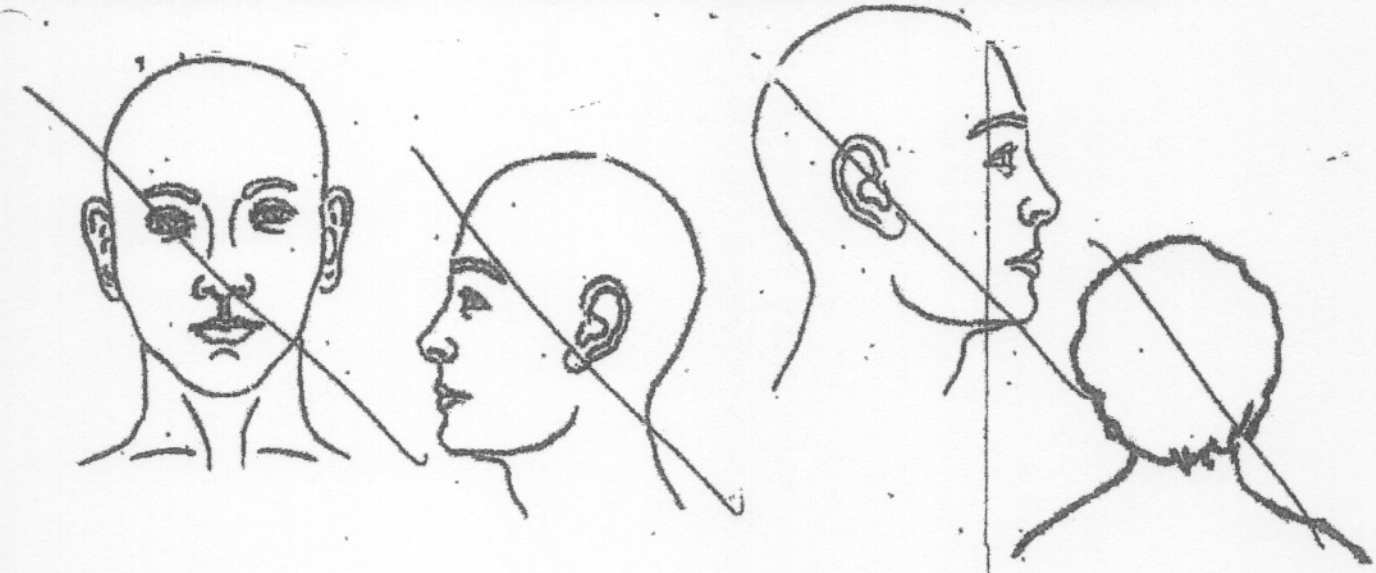
No	Post assault activity	Yes	Patient Statements	Unknown
	Urinated			
	Defecated			
	Genital wash/wipe			
	Douche			
	Bath/shower			
	Brushed teeth			
	Vomited			
	Smoked			
	Drank/ate			
	Use of intravaginal product		Specify:	
	Clothing change/missing			
	Other:			

PHYSICAL EXAMINATION/ASSESSMENT

G. General physical assessment

Pulse: _____ Respiration: _____ Blood pressure: _____ Temperature: _____ Weight: _____

