Read through the instructions/Checklist before proceeding with exam.

REGARDLESS OF WHEN THE LAST ASSAULT/ABUSE TOOK PLACE, FOLLOW STEPS 1-12.

1. Obtain victim or parent’s signature on evidence collection consent form if possible. However, in any case of suspected child abuse, consent is not required for examination by a physician including taking photographs. Lack of signed consent should not delay examination of the patient (See Texas Family Code, Chapter 32, Subchapter A).

2. Complete history and physical examination and record on enclosed form. Initial each page.

3. Obtain throat, vaginal (children) or cervical (adults) or urethral (males), and anal cultures for gonorrhea. Do not use wooden swabs. Consider type of act, chronicity of abuse, exam findings, and time lapse in selecting which orifice to culture.

4. Obtain vaginal (children) or cervical (adults) or urethral (males), and anal cultures for Chlamydia. Use dacron or small cotton swabs. Consider type of act, chronicity of abuse, exam findings, and time lapse in selecting which orifice to culture.

5. If indicated, obtain photographs with colposcope or camera.

6. Be sure all specimens are labeled with patient’s name, specimen source, and date.

7. Obtain 3 ml blood (children optional) or 5 ml (adults) for RPR, as indicated.

8. Obtain 3 ml blood (children) or 5 ml (adults) for HIV as indicated; consider simultaneous testing for Hepatitis titers.

9. Test for pregnancy as indicated.

10. Consider the following if symptoms/signs warrant testing: urinalysis, urine culture, wet mount, KOH prep.


12. Refer for counseling as needed.

NOTE: WHEN THE LAST INCIDENT OCCURRED WITHIN 72 HOURS:

13. In addition to steps 1-12 above, complete the “Sexual Assault Evidence Collection Kit,” according to kit’s enclosed instructions.

Assistant’s Name (Please Print)                          Examiner’s Name (Please Print)

Assistant’s Signature  Date                          Examiner’s Signature  Date
I. GENERAL INFORMATION (Print or Type)

<p>| | | | | | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>1. Name of Patient</td>
<td></td>
<td>Patient I.D. #</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Address</td>
<td>City</td>
<td>County</td>
<td>State</td>
<td>Phone</td>
<td></td>
</tr>
<tr>
<td>3. Age</td>
<td>DOB</td>
<td>Sex</td>
<td>Race</td>
<td>Date/Time of Arrival</td>
<td>Date/Time of Exam</td>
</tr>
<tr>
<td>4. Name of ( ) Mother</td>
<td>( ) Stepmother</td>
<td>( ) Guardian</td>
<td>Address</td>
<td>City</td>
<td>County</td>
</tr>
<tr>
<td></td>
<td>Work Phone</td>
<td>Home Phone</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>5. Name of ( ) Father</td>
<td>( ) Stepfather</td>
<td>( ) Guardian</td>
<td>Address</td>
<td>City</td>
<td>County</td>
</tr>
<tr>
<td></td>
<td>Work Phone</td>
<td>Home Phone</td>
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<td></td>
<td></td>
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<tr>
<td>6. Siblings: Name</td>
<td>DOB</td>
<td>Name</td>
<td>DOB</td>
<td>Name</td>
<td>DOB</td>
</tr>
<tr>
<td>7. Phone report made to</td>
<td>( ) Law Enforcement Agency</td>
<td>Name</td>
<td>Agency</td>
<td>I.D. #</td>
<td>Phone</td>
</tr>
<tr>
<td></td>
<td>( ) Child Protective Services</td>
<td>Name</td>
<td>Agency</td>
<td>I.D. #</td>
<td>Phone</td>
</tr>
<tr>
<td>8. Responding Officer:</td>
<td>Agency</td>
<td>I.D. #</td>
<td>Phone</td>
<td></td>
<td></td>
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<tr>
<td>9. Police Case Number:</td>
<td></td>
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</table>

10. Place of exam:  
- [ ] Clinic  
- [ ] Emergency Center  
- [ ] Inpatient  
- [ ] Other  

11. Referring Agency:  
- [ ] Child Protective Services  
- [ ] Police  
- [ ] Parent  
- [ ] Other  
- [ ] None  

____________________________________________  
Signature  Date
II. AUTHORIZATION

I hereby authorize ____________________________ to perform a medical examination for evidence of physical and/or sexual abuse and request medical treatment if indicated. I understand this may include the following:

1. Medical examination of the genital area, which may include pelvic (internal) examination on post pubertal females.
2. Collection of blood, urine, tissues and related specimens as needed.
3. Photographs which may include the genital area for the purpose of documentation.

