

## DoD SEXUAL ASSAULT FORENSIC EXAMINATION REPORT

### PRIVACY ACT STATEMENT

**AUTHORITY:** Section 301 of Title 5 U.S.C. and Chapter 55 of Title 10 U.S.C.; DoDD 6495.01, Sexual Assault Prevention and Response (SAPR) Program; and DoDI 6495.02 Sexual Assault Prevention and Response Program Procedures.

**PRINCIPAL PURPOSE(S):** Information on this form will be used to document the medical/forensic examination of the sexual assault victim. The DD Form 2911 also documents the reporting preference (Restricted or Unrestricted) of the sexual assault victim as part of the sexual assault prevention and response program.

**ROUTINE USE(S):** None.

**DISCLOSURE:** Completion of this form is voluntary; however, failure to complete this form with the information requested impedes the effective management of care and support required by the procedures of the sexual assault prevention and response program.

Patient Identification

### Sensitive Information Document

**PART I (NOTE: Conduct a SAFE for up to one full week following a sexual assault, or longer if circumstances dictate.)**

#### A. GENERAL INFORMATION *(Print or type)*

**Name of Medical Facility:**

<b>1a. NAME OF PATIENT</b> <i>(Last, First, Middle Initial)</i>			<b>b. PATIENT ID NUMBER</b>			
<b>2a. ADDRESS</b>		<b>b. CITY</b>	<b>c. COUNTY</b>	<b>d. STATE</b>	<b>e. ZIP CODE</b>	
<b>f. TELEPHONE</b> <i>(Include Area Code)</i> (1) Home: (2) Work:						
<b>3a. AGE</b>	<b>b. DATE OF BIRTH</b> <i>(YYYY/MM/DD)</i>	<b>c. GENDER</b> <i>(X)</i> <input type="checkbox"/> M <input type="checkbox"/> F	<b>d. ETHNICITY</b> <i>(X)</i> <input type="checkbox"/> (1) Hispanic or Latino <input type="checkbox"/> (2) Not Hispanic or Latino	<b>e. RACE</b> <i>(X)</i> <input type="checkbox"/> (1) American Indian/ Alaska Native <input type="checkbox"/> (2) Asian <input type="checkbox"/> (3) Black or African American <input type="checkbox"/> (4) White <input type="checkbox"/> (5) Native Hawaiian/ Other Pacific Islander		
<b>4a. ARRIVAL DATE</b> <i>(YYYY/MM/DD)</i>		<b>b. TIME</b>		<b>5a. DISCHARGE DATE</b> <i>(YYYY/MM/DD)</i>		
<b>b. TIME</b>						

#### B. NOTIFICATION AND AUTHORIZATION:

**Location of Assault:**  On Installation  Off Installation **Jurisdiction:**  City  County  Other **Civilian or Foreign Assisting Agency:**

<b>1a. NAME OF SEXUAL ASSAULT RESPONSE COORDINATOR (SARC)</b> <i>(Last, First, Middle Initial)</i>			<b>b. TELEPHONE</b> <i>(Include Area Code)</i>		
<b>2a. NAME OF SEXUAL ASSAULT FORENSIC EXAMINER</b> <i>(Last, First, Middle Initial)</i>		<b>b. RANK</b>	<b>c. TITLE</b>	<b>d. TELEPHONE</b> <i>(Include Area Code)</i>	
<b>3a. NAME OF VICTIM ADVOCATE (VA)</b> <i>(Last, First, Middle Initial)</i>			<b>b. TELEPHONE</b> <i>(Include Area Code)</i>		
<b>4a. NAME OF MILITARY CRIMINAL INVESTIGATIVE OFFICER (UNRESTRICTED REPORT)</b> <i>(Last, First, Middle Initial)</i>			<b>b. TELEPHONE</b> <i>(Include Area Code)</i>		
<b>c. AGENCY</b>		<b>d. ID NUMBER</b>		<b>e. DATE</b> <i>(YYYY/MM/DD)</i>	
<b>5a. NAME OF SERVICE DESIGNATED EVIDENCE COLLECTING OFFICER (RESTRICTED REPORT)</b> <i>(Last, First, Middle Initial)</i>				<b>b. TELEPHONE</b> <i>(Include Area Code)</i>	
<b>c. AGENCY</b>		<b>d. ID NUMBER</b>	<b>e. DATE</b> <i>(YYYY/MM/DD)</i>	<b>f. TIME</b>	<b>g. RESTRICTED REPORT CONTROL NUMBER (RRCN)</b>