H. Head, neck, and oral examination: Please diagram, measure, and describe areas of patient trauma and non-

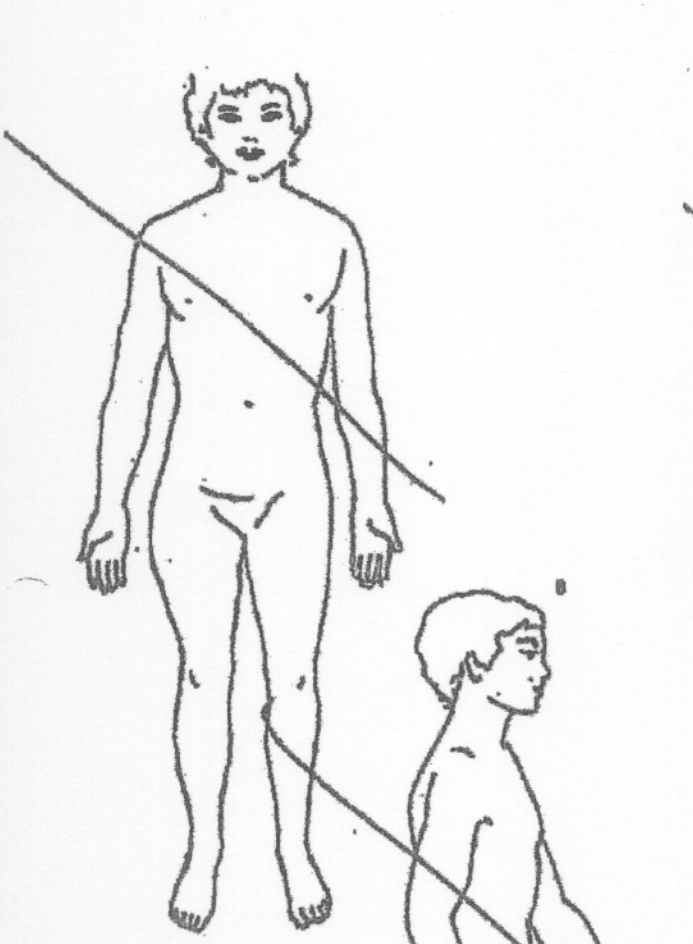


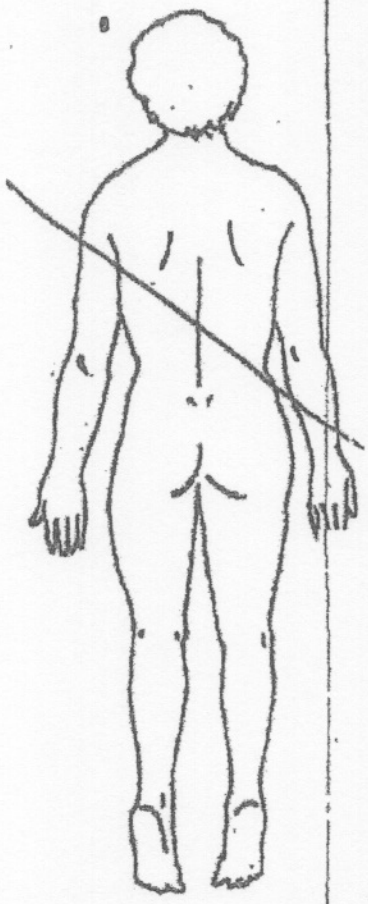
I. Strangulation assessment ☐No ☐Yes ☒N/A

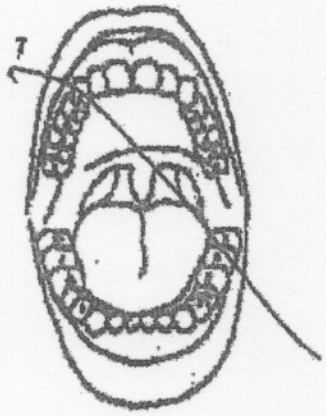
Breathing Changes	Voice Changes	Swallowing Changes	Physical	Behavioral Changes	Other
☐ Difficulty breathing ☐ Hyperventilation ☐ Unable to breath ☐ Other:	☐ Raspy voice ☐ Hoarse voice ☐ Coughing ☐ Unable to speak	☐ Trouble swallowing ☐ Painful to swallow ☐ Neck Pain ☐ Nausea ☐ Vomiting	☐ Petechiae eye ☐ Contusion/Bruise ☐ Ligature marks ☐ Other: _____ Note on body map	☐ Agitation ☐ Amnesia ☐ Hallucinations ☐ Combativeness	☐ Loss of consciousness ☐ Dizzy ☐ Headaches ☐ Urinated ☐ Defecated