I further understand the physicians and staff are required by law to notify child protection authorities of known or suspected child abuse. All medical reports, including laboratory reports, photographs and forensic results may be released to Child Protective Services and/or the police department and the District Attorney having jurisdiction, or as otherwise allowed by law.

Patient/Parent/Guardian (Circle one) Date Witness

III. MEDICAL HISTORY

1. Usual Health Provider: ____________________________

2. Hospitalization/Surg/Trauma: ____________________________

3. Past Health Problems: ____________________________

4. Medicines: ____________________________

5. Allergies: ____________________________

6. Behavior/Emotional Symptoms (If “YES”, indicate duration and other details):

   Sleep disturbances  YES  NO  UNK  ____________________________
   Eating problems  YES  NO  UNK  ____________________________
   School problems  YES  NO  UNK  ____________________________
   Sexual acting out  YES  NO  UNK  ____________________________
   Fear  YES  NO  UNK  ____________________________
   Anger  YES  NO  UNK  ____________________________
   Signs of depression  YES  NO  UNK  ____________________________
   Suicide  YES  NO  UNK  ____________________________
   Runaway  YES  NO  UNK  ____________________________
   Other symptoms  YES  NO  UNK  ____________________________

Signature Date
7. Physical Symptoms/History (If “YES”, indicate duration and other details):

<table>
<thead>
<tr>
<th>Symptom</th>
<th>YES</th>
<th>NO</th>
<th>UNK</th>
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</thead>
<tbody>
<tr>
<td>Abdominal/pelvic pain</td>
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<tr>
<td>Vomiting</td>
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<tr>
<td>Genital discomfort or pain</td>
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<tr>
<td>Dysuria</td>
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<tr>
<td>Urinary tract infection</td>
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<td>Enuresis</td>
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<tr>
<td>Encopresis</td>
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<td></td>
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<tr>
<td>Vaginal itching/Penile irritation</td>
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<td></td>
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<tr>
<td>Vaginal discharge/Penile discharge</td>
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<tr>
<td>Vaginal bleeding/Penile bleeding</td>
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<tr>
<td>Rectal pain</td>
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<tr>
<td>Rectal bleeding</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Constipation</td>
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<td></td>
<td></td>
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<tr>
<td>Diarrhea</td>
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</tbody>
</table>

8. Sexual History

- Hx of voluntary sexual intercourse? YES NO
- Use of contraception? YES NO
- Hx of prior STD? YES NO
- History of prior abuse? YES NO

If yes, describe: ________________________________________________________________

Female
- Menarche? YES NO
- Age:______ Date LMP:______
- Was last menses normal in flow/duration? YES NO
- Use of tampons? YES NO
- Hx pregnancy(s)? YES NO

IV. HISTORY OF ASSAULT/ABUSE

1. Include any statements made by child to you (use quotes when possible) and pertinent information from other sources (identify source). Attach additional sheets as necessary.
2. Did abuse cause: Bleeding? YES NO UNK  
Pain? YES NO UNK

3. Number of assailant(s): _____

4. Assailant relationship to victim:  
   □ Stranger  □ Relative  □ Acquaintance  □ Other:_________________

5. Did victim injure assailant?  YES NO UNK  Specify:_________________

6. Estimated time since last incident:_________________

7. History of ejaculate? (Circle one) YES PROBABLE/POSSIBLE NO UNK  Site(s):_________

8. Condom used? (Circle one) YES NO UNK

9. Lubricant used?  YES NO UNK

10. Since the assault, has the patient: (If the assault was > 72 hours ago, □ N/A)  
    Wiped/washed off YES NO UNK  
    Bathed/showered YES NO UNK  
    Urinated YES NO UNK  
    Defecated YES NO UNK  
    Rinsed mouth/brushed teeth YES NO UNK  
    Eaten/drank YES NO UNK  
    Changed clothes YES NO UNK  
    Douched YES NO UNK

11. What did the activity involve?  

   Type of Contact  (Check all that apply)

