



South Carolina Law Enforcement Division Sexual Assault Examination Protocol

Patient Information:

Name of Hospital: _____ Date: _____ Time admitted: _____

Patient Name: _____ Ethnicity: _____

Date of Birth: _____ Age: _____ Gender: M F Marital Status: _____

Parent or Guardian: _____ N/A

Law Enforcement:

Agency _____ Case Number: _____

Anonymous Collection Requested: Yes No

Reporting Officer: _____ Time: _____

Investigator: _____ Time: _____

Advocacy: (if indicated)

Rape Crisis Advocate: _____ Time Notified: _____ Time of Arrival: _____

Other: _____ Time Notified: _____ Time of Arrival: _____

Interpreter: _____ N/A

Persons present during collection of history:

Advocate Family Law Enforcement Other: _____

Persons present during medical exam:

Advocate Family Other: _____

Pertinent Medical History:

LMP Date: _____ Normal? No Yes G _____ P _____

Are there any recent (60 days) anal-genital injuries, surgeries, diagnostic procedures or medical treatment that may affect the interpretation of current physical findings? Yes No

Describe: _____

Are there any other pertinent medical conditions or injuries that may affect the interpretation of current physical findings? No Yes

Describe: _____

Current medications: _____ None



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Patient name: _____

Medical History (cont.):

Pre and post assault related history:

- Consensual intercourse within last 7 days? No Yes Date: _____
 - Oral No Yes
 - Vaginal No Yes
 - Anal No Yes
- If yes, was a condom used? No Yes
- Other contraception used? No Yes Describe: _____

Medications, Social Drugs or Alcohol:

Did patient ingest alcohol or drugs? No Yes Unsure

If yes: Voluntary Forced Coerced Suspected

If yes: Alcohol Drugs Date: _____ Time: _____

Describe: _____

Any voluntary use of alcohol prior to assault? No Yes

Any voluntary use of drugs 96 hours prior to assault? No Yes

Any voluntary use of alcohol or drugs between time of assault and forensic exam? No Yes

Post assault hygiene/ activity:

	No	Yes	Describe:
Urinated	<input type="checkbox"/>	<input type="checkbox"/>	_____
Defecated	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genital or body wipes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Douched	<input type="checkbox"/>	<input type="checkbox"/>	_____
Removed tampon/diaphragm	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brushed teeth	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mouthwash	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bath/shower/wash	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ate or drank	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vomited	<input type="checkbox"/>	<input type="checkbox"/>	_____
Changed	<input type="checkbox"/>	<input type="checkbox"/>	_____
Smoked	<input type="checkbox"/>	<input type="checkbox"/>	_____

Assault History:

Date of assault: _____ Time of assault: _____

Location of assault: _____

Were there any witnesses to the assault? No Yes - identify: _____



Patient name: _____

Is assailant known to:

- Have an STI? No Yes Unsure If yes, describe: _____
- Have had a vasectomy? No Yes Unsure
- Have used alcohol or drugs? No Yes Unsure
 - If yes: Alcohol Drugs Describe: _____

Description of contact between victim and assailant:

Penetration of vagina by:	No	Yes	Attempted	Unsure	Describe
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"/>	_____

Penetration of anus by:	No	Yes	Attempted	Unsure	Describe
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"/>	_____

Oral copulation of genitals:	No	Yes	Attempted	Unsure	Describe
Of patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Of assailant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Non-genital acts:	No	Yes	Attempted	Unsure	Describe
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"/>	_____
Fondling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Other acts:	No	Yes	Attempted	Unsure	Describe
Masturbation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Photographs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____



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Contraception or lubricant used:	No	Yes	Attempted	Unsure	Describe
Foam used	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Jelly used	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lubricant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Condom used	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Ejaculation occurred in or on the following:	No	Yes	Attempted	Unsure	Describe
Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vagina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Clothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bedding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

General Physical Examination:

Describe general physical appearance: _____

Describe general demeanor: Quiet Anxious
 Tearful Angry
 Trembling Controlled
 Sobbing Tense

Responds to questions: Briefly Reluctantly Readily

Eye contact: Good Poor

Describe demeanor: _____

Is patient complaining of non-genital injury, pain and/or bleeding? No Yes

If yes, describe: _____

Is patient complaining of anal-genital injury, pain and/or bleeding? No Yes

If yes, describe: _____



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Genital Examination - Female:

- Exam position used: Supine Lithotomy Lateral Knee-chest
- Exam methods for genital examination: Water lubricated speculum
 Foley catheter
 Toluidine Blue Dye
 Colposcope
- UV light (Woods light): Positive Negative N/A **indicate location on diagram on page 7*