#### C. REPORTING INFORMATION

<p>1. In unrestricted reporting, I understand that Military Medical Treatment Facilities and Healthcare Providers are required by Department of Defense regulations to report sexual assaults to Military Criminal Investigative Organization authorities (e.g., CID, NCIS, AFOSI). Under these circumstances, the report must state the name of the injured person, current whereabouts, and the type and extent of injuries. In Restricted reporting, I understand that Military Medical Treatment Facilities and Healthcare Providers are required by Department of Defense regulations to report sexual assaults to the Sexual Assault Response Coordinator (SARC).</p>	<i>(Initial)</i>
<p>2. The Sexual Assault Response Coordinator (SARC) and/or Victim Advocate (VA) have explained the difference between Unrestricted and Restricted Reporting options. I have elected:</p> <p><input type="checkbox"/> <b>UNRESTRICTED REPORTING</b>    <input type="checkbox"/> <b>RESTRICTED REPORTING (Only applicable to Active Duty, and Reserve and National Guard in active service or inactive duty training)</b></p> <p><b>Note:</b> Military dependents under age 18 who have been sexually assaulted by either parent and/or caregiver are not covered under the sexual assault restricted reporting policy.</p>	<i>(Initial)</i>
<p>3. I understand what my options are and do not have questions.</p>	<i>(Initial)</i>

**D. PATIENT CONSENT**

1. I understand that the Sexual Assault Forensic Examination (also known as a "SAFE") that I am about to undergo is optional. When I give my consent, a healthcare professional may examine me to find and collect evidence of an assault. I understand that as part of the examination, the provider can collect specimens to include my hair, urine and/or blood, both now and at a later date, if necessary.

 YES

 NO

(Initial)

**Patient Identification**

2. I understand that I may withdraw my consent at any time for any portion of the examination and that it will not impact my right to medical care.

 YES

 NO

(Initial)

3. I understand that collection of evidence may include photographing injuries and that these photographs may include the genital area.

 YES

 NO

(Initial)

4. I understand that samples of my blood and/or urine may need to be tested for drugs as part of my treatment. I also understand that testing for drugs will also show prescriptions, other drugs, and alcohol that I have voluntarily consumed. I understand that illegal drugs or alcohol (if I am under age 21) in my body could be used to show that I engaged in misconduct if I am a Service member. I consent to this testing and the release of the result to law enforcement.

 YES

 NO

(Initial)

5. I understand that some of the information that I provide may be collected for health and forensic purposes and provided to health authorities and other qualified persons for a valid educational or scientific interest and/or epidemiological studies. However, none of my personally identifying data (name, patient identification number, etc.) will be disclosed for these purposes.

 YES

 NO

(Initial)

6. I hereby consent to a sexual assault medical forensic examination (SAFE).

 YES

 NO

(Initial)

7. If I have elected to make an Unrestricted Report, I understand and consent to the release of my records and all evidence collected from this exam to law enforcement.

 YES

 NO

(Initial)

8. If I have elected to make a Restricted Report, I understand that my records and all evidence collected should not be reviewed or tested unless I choose to convert to an Unrestricted Report.

 YES

 NO

(Initial)

**9a. PATIENT SIGNATURE**

b. DATE (YYYY/MM/DD)

c. TIME

**10. PATIENT PARENT OR GUARDIAN (If applicable)**

a. SIGNATURE

b. ADDRESS (If different from patient) (Include ZIP Code)

c. DATE (YYYY/MM/DD)

d. TIME

**11. WITNESS TO PATIENT SIGNATURE**

a. SIGNATURE

b. ADDRESS (Include ZIP Code)

c. DATE (YYYY/MM/DD)