   Perpetrator     Child

   □ genital       oral
   □ oral          genital
   □ oral          oral
   □ genital       genital
   □ genital       anal
   □ anal          genital
   □ digital       genital
   □ digital       anal
   □ genital       digital
   □ hand          genital
   □ genital       hand

   If foreign object was used, describe:_________________________________________________________________

_________________________                  ____________________
Signature                     Date
V. PHYSICAL EXAM

1. Note any concerns regarding the behavior of the child:
   - □ Fixed, frozen stare or overall lack of responsiveness to people or environment
   - □ Child actively withdraws from any physical contact with adults
   - □ Child did not try to avoid medical procedures or examination/lay very still without protesting
   - □ Child demonstrated excessive activity level for his/her age
   - □ Child demonstrated very aggressive behavior (describe):__________________________________________
   - □ Other (explain):________________________________________________________________________
   - □ Not applicable (no concerns)

   Child was:  □ fully  □ partially  □ not cooperative

2. Vital signs
   - Pulse:  ______  Temperature:  ______  Respirations:  ______  Blood Pressure:  ______

3. Height:____  Weight:____ (Include percentiles of children under age six)

4. Emotional Demeanor (crying, angry, lethargic, normal depressed, shocked, etc.)___________
   ______________________________________________________________________________________

5. General Exam

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<tbody>
<tr>
<td>NL</td>
<td>ABL</td>
<td>COMMENTS</td>
</tr>
<tr>
<td>-----------------------------</td>
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<tr>
<td>HEENT</td>
<td></td>
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<tr>
<td>Lungs</td>
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<td>CV</td>
<td></td>
<td></td>
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<tr>
<td>Abdomen</td>
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<tr>
<td>Neurologic</td>
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</tbody>
</table>

6. Indicate and describe any areas of trauma on bodily surfaces/excepting genitalia (including bitemarks).
7. Sexual Maturity

Tanner Staging

<table>
<thead>
<tr>
<th>Breast</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genitals</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

8. Genital Exam

Exam positions used: □ Supine □ Knee-chest □ Lateral □ Other: _______________________

Speculum used? YES NO

FEMALE: Note any signs of acute and nonacute trauma (lacerations, petechial hemorrhages, partial or complete clefts, attenuation, scars, etc.). Include any other abnormalities which may or may not be related to sexual abuse (erythema, labial adhesions, neovascularization; rashes, discharge, etc.)

LABEL ABNORMALITIES:

VULVA: ________________________

VESTIBULE: ________________________

VAGINA: ________________________

CERVIX: ________________________

UTERUS: ________________________

ADNEXA: ________________________

HYMEN: ________________________

RECTUM: ________________________

ANUS: ________________________
7. Sexual Maturity

<table>
<thead>
<tr>
<th>Tanner Staging</th>
<th>Genitals</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>

8. Genital Exam

Exam positions used:  
- [ ] Supine  
- [ ] Knee-chest  
- [ ] Lateral  
- [ ] Other: ______________________

MALE: Note any signs of acute and nonacute trauma (bruises, lacerations, swelling, bitemarks, scarring, change in Sphincter tone). Include any other abnormalities which may or may not be attributable to sexual abuse (discharge, rash, skin tags, smooth areas on anus).

LABEL ABNORMALITIES:

- **PENIS:** ______________________
- **SCROTUM:** ______________________
- **MEATUS:** ______________________
- **TESTICLES:** ______________________
- **PERINEUM:** ______________________
- **RECTUM:** ______________________
- **ANUS:** ______________________

_______________________________________________

Signature       Date
VI. DIAGNOSTIC IMPRESSIONS

(Check any that apply)

- 1. NORMAL EXAMINATION
  - Consistent with type(s) of sexual acts described
  - Consistent with time lapse since last incident of abuse
  - Seen in non-abused children, but does not rule out sexual or physical abuse

- 2. ABNORMAL EXAMINATION
  - Consistent with type(s) of sexual acts described
  - Consistent with time lapse since last incident of abuse
  - Inconsistent with type of acts described; suggests more penetrating acts of trauma
  - Could be consistent with sexual or physical abuse, but also seen in non-abused children
  - Consistent with a separate diagnosis (may coincide with findings of abuse).
    Specify (lichen sclerosis, pinworms, candida infections, normal hymenal variations, etc.)

VII. TREATMENT PLAN (in addition to any item on page 1 of 8):

______________________________________________________________

Signature                          Date