

AUTHORIZATION FOR MEDICAL FORENSIC ASSESSMENT, TREATMENT, COLLECTION OF EVIDENCE, AND RELEASE OF MEDICAL RECORDS

I hereby authorize _____ (Examiner),
a representative of _____ (Facility) to perform a medical forensic
assessment (may include assessing my body), provide treatment (may include medications to prevent pregnancy and
infection), and collect forensic evidence (may include taking photographs, swabbing skin for DNA, and asking questions
about what occurred). _____(Initial)

_____ (Initial) I understand that I may pause or stop the examination at any time.

_____ (Initial) I permit do not permit photographic or digital image or video documentation.

_____ (Initial) I permit do not permit the use of the photographs, digital images or videos to be
utilized for teaching or educational purposes. The photographs,
digital images or videos would not have any identifying
information.

_____ (Initial) I permit do not permit release of copies of the complete medical forensic report to the
investigating law enforcement agency who has jurisdiction.

_____ (Initial) I understand that I may decline to have photographs taken and still receive medical care.

I release _____ (Facility)
and its representative from legal responsibility or liability for the release of this information.

Signature of Patient (Parent or Guardian)

Name of Patient (Parent or Guardian)

Signature of Witness

Name of Witness

Date

Time

Track-Kit bar code

PATIENT LABEL OR
PATIENT'S NAME: _____
MRN #: _____

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Examiner's Initials: _____

MEDICAL FORENSIC ASSESSMENT REPORT

PATIENT'S DEMOGRAPHICS

Legal name: _____ Preferred name: _____

DOB: _____ Race: _____ Medical record number: _____

Address: _____ Phone: _____

Patient brought in by (name): _____ Relationship/Agency: _____

Advocate Present Name/Agency _____

Interpreter Use Name/Agency _____

LAW ENFORCEMENT

Report

Law Enforcement Agency _____ Case Number: _____

Non-Report (Only for patients who do not meet mandatory reporting requirements in Texas)

Non-Report Unique Identifier: _____

SIGNIFICANT FORENSIC AND MEDICAL HISTORY

Vital signs: Time: _____ Temp: _____ Pulse: _____ Resp: _____ BP: _____ O₂ sat: _____

Repeat vital signs: Time: _____ Temp: _____ Pulse: _____ Resp: _____ BP: _____ O₂ sat: _____

Allergies: _____

Current Medications: _____

Last menstrual period: _____ Current contraceptives used: _____

Past surgical procedures: _____

Past medical history (include vaginal deliveries, episiotomies, straddle injuries): _____

GENERAL APPEARANCE/BEHAVIORS

Objective description of patient's appearance, behaviors and mannerisms: _____

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Examiner's Initials: _____

PATIENT LABEL OR PATIENT'S NAME: _____ MRN #: _____

MEDICAL FORENSIC ASSESSMENT REPORT

HISTORY OF ASSAULT(S): Patient's description of assault(s) including contact or penetration.

To assist with assessing ongoing safety of the patient and others, include history of violence, consensual partner same as assailant, weapon used or present during assault, and, or verbal threats made by perpetrator.

Date of Assault(s): _____

Time of Assault (or range of times of assaults): _____

Number of Reported Perpetrators: _____ Unknown

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Examiner's Initials: _____

PATIENT LABEL OR PATIENT'S NAME: _____ MRN #: _____

MEDICAL FORENSIC ASSESSMENT REPORT

PRIOR TO EVIDENCE COLLECTION, patient has:

- Bathed _____ Showered _____ Wiped/washed _____
- Urinated _____ Defecated _____ Vomited _____
- Changed underwear _____ Changed clothes _____ Had food or drink _____
- Brushed teeth/used mouthwash _____ Smoked/vaped _____
- Swam _____ Other: _____ None of the above _____

AT TIME OF ASSAULT(S), was:

- Lubricant used during assault(s)? Yes No Unknown
- What kind? Patient's saliva Reported perpetrator's saliva
- Other: _____

Condom used during assault(s)? Yes No Unknown Not applicable (NA)

Tampon present during assault? Yes No Unknown NA

Patient menstruating? Yes No Unknown NA

Reported perpetrator menstruating? Yes No Unknown NA

Reported perpetrator injured in any way? Yes No Unknown NA

If known, where? _____

Was there penetration? Oral Genitalia Anus Unknown

Other (specify): _____

Was there ejaculation? Oral Genitalia Anus Unknown

Other (specify): _____

Did you experience any bleeding? Yes No During After At present

AT TIME OF ASSESSMENT, was:

Tampon present? Yes No

Menstruation? Yes No

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MEDICAL FORENSIC ASSESSMENT REPORT

BODY SURFACE ASSESSMENT

Include details of injury.