d. TIME

<b>E. PATIENT HISTORY</b>				<b>Patient Identification</b>			
1a. NAME OF PERSON PROVIDING HISTORY <i>(Last, First, Middle Initial)</i>							
b. RELATIONSHIP TO PATIENT		c. DATE (YYYY/MM/DD)	d. TIME				
<b>2. PERTINENT MEDICAL HISTORY</b>							
a. LAST MENSTRUAL PERIOD	b. Any recent (60 days) anal-genital injuries, surgeries, diagnostic procedures, or medical treatment that may affect the interpretation of current physical findings? <i>(If yes, describe)</i>						
	<input type="checkbox"/> No	<input type="checkbox"/> Yes					
c. Any other pertinent medical condition(s) that may affect the interpretation of current physical findings? <i>(If yes, describe)</i>							
<input type="checkbox"/> No							
<input type="checkbox"/> Yes							
d. Any pre-existing physical injuries? <i>(If yes, describe)</i>							
<input type="checkbox"/> No							
<input type="checkbox"/> Yes							
<b>3. PERTINENT NON-ASSAULT RELATED HISTORY</b>							
a. Other non-assault sexual activity within past 5 days? <b>Do NOT record any other information regarding sexual history on this form.</b>							
<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unsure If yes or unsure, complete items b. through f. below. If no, then check the "No" box to the left and proceed to item 4.							
<i>(X and complete as applicable)</i>	No	Yes	Unsure	<i>(If Yes)</i>			
b. Anal (within past 5 days)?				When?			
c. Vaginal (within past 5 days)?				When?			
d. Oral (within past 5 days)?				When?			
e. Did ejaculation occur?				Where?			
f. Was a condom used?							
<b>4. POST-ASSAULT HYGIENE/ACTIVITY</b>				Not Applicable if over 5 days			
<i>(X and complete as applicable)</i>				No	Yes		
a. Urinated				h. Brushed teeth		No	Yes
b. Defecated				i. Gargled/mouthwash			
c. Genital or body wipes <i>(If yes, describe)</i>				j. Vomited			
d. Douched <i>(If yes, with what)</i>				k. Ate or drank			
e. Removed/inserted				l. Used cream/ointment/lotion on body part involved in assault <i>(If yes, describe)</i>			
<input type="checkbox"/> Tampon <input type="checkbox"/> Diaphragm <input type="checkbox"/> Nuva ring				m. Changed clothing <i>(If yes, describe)</i>			
f. Oral gargle/rinse				n. Changed body piercings <i>(If yes, describe)</i>			
g. Bath/shower/wash							
<b>F. ASSAULT HISTORY</b>							
1a. DATE OF ASSAULT(S) (YYYY/MM/DD)				2. LOCATION AND PERTINENT PHYSICAL SURROUNDINGS			
b. TIME							
<b>3. PHYSICAL EFFECTS OF ASSAULT.</b> If injuries are described or if remarkable findings or possible trauma are observed, please photograph.							
a. Non-genital injury, pain and/or bleeding (including tenderness). <i>(If yes, describe.)</i>							
<input type="checkbox"/> No							
<input type="checkbox"/> Yes							
b. Genital/rectal injury, pain and/or bleeding (including tenderness). <i>(If yes, describe.)</i>							
<input type="checkbox"/> No							
<input type="checkbox"/> Yes							
<b>4. INJURIES INFLICTED UPON THE ASSAILANT(S) DURING ASSAULT?</b> <i>(If yes, describe injuries, possible locations on the body, and how they were inflicted.)</i>							
<input type="checkbox"/> No							
<input type="checkbox"/> Yes							
5a. NUMBER OF ASSAILANT(S)		b. ASSAILANT(S) RELATIONSHIP TO VICTIM <i>(Indicate/number all that apply)</i>					
		<input type="checkbox"/>	Stranger	<input type="checkbox"/>	Acquaintance	<input type="checkbox"/>	Relative <i>(Specify)</i> _____
		<input type="checkbox"/>	Other <i>(Specify)</i> _____				

**G. PATIENT'S DESCRIPTION OF THE ASSAULT**

Please record the patient's description of the assault.  
Add additional pages if necessary.

Patient Identification

<b>H. ACTS DESCRIBED BY PATIENT</b>  - Describe any penetration of the genital, anal or oral opening, no matter how slight or brief.  - Type of sexual intercourse (oral, vaginal, anal).  - If more than one assailant, identify by number.	<b>Patient Identification</b>
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<b>1. PENETRATION OF VAGINA BY</b> a. Penis b. Finger c. Object (If yes, describe the object)	No	Yes	Attempted	Unsure	Describe:

<b>2. PENETRATION OF ANUS BY</b> a. Penis b. Finger c. Object (If yes, describe the object)	No	Yes	Attempted	Unsure	Describe:

<b>3. ORAL COPULATION OF GENITALS</b> a. Of patient by assailant b. Of assailant by patient	No	Yes	Attempted	Unsure	Describe:

<b>4. ORAL COPULATION OF ANUS</b> a. Of patient by assailant b. Of assailant by patient	No	Yes	Attempted	Unsure	Describe:

<b>5. NON-GENITAL ACT(S)</b> a. Licking b. Kissing c. Suction injury d. Biting e. Strangulation/choking	No	Yes	Attempted	Unsure	Describe:

<b>6. OTHER ACT(S)</b> (Describe)					
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<b>7. DID EJACULATION OCCUR?</b> (If yes, location(s))	No	Yes	Unsure	
<input type="checkbox"/> Mouth <input type="checkbox"/> Rectum <input type="checkbox"/> Vagina <input type="checkbox"/> Body surface <input type="checkbox"/> Genitals <input type="checkbox"/> On clothing <input type="checkbox"/> Anus <input type="checkbox"/> On bedding				<input type="checkbox"/> Other (note location(s))

<b>8. CONTRACEPTIVE OR LUBRICANT PRODUCT(S)</b> a. Condom used? b. Lubricant used? c. Other Contraceptive used?	No	Yes	Unsure	Describe Type/Brand, if known:

**I. GENERAL PHYSICAL EXAMINATION**  
 - Record all findings using diagrams, legend, and a consecutive numbering system.  
 - If injuries are described or if remarkable findings or possible trauma are observed, please photograph.