Patient Name: _____

J. Physical Assessment Body Maps: Please diagram, measure, and describe areas of patient trauma, pain, and alternate light source findings (if used) on the maps below.
Sexual Maturation Stage/Tanner Stage: [illegible]





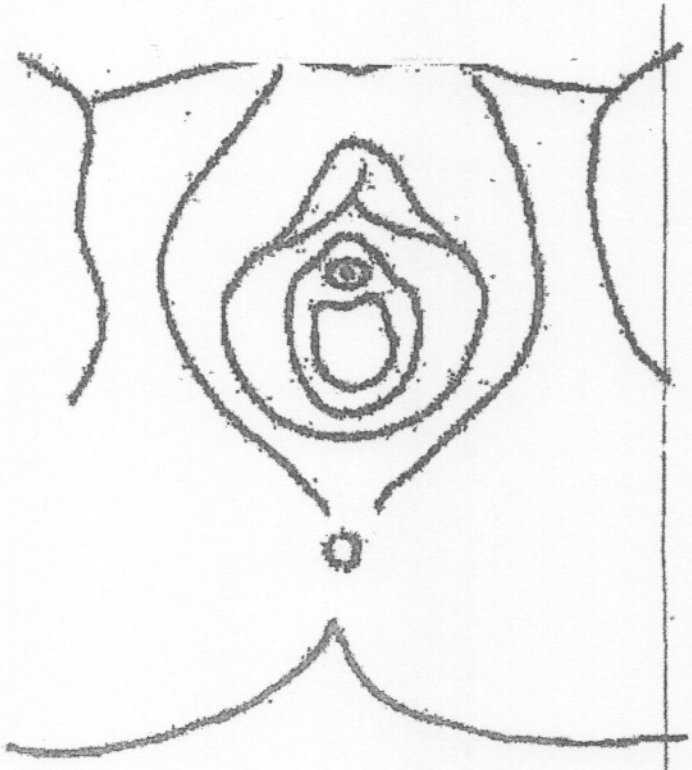


Patient Name: _____

K. Detailed Anogenital Examination Female Patient: ☐ N/A

Anogenital Structure	Trauma identified (describe and document on body map)
Anus	
Rectum	
Vulva:	
Vestibule/Periurethral/ Clitoris/Clitoral hood	
Perineum	
Labia majora	
Labia minora	
Posterior fourchette	
Fossa navicularis	
Hymen	
Vagina	
Cervix	

Please diagram, measure, and describe areas of patient trauma, pain, alternate light source findings, and Toluidine Blue positive areas (if used) on the maps below.



Patient Name: _____

Detailed Anogenital Examination Female Patient Continued: Please diagram, measure, and describe areas of patient trauma, pain, alternate light source findings, and Toluidine Blue positive areas (if used) on the maps below.

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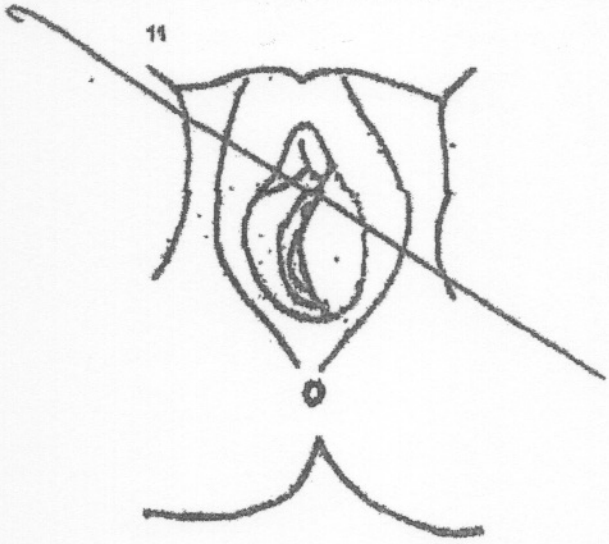