Genital Examination - Male:

- Circumcised? Yes No
- Exam position used: Supine Lithotomy Lateral Other (describe) _____
- Exam methods for genital examination: Toluidine Blue Dye Colposcope UV light

Strangulation Assessment*: NA **Note patient history*

- Object used on neck: One hand Two hands Forearm Other _____
- Location of assailant: In front of victim Behind victim
- How long was the patient strangled? _____ How many times? _____
- Any loss of consciousness? Yes No • Incontinence? Yes No
- Throat hoarseness? Yes No
- Voice at time of exam _____

Drug Facilitated Sexual Assault Assessment*: NA **Note patient history*

- Orientation: Oriented x 3 Disoriented; Describe: _____
- Ability to recall events: Well No memory Lapses of memory
- Patient Statement: _____
- Patient's speech: Clear Garbled Slow
- Patient's gait: Steady Unsteady; Describe: _____
- History of nausea: Yes No Vomiting: Yes No How many times? _____
- Other concerning symptoms or assessments: _____

Lab tests performed:

Pregnancy Positive Negative N/A

Wet prep/KOH prep

Chlamydia NAAT - site: _____

Urinalysis

Trichomoniasis NAAT - site: _____

Other _____

Gonorrhea NAAT – site: _____

RPR, syphilis

HIV

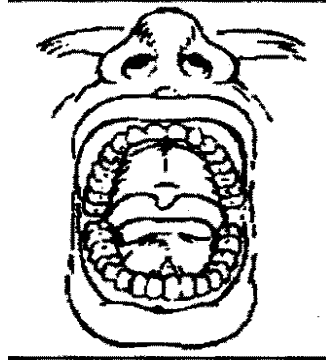
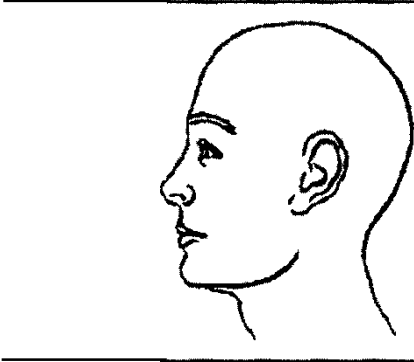
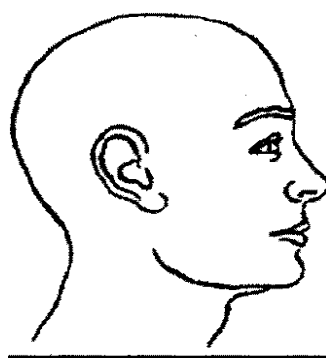
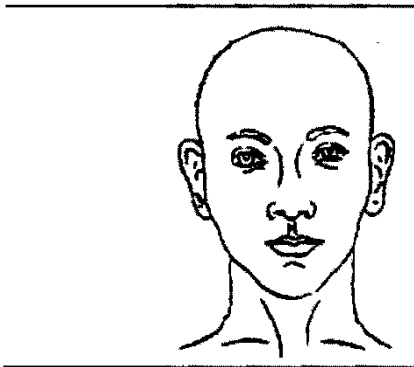
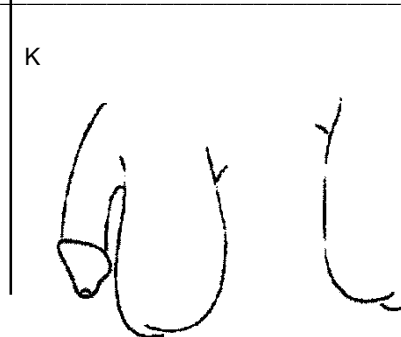
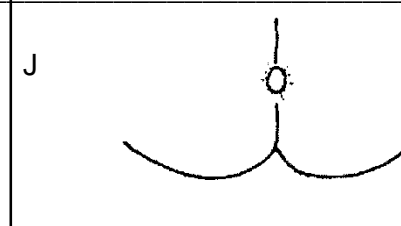
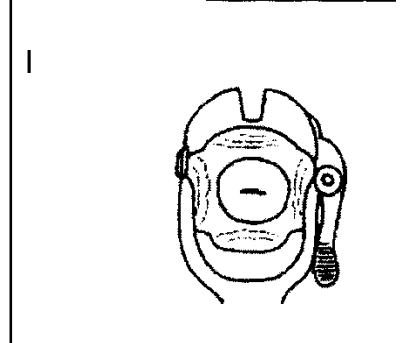
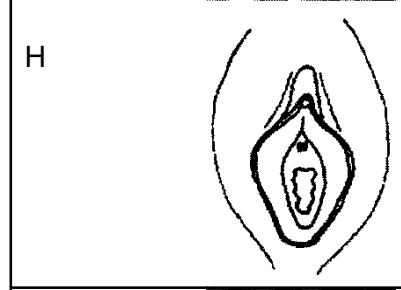
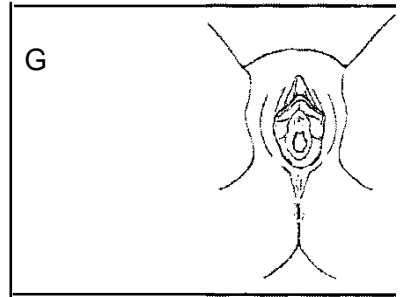
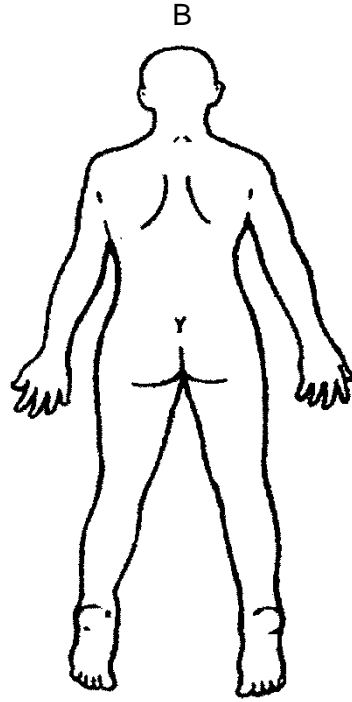
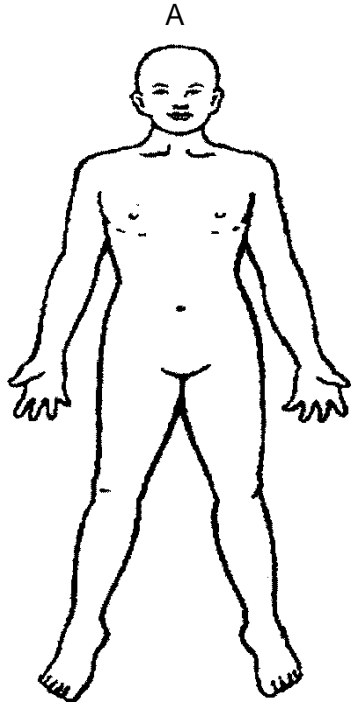
Radiological studies: _____