1a. Weight    b. Blood Pressure    c. Pulse    d. Resp    e. Temp    f. Pulse Oxygen

2a. Exam Started    b. Exam Completed  
 Date (YYYYMMDD)    Time    Date (YYYYMMDD)    Time

**Patient Identification**

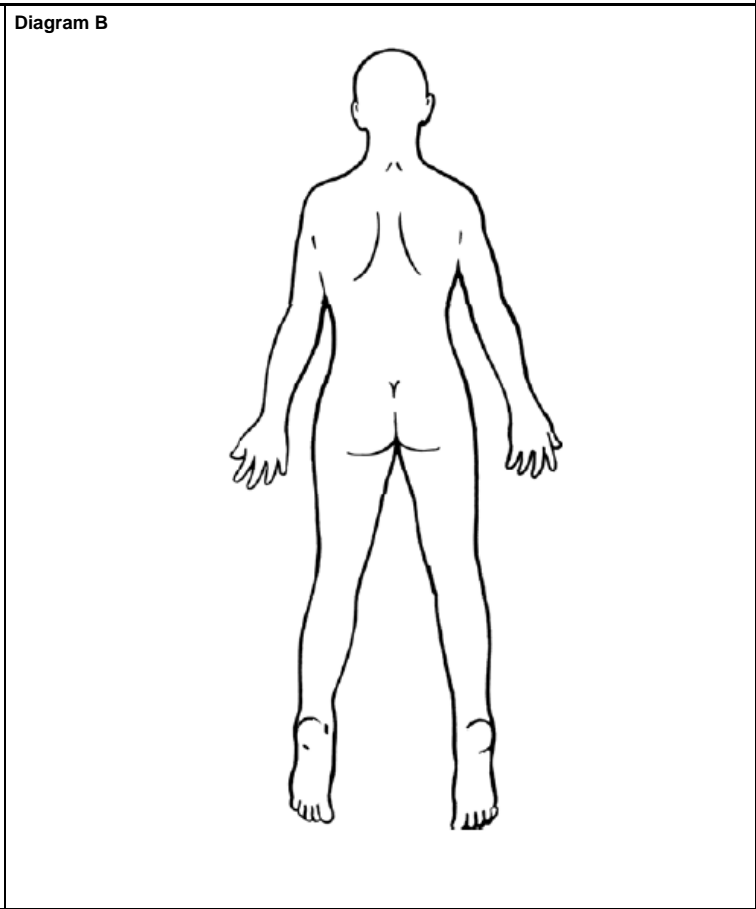
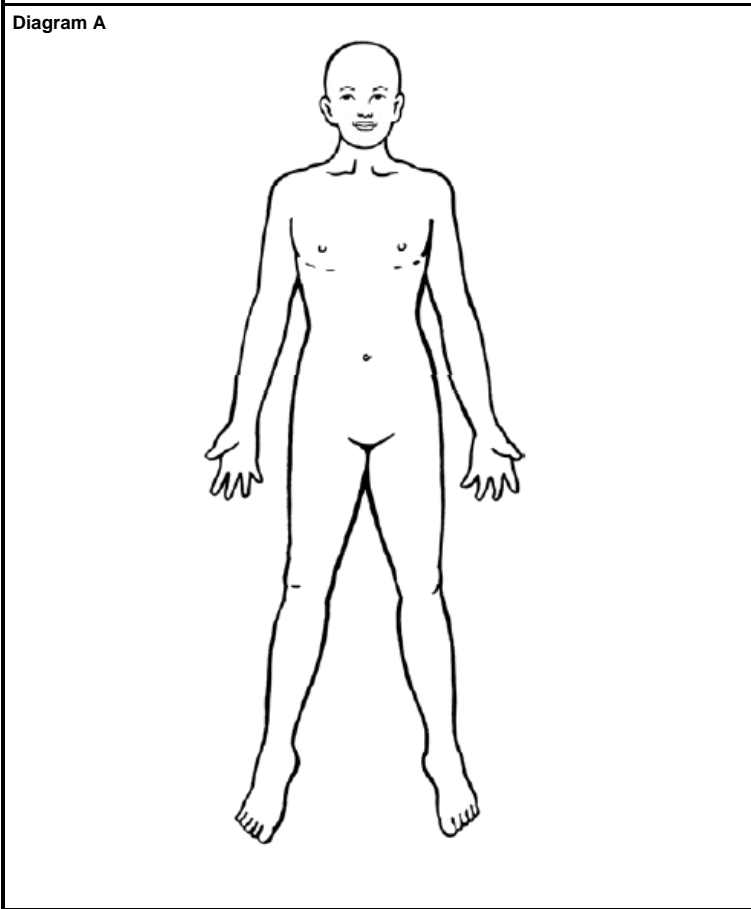
3. Describe general physical appearance. (Use observations, not conclusions.)  
 4. Describe general demeanor. (Including affect, behavior and orientation. Use observations, not conclusions.)  
 5. Describe condition of clothing upon arrival. (If the patient has not changed after the assault)