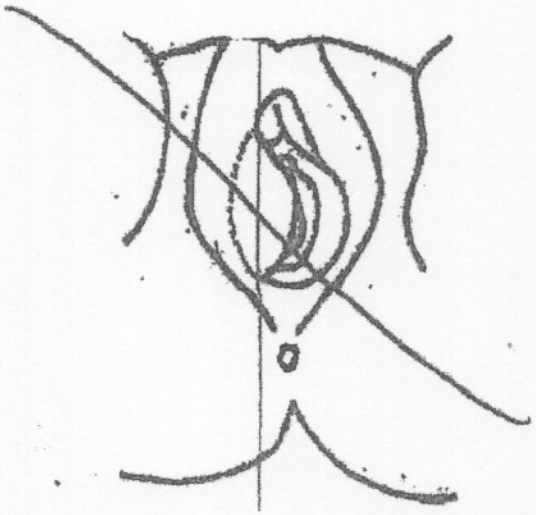

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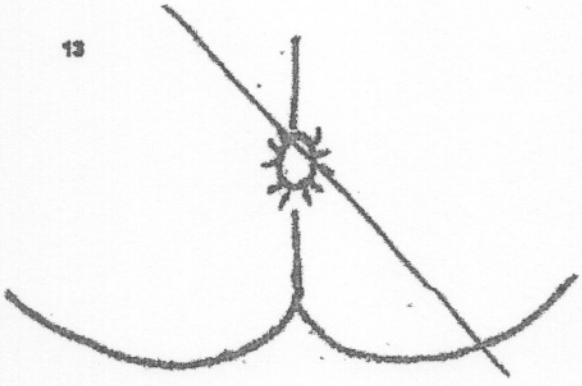
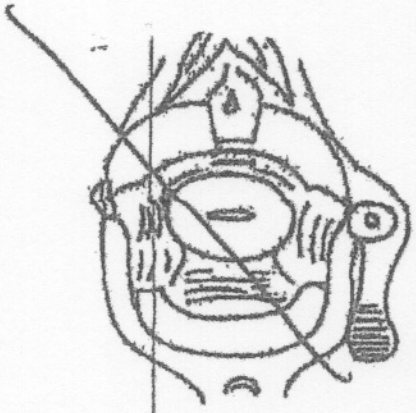


