



# 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: \_\_\_\_\_



Sexual Assault Examination Protocol

Patient's description of assault:

Patient name: \_\_\_\_\_

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Assailant Name(s) (if known)	Age	Gender	Ethnicity	Relationship

Method(s) employed by assailant(s):	No	Yes	If yes, describe:
Weapons	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Threatened	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Injuries inflicted	<input type="checkbox"/>	<input type="checkbox"/>	_____
• Types of weapons	<input type="checkbox"/>	<input type="checkbox"/>	_____
Physical blows	<input type="checkbox"/>	<input type="checkbox"/>	_____
Grabbing/holding/pinching	<input type="checkbox"/>	<input type="checkbox"/>	_____
Physical restraints	<input type="checkbox"/>	<input type="checkbox"/>	_____
Strangulation	<input type="checkbox"/>	<input type="checkbox"/>	_____
Burns	<input type="checkbox"/>	<input type="checkbox"/>	_____
Verbal threats of harm	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other methods	<input type="checkbox"/>	<input type="checkbox"/>	_____

Were any injuries inflicted upon the assailant during the assault?  No  Yes

If yes, describe: \_\_\_\_\_

If yes: Time: \_\_\_\_\_ Date: \_\_\_\_\_



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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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Patient name: \_\_\_\_\_

**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\*:**  N/A *\*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  Gonorrhea NAAT – site: \_\_\_\_\_
- Chlamydia NAAT- site: \_\_\_\_\_  RPR, syphilis
- Urinalysis  HIV
- Trichomoniasis NAAT - site: \_\_\_\_\_
- Other \_\_\_\_\_