6. Collect outer and underclothing if indicated.  Not indicated  
 7. Conduct a physical examination. Use the history obtained earlier to guide your examination and recovery of evidence.  Findings  No Findings Observed

8. Scan the entire body with an Alternate Light Source (such as a Wood's Lamp). Collect dried and moist secretions, stains, and foreign materials from the body. Label box and envelope with the location of the collection.  Findings  No Findings Observed

9. Was there a history of scratching?  No  Yes  Unsure    If yes or unsure, collect fingernail clippings. If there is not enough fingernail to clip, then swab fingernails.

10. Was there a history of kissing, licking or sucking parts of the body?  No  Yes  Unsure  
 If yes or unsure, collect swabs of the body areas that were believed to be contacted by the suspect's mouth. (Head and genitals are addressed in the next sections.)



**LEGEND: TYPES OF FINDINGS. RECORD ALL CLOTHING AND SPECIMENS COLLECTED IN SECTION O.**

<b>AB</b> Abrasion	<b>BU</b> Burn	<b>DF</b> Deformity	<b>FB</b> Foreign Body	<b>MS</b> Moist Secretion	<b>PE</b> Petechiae	<b>SW</b> Swelling
<b>ALS</b> Alternate Light Source	<b>CS</b> Control Swab	<b>DS</b> Dry Secretion	<b>IN</b> Induration	<b>OF</b> Other Foreign Materials (describe)	<b>PS</b> Potential Saliva	<b>TB</b> Toluidine Blue®
<b>BI</b> Bite	<b>CT</b> Contusion (bruise)	<b>ER</b> Erythema (redness)	<b>IW</b> Incised Wound	<b>OI</b> Other Injury (describe)	<b>SHX</b> Sample Per History	<b>TE</b> Tenderness
	<b>DE</b> Debris	<b>F/H</b> Fiber/Hair	<b>LA</b> Laceration		<b>SI</b> Suction Injury	<b>V/S</b> Vegetation/Soil

Locator #	Type	Description	Locator #	Type	Description

**J. HEAD, NECK, THROAT AND ORAL EXAMINATION**  
 - Record all findings, including tenderness and pain, using diagrams, legend, and a consecutive numbering system.  
 - If injuries are described or if remarkable findings or possible trauma are observed, please photograph.

1. Examine the face, head, hair, scalp, neck and throat for injury and foreign materials.  
 Findings  No Findings Observed