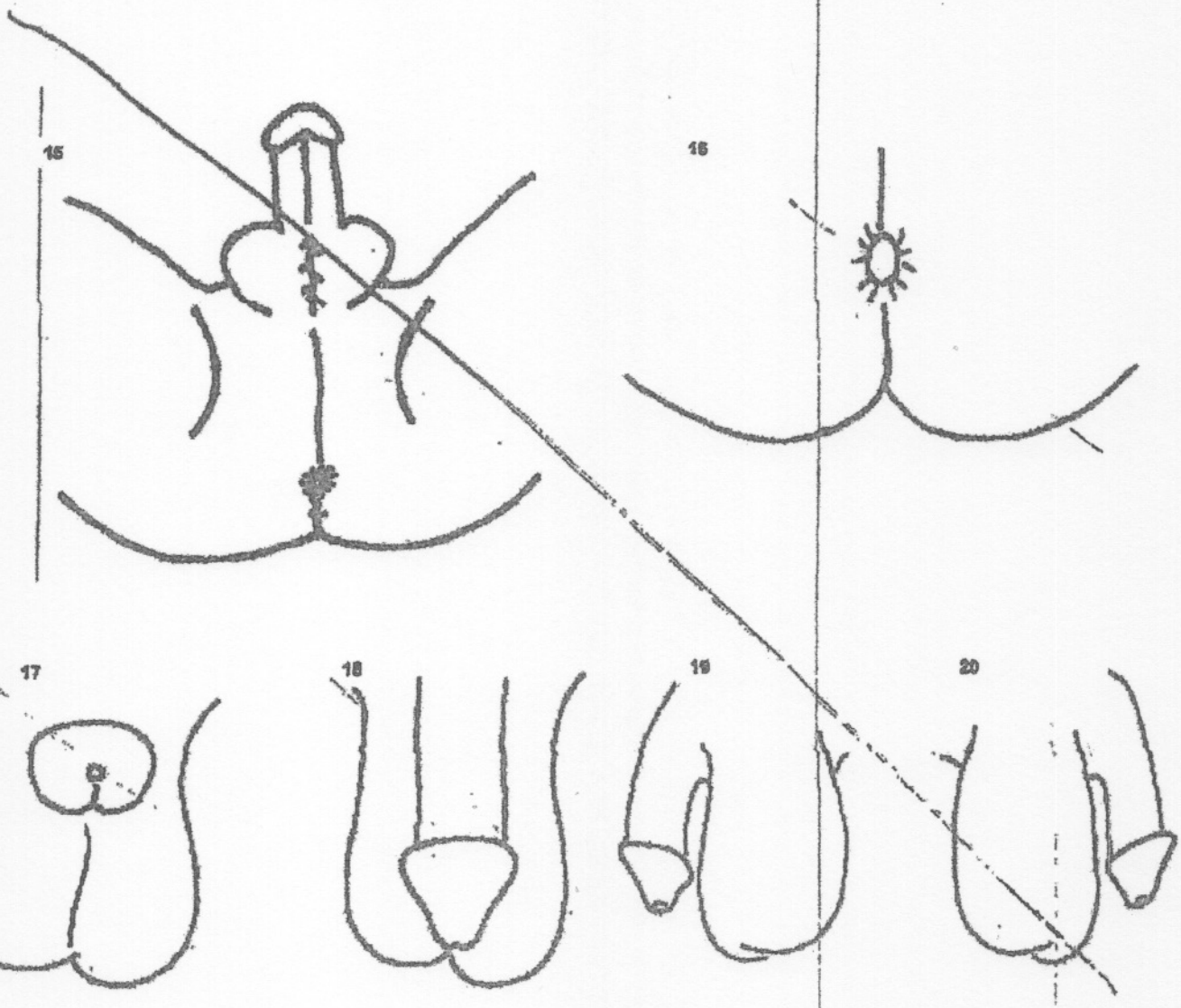


Patient Name: _____

L. Detailed Anogenital Examination Male Patient: ☒ N/A ☐ Circumcised ☐ Uncircumcised

No Trauma	Anogenital Structure	Trauma Identified (describe and document on body map)
	Anus	
	Rectum	
	Glans Penis	
	Periurethral area	
	Penis (shaft)	
	Scrotum	

Please diagram, measure, and describe areas of patient trauma, pain, alternate light source findings, and Toluidine Blue positive areas (if used) on the maps below.



Patient Name: _____

M. Diagnostic/Treatment(s) Provided and/or Recommended:

Diagnosis: Medical forensic evaluation for sexual assault/abuse Other: _____

Pregnancy Test: ☐ [illegible] ☐ Not indicated

Other diagnostics, describe:

Analgesia / Other	Time/Dose	Response to treatment
Ibuprofen, PO		
Acetaminophen, PO		
Anti-emetics:		
Tetanus:		
Other:		

Emergency Contraception	Time/Dose	Comments
Not indicated		
Declined		
Levonorgestrel PO 1.5 mg (Plan B/Next Choice, etc.)		
Other:		

STI Prophylaxis	Time/Dose		
Ceftriaxone (Rocephin) 250 mg, IM			
Metronidazole (Flagyl) 2 gm, PO			
Azithromycin (Zithromax) 1 gm, PO			
Cefixime (Suprax) 400 mg, PO			
Doxycycline 100 mg, BID x 7 days			
Other:			
Other:			

Other treatments discussed or recommended during emergency evaluation:

Medical follow-up referral information discussed with and given to patient: ☐No ☐Yes

Applicable aftercare, resources and referrals discussed with and given to patient: ☐No ☐Yes