Consult: _____

Surgical procedure required: No Yes, describe _____



Patient name: _____



Location #	Description	Location #	Description



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Evidence Collected:

Clothing collected – describe below N/A Changed Clothes Bathed

- Shirt _____
- Pants _____
- Underwear/Panties _____
- Bra _____
- Jacket _____
- Belt _____
- Shoes _____
- Other _____
- Debris sheet (from kit) _____

DNA Evidence Collected:

	No	Yes	Describe
Miscellaneous Collection	<input type="checkbox"/>	<input type="checkbox"/>	_____
Suspected Saliva (Lick/Kiss/Suck/Bite Marks)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oral swabs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fingernail scrapings/cuttings	<input type="checkbox"/>	<input type="checkbox"/>	_____
Known DNA buccal swab (<i>required</i>)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Combed pubic hairs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vaginal swabs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rectal swabs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Suspected body fluid	<input type="checkbox"/>	<input type="checkbox"/>	_____

Toxicology Evidence Collected:

Blood/gray top tube	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vomit	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

Photographs Number of photographs taken _____

Medications administered:

- Gonorrhea prophylaxis: _____ N/A Chlamydia prophylaxis: _____ N/A
- Pregnancy prevention: _____ N/A Tetanus toxoid: _____ N/A
- Other: _____ Trichomonas prophylaxis: _____ N/A

Discharge Information:

Time: _____ Discharged to: _____

Accompanied by: _____

Admitted to hospital: No Yes Room Number: _____ Admitting MD: _____

Consults: N/A Yes _____

Follow-up:

Medical: _____ Date: _____

Counselor: _____ Date: _____

Signature of Examiner: _____ Are you a SANE? yes no

Signature of Officer Receiving Evidence: _____ Date: _____ Time: _____

Name of Officer: _____ / _____ Agency: _____

(PRINTED)

(SIGNATURE)