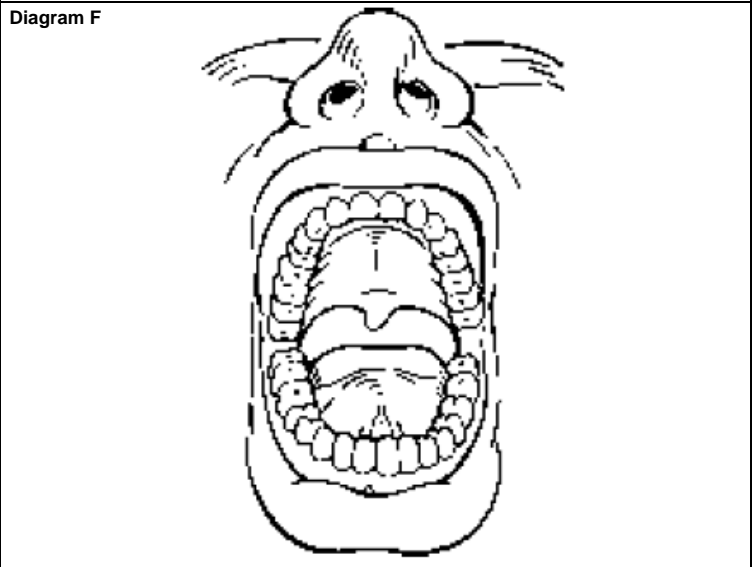
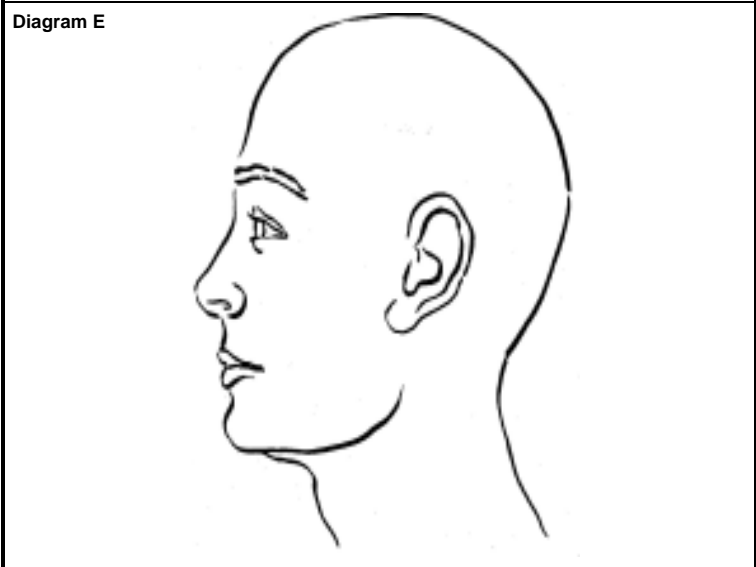
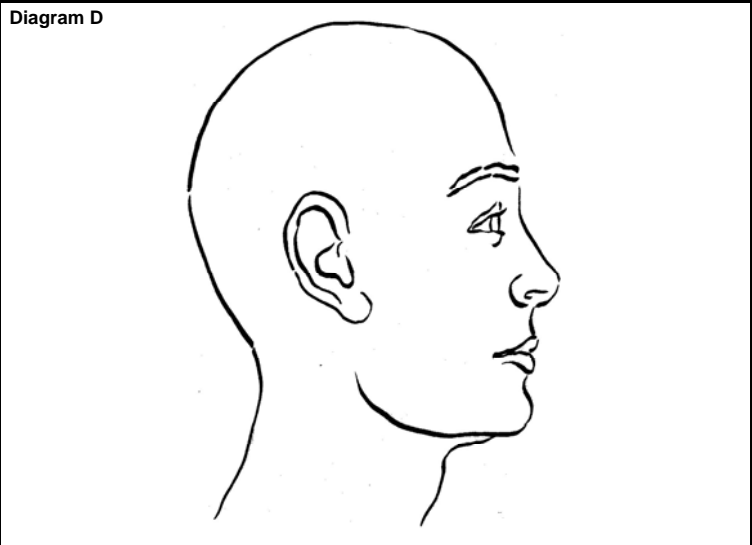
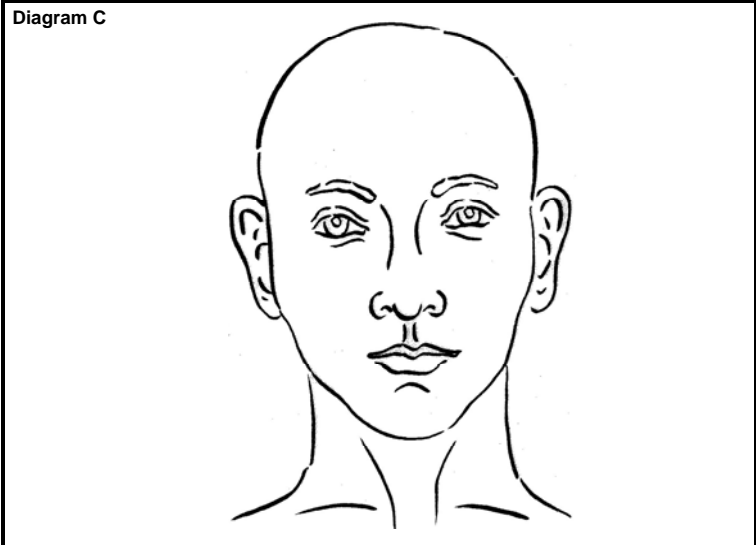
2. Collect dried and moist secretions, stains, and foreign materials from the face, head, hair, neck, throat and scalp.  Findings  No Findings Observed

3. Examine the oral cavity for injury and foreign material (if indicated by assault history). Collect foreign materials.  
 Exam done:  Not applicable  Yes  Findings  No Findings Observed