Discharge safety discussed with patient: ☐No ☐Yes

Patient Name: _____ /Case Number: _____

N. Evidence collection kit used: ☒ Yes ☐ No Comments: _____

FORENSIC SPECIMEN COLLECTION

Forensic Specimen or Items and PLACED in the Kit

Patient Reference Samples:	Trace Evidence/Envelopes:	Swabs/Envelopes:	Smears:	Bag/Additional:
☒ Reference head hair	☒ Combed head hair	☒ Oral (2)	☒ Oral	☒ Undergarment
☐ Reference pubic hair	☐ Combed pubic hair	☒ Anal/Perianal (2)	☒ Anal/ Perianal	☐ Tampon
☒ Buccal swabs	☐ Other: _____	☒ Vulvar/Penile (2)	☒ Vaginal	☐ Sanitary Item
	☐ Other: _____	☒ Vaginal/Cervical (2)	☐ Penile	☐ Diaper
		☐		☐ Condom
				☐ Other: _____

☐ Body/fingernail/misc. _____

Photograph(s) taken ☐ Yes ☒ No

Type: ☐ Digital ☐ Colposcopic Digital

Location(s): ☐ Body ☐ Anogenital ☐ Oral

☐ Other: _____

☐ Other: _____

Other Forensic Specimens or Items collected that were NOT PLACED in the Kit: ☒ Yes ☐ No

☒ Toxicology (blood) ☒ Toxicology (urine)

☐ Paper Bags (number): _____ ☐ Other: _____

List Clothing or Miscellaneous Items (one article per paper bag):

Item	Description/Condition

CHAIN OF CUSTODY INITIATED

Items released to: _____ Date/Time: _____

Items released by: _____

INVESTIGATING AGENCY INFORMATION

Law Enforcement Contacted: ☐ Yes

Complaint # (if any): _____

Law Enforcement Agent: _____

Officer Name: _____

Children/Adult Protective Services Report: ☐ NA ☐ Yes ☐ No

Agency/Worker: _____

MEDICAL EXAMINER INFORMATION

Examining Agency: _____

Printed

Examiner

Signature of Other Medical Forensic Examiner (if applicable)

Date

Printed Name of Medical Forensic Examiner

White—Medical Records Yellow—Piece in Kit Pink—Law Enforcement

VOLUNTARY RELEASE OF EVIDENCE, IN [illegible] ITEMS

This IS NOT a consent for examination or treatment.

Patient Authorization to Release Information/Evidence

Information about Release for Patients (Health provider review with patient)

- I understand that I do not have to sign this release.
- I understand I may inspect or receive a copy of any records used and/or disclosed under this authorization.
- I understand I have the right to revoke this authorization at any time, provided I do so in writing. However, once evidence kit and records have been released by the healthcare facility, I understand the facility can no longer get them back.
- I understand if I decline to release this information, my health care provider will keep the information confidential. I understand this information could be released to the police and prosecutor without my permission if my health care provider is required by law to do so.
- I understand the law enforcement agency, prosecuting attorney, and state police crime lab receiving information and items approved below are not health care providers covered by federal health privacy regulations. I understand these organizations may disclose this information to additional parties if allowed by law.

Patient Release

I, _____, authorize
(Name of Patient)

to use, disclose, and release the following items noted below with my initials for the purposes of criminal investigation and to assist in the prosecution of the person or persons responsible for the crime.

I authorize the release of the following information and items: (patient initial each)

_____ Sexual assault evidence kit contents and included record
_____ Clothing
_____ Photographs
_____ Urine and/or blood for toxicology
_____ Other _____

Recipients of my health and medical information and items:

- Michigan State Police Forensic Laboratories
- Law Enforcement Agency (name agency): _____
- Prosecuting Attorney Office for County of _____

Expiration of Authorization: This authorization expires upon final adjudication of the criminal matter, provided it has not been revoked.

Authorizing Signature: I authorize the use, disclosure, and release of the items stated in this authorization.

Patient Signature _____

Parent/Guardian Signature *(if required)* _____

Relationship _____

Witness Signature _____ Date of Signatures _____