Radiological studies: \_\_\_\_\_

Consult: \_\_\_\_\_

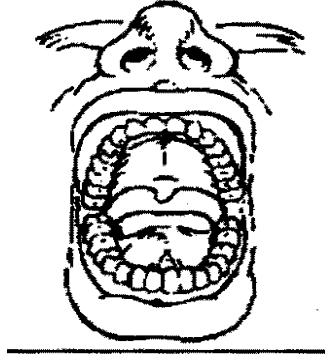
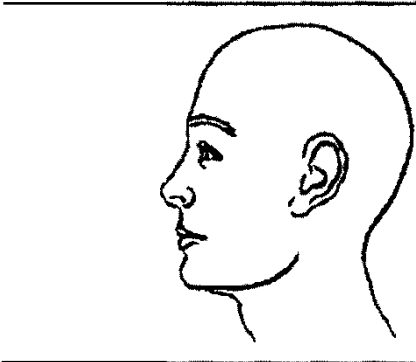
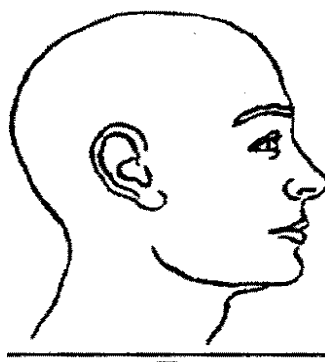
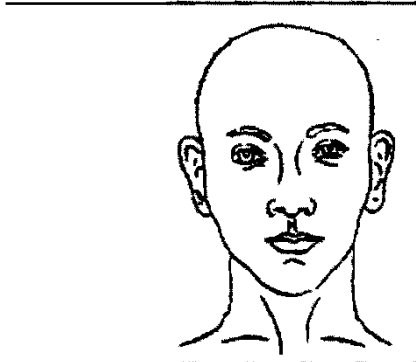
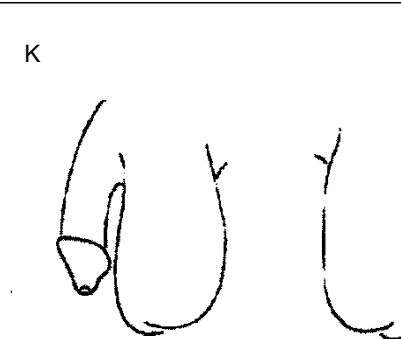
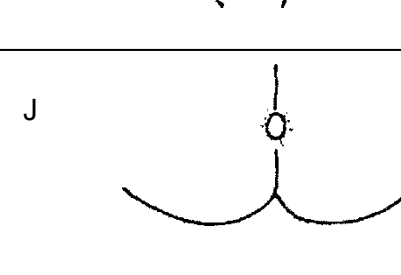
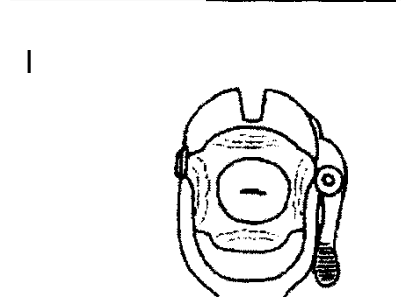
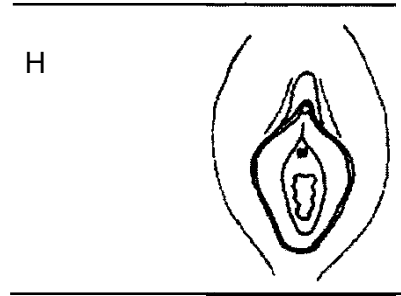
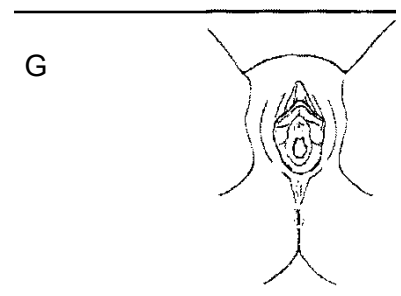
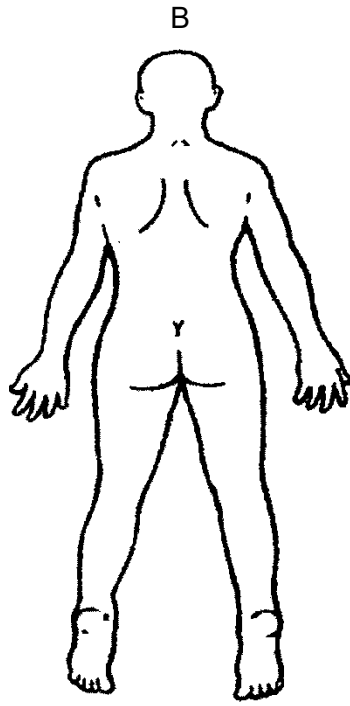
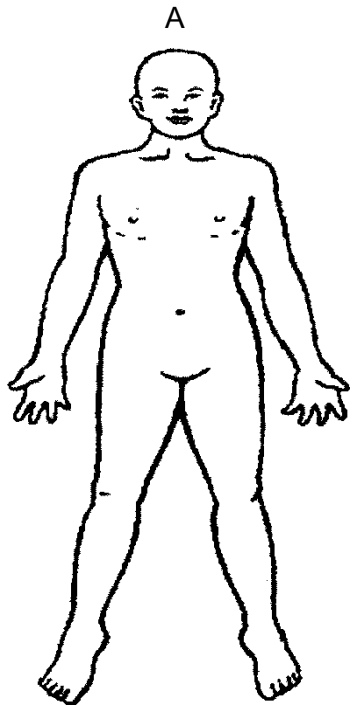
Surgical procedure required:  No  Yes, describe \_\_\_\_\_



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Sexual Assault Examination Protocol

Patient name: \_\_\_\_\_



Location #	Description	Location #	Description



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Patient name: \_\_\_\_\_

**Evidence Collected:**

**Clothing collected** – describe below  N/A  Changed Clothes  Bathed

- Shirt \_\_\_\_\_
- Pants \_\_\_\_\_
- Underwear/Panties \_\_\_\_\_
- Bra \_\_\_\_\_
- Jacket \_\_\_\_\_
- Belt \_\_\_\_\_
- Shoes \_\_\_\_\_
- Other \_\_\_\_\_
- Debris Collection (from kit) \_\_\_\_\_

**DNA Evidence Collected:**

	No	Yes	Describe
Miscellaneous Materials	<input type="checkbox"/>	<input type="checkbox"/>	_____
Suspected Saliva (Lick/Kiss/Bite Marks)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oral Swabs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fingernail Swabs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Known DNA Standard - Buccal ( <i>required</i> )	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pubic Hair Combings	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vaginal/Penile 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  No  Yes \_\_\_\_\_
- Urine  No  Yes \_\_\_\_\_
- Vomit  No  Yes \_\_\_\_\_
- Other  No  Yes \_\_\_\_\_

Photographs  No  Yes 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: \_\_\_\_\_  
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