**Patient Identification**

4. Collect at a minimum 1 external mouth swab and 2 swabs from the oral cavity (if indicated by history).

5. Collect head hair combing or brushing.



**LEGEND: TYPES OF FINDINGS. RECORD ALL SPECIMENS COLLECTED IN SECTION O.**

<b>AB</b> Abrasion	<b>BU</b> Burn	<b>DF</b> Deformity	<b>FB</b> Foreign Body	<b>MS</b> Moist Secretion	<b>PE</b> Petechiae	<b>SW</b> Swelling
<b>ALS</b> Alternate Light Source	<b>CS</b> Control Swab	<b>DS</b> Dry Secretion	<b>IN</b> Induration	<b>OF</b> Other Foreign Materials (describe)	<b>PS</b> Potential Saliva	<b>TB</b> Toluidine Blue®
<b>BI</b> Bite	<b>CT</b> Contusion (bruise)	<b>ER</b> Erythema (redness)	<b>IW</b> Incised Wound	<b>OI</b> Other Injury (describe)	<b>SHX</b> Sample Per History	<b>TE</b> Tenderness
<b>DE</b> Debris	<b>F/H</b> Fiber/Hair	<b>LA</b> Laceration		<b>SI</b> Suction Injury	<b>V/S</b> Vegetation/Soil	

Locator #	Type	Description	Locator #	Type	Description

**K. GENITAL EXAMINATION - FEMALE**

- Record all findings, including tenderness and pain, using diagrams, legend, and a consecutive numbering system.
- If injuries are described or if remarkable findings or possible trauma are observed, please photograph.

**1. Examine the inner thighs, external genitalia, and perineal area.**

If there are findings, describe (including location). (If available and appropriate, consider the use of toluidine blue dye.)  Findings  No Findings Observed

- |                                       |  |
|---------------------------------------|--|
| <input type="checkbox"/> Abdomen      | <input type="checkbox"/> Clitoral hood and surrounding area  |
| <input type="checkbox"/> Thighs       | <input type="checkbox"/> Periarethral tissue/urethral meatus |
| <input type="checkbox"/> Perineum     | <input type="checkbox"/> Hymen                               |
| <input type="checkbox"/> Labia majora | <input type="checkbox"/> Fossa navicularis                   |
| <input type="checkbox"/> Labia minora | <input type="checkbox"/> Posterior fourchette                |

**Patient Identification**

**2. Scan the area with an Alternate Light Source.** Collect dried and moist secretions, stains, and foreign materials.  Findings  No Findings Observed

**3. Collect pubic hair combing or brushing. If there is no pubic hair, conduct an external swab of genitalia.**

**4. Examine the vagina and cervix.** If there are findings, describe (including location). (If available and appropriate, consider the use of toluidine blue dye.)

Findings  No Findings Observed

a. Collect the following swabs: 2 pubic mound (if there is no pubic hair), 2 vaginal, and 2 cervical.

**5. Examine the buttocks, anus, and perineum.**

a. Findings from buttocks, anus, or perineum. If there are findings, describe (including location) (If available and appropriate, consider use of toluidine blue dye.).

Yes  No Findings Observed

b. Collect dried and moist secretions, and foreign materials.

Findings  No Findings Observed

c. Collect 2 swabs of the perineum. d. Collect 2 anal swabs.

**6. Conduct a rectal exam (using anoscope if possible) if rectal injury is suspected or if there is any sign of rectal bleeding.**

a. Rectal exam done:  Yes  Not applicable

b. Rectal bleeding:  No  Yes

c. Was an anoscopic exam done?  No  Yes

d. If exam was done, what position was used?  Supine Lithotomy  Other (describe)

e. If exam was done, describe findings: f. Collect a rectal swab if indicated.

**Diagram G**



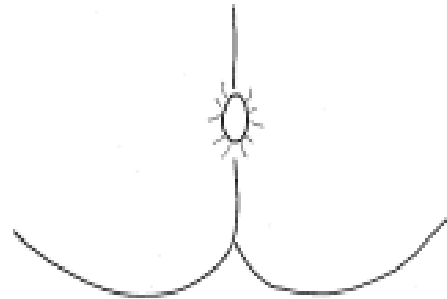
**Diagram H**



**Diagram I**



**Diagram J**



**LEGEND: TYPES OF FINDINGS. RECORD ALL SPECIMENS COLLECTED IN SECTION O.**

<b>AB</b> Abrasion	<b>BU</b> Burn	<b>DF</b> Deformity	<b>FB</b> Foreign Body	<b>MS</b> Moist Secretion	<b>PE</b> Petechiae	<b>SW</b> Swelling
<b>ALS</b> Alternate Light Source	<b>CS</b> Control Swab	<b>DS</b> Dry Secretion	<b>IN</b> Induration	<b>OF</b> Other Foreign Materials (describe)	<b>PS</b> Potential Saliva	<b>TB</b> Toluidine Blue <sup>®</sup>
<b>Bl</b> Bite	<b>DE</b> Debris	<b>ER</b> Erythema (redness)	<b>IW</b> Incised Wound	<b>OI</b> Other Injury (describe)	<b>SHX</b> Sample Per History	<b>TE</b> Tenderness
		<b>F/H</b> Fiber/Hair	<b>LA</b> Laceration		<b>SI</b> Suction Injury	<b>V/S</b> Vegetation/Soil

Locator #	Type	Description	Locator #	Type	Description



**L. GENITAL EXAMINATION - MALE**

- Record all findings, including tenderness and pain, using diagrams, legend, and a consecutive numbering system.
- If injuries are described or if remarkable findings or possible trauma are observed, please photograph.

**1. Examine the inner thighs, external genitalia, and perineal area.**

If there are findings, describe (including location). (If available and appropriate, consider the use of toluidine blue dye.)  Findings  No Findings Observed

<input type="checkbox"/> Abdomen	<input type="checkbox"/> Urethral meatus	<input type="checkbox"/> Glans
<input type="checkbox"/> Thighs	<input type="checkbox"/> Shaft	<input type="checkbox"/> Testes
<input type="checkbox"/> Foreskin	<input type="checkbox"/> Scrotum	

Patient Identification

**2. Circumcised:**  No  Yes

**3. Scan the area with an Alternate Light Source (such as a Wood's Lamp).** Collect dried and moist secretions, stains, and foreign materials.  Findings  No Findings Observed

**4. Collect pubic hair combing or brushing. If no pubic hair, conduct external swab at base of penis.**

**5. If indicated by assault history, collect the following swabs: 2 penile and 2 scrotal.**

**6. Examine the buttocks and perineum (if indicated by history).**

- a. Findings from buttocks, anus, or perineum.  Yes  None Observed
- b. Collect dried and moist secretions, and foreign materials.  Findings  No Findings Observed

If there are findings, describe (including location). (If available and appropriate, consider the use of toluidine blue dye.)

**7. Collect 2 anal swabs.**

**8. Conduct a rectal exam (using anoscope if possible) if rectal injury is suspected or if there is any sign of rectal bleeding.**

- a. Rectal exam done?  Yes  No
- b. Rectal bleeding:  Yes  None Observed
- c. Was an anoscopic exam done?  Yes  No
- d. If exam was done, what position was used?  Supine  Other (describe)
- e. If exam was done, describe findings:

Diagram K

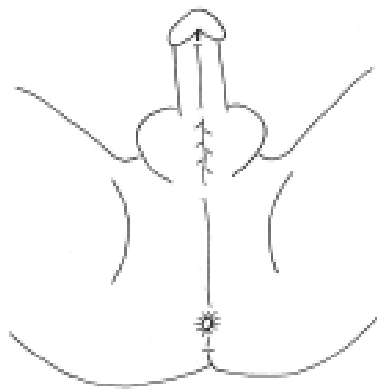


Diagram L

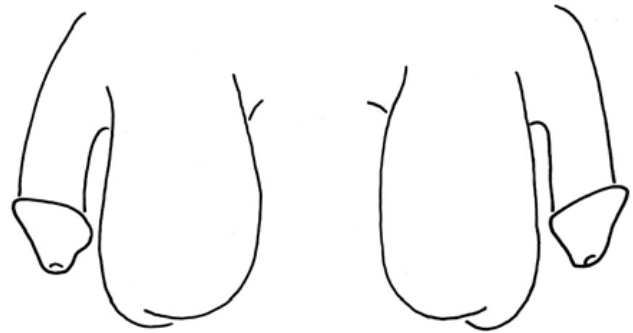


Diagram M

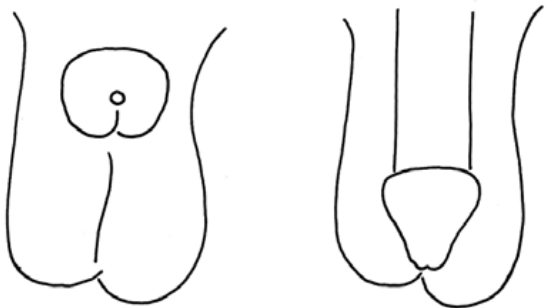