- No acute injury noted
 See body diagram
 Alternate light source used
-
-
-

ANOGENITAL ASSESSMENT

Include details of injury. No acute injury noted See anogenital diagram

- Colposcope used Other form of magnification: _____

- Toluidine blue dye used
 Speculum used
 Foley catheter used
 Gyne swab used

Sexual Maturation Rating (Tanner Stage): Breast: NA 1 2 3 4 5

Genitalia: 1 2 3 4 5

NA Not visualized Labia majora: _____

NA Not visualized Labia minora: _____

NA Not visualized Posterior fourchette: _____

NA Not visualized Fossa navicularis: _____

NA Not visualized Hymen: _____

NA Not visualized Vagina: _____

NA Not visualized Cervix: _____

NA Not visualized Perineum: _____

NA Not visualized Anus: _____

NA Not visualized Penis: _____

NA Not visualized Scrotum: _____

END OF MEDICAL FORENSIC ASSESSMENT REPORT Ending time of exam: _____

PLAN OF CARE FOR THE ENCOUNTER:

Examiner Signature Date Time

PATIENT LABEL OR
PATIENT'S NAME: _____
MRN #: _____

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MEDICAL FORENSIC ASSESSMENT REPORT

EVIDENCE COLLECTION

For DNA testing purposes, the crime laboratory personnel require the following information:

Gender assigned at birth: _____ Gender patient identifies: _____

Sexual contact within the last four days: Yes No NA

If DNA is recovered, last sexual contacts may be requested to provide a DNA sample to exclude them.

EVIDENCE ITEMS INCLUDED IN THE KIT (Provide description as needed such as number of swabs collected is not two)

Oral swabs (2) _____ Vulva swabs (2) _____

Patient's Known DNA swabs (2) _____ Vaginal/cervical swabs (2) _____

Head hair combing & comb _____ Scrotal swabs (2) _____

Clipped head hair _____ Penile swabs (2) _____

Fingernail swabs (4) _____ Anal swabs (2) _____

Pubic hair combing & comb _____ Underwear _____

Clipped pubic hair _____ Diaper _____

Changing paper _____ Bra _____

Dried secretions/debris:

Left neck Right neck Left breast Right breast Abdomen Mons

Other (describe): _____

Other evidence (describe): _____

EVIDENCE ITEMS NOT INCLUDED IN THE KIT

_____ # paper bags Photographs/images/videos available See below:

Toxicology kit containing: Grey top blood tube #: _____ Urine #: _____

Article # _____ Description: _____

Article # _____ Description: _____

Article # _____ Description: _____

Article # _____ Description: _____

Article # _____ Description: _____

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MEDICAL FORENSIC ASSESSMENT FOLLOW-UP CARE

PATIENT ONGOING AND FOLLOW-UP CARE

- | | | |
|---|------------------------------|-----------------------------|
| Medical, sexually transmitted infection testing follow-up recommended | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Counseling referral information provided | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Written and verbal discharge instructions provided | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Kit tracking information provided to patient/guardian | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| HHS <i>Information Sheet for Survivors of Sexual Assault</i> provided | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| DFPS mandatory report made if abuse suspected | <input type="checkbox"/> Yes | <input type="checkbox"/> NA |

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CHAIN OF CUSTODY, RECEIPT OF INFORMATION, AND EVIDENCE

CHAIN OF CUSTODY

LOCK BOX	<input type="checkbox"/> NA	<input type="checkbox"/> Sealed sexual assault evidence collection kit	<input type="checkbox"/> Clothing
<input type="checkbox"/> Other: _____			
Item(s) placed in secure lock box by: _____			
_____ Examiner Signature	_____ Date	_____ Time	

LAW ENFORCEMENT INFORMATION

Law enforcement agency: _____ Case number: _____

Officer's name: _____ Badge #: _____

I have received the following items:

- One sealed sexual assault evidence collection kit
- Sealed clothing bags. Number of bags: _____
- Photographs/digital images/videos. Number of image/videos: _____
- Toxicology kit: _____
- Other: _____

Name of person releasing articles:

Signature Printed Name

Date Time

Received by:

Signature Printed Name

Agency Badge #

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Examiner's Initials: _____

PATIENT LABEL OR
PATIENT'S NAME: _____
MRN #: _____

AUTHORIZATION FOR MEDICAL FORENSIC ASSESSMENT

I hereby request _____ (facility) to perform a medical forensic sexual assault assessment for the forensic evidence from the law enforcement jurisdiction to which the crime was reported.

Patient's Name

Date

Time

Law Enforcement Agency

Case #

Officer's Name

Badge #

Texas Code of Criminal Procedure Chapter 56A, amended 2021.

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