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 #: _____

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: _____O_2 sat: _____

Repeat vital signs: Time: _____Temp: _____ Pulse: _____Resp:_____BP: _____O_2 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:_____

_____

_____

PATIENT LABEL OR

PATIENT'S NAME: _____

MRN #: _____

Examiner's Initials: _____

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

PATIENT LABEL OR

PATIENT'S NAME: _____

MRN #: _____

Examiner's Initials: _____

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

PATIENT LABEL OR

PATIENT'S NAME: _____

MRN #: _____

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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 #: _____

Examiner's Initials: _____

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:_____

PATIENT LABEL OR

PATIENT'S NAME: _____

MRN #: _____

Examiner's Initials: _____

MEDICAL FORENSIC ASSESSMENT FOLLOW-UP CARE

PATIENT ONGOING AND FOLLOW-UP CARE

Medical, sexually transmitted infection testing follow-up recommended	☐ Yes	☐ No
Counseling referral information provided	☐ Yes	☐ No
Written and verbal discharge instructions provided	☐ Yes	☐ No
Kit tracking information provided to patient/guardian	☐ Yes	☐ No
HHS *Information Sheet for Survivors of Sexual Assault* provided	☐ Yes	☐ No
DFPS mandatory report made if abuse suspected	☐ Yes	☐ NA

PATIENT LABEL OR

PATIENT'S NAME: _____

MRN #: _____

Examiner's Initials: _____

CHAIN OF CUSTODY, RECEIPT OF INFORMATION, AND EVIDENCE

CHAIN OF CUSTODY

LOCK BOX ☐ NA ☐ Sealed sexual assault evidence collection kit ☐ Clothing

☐ 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 #

PATIENT LABEL OR

PATIENT'S NAME: _____

MRN #: _____

Page ____ of ____

Examiner's Initials: _____

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.

PATIENT LABEL OR

PATIENT'S NAME: _____

MRN #: _____

Examiner's Initials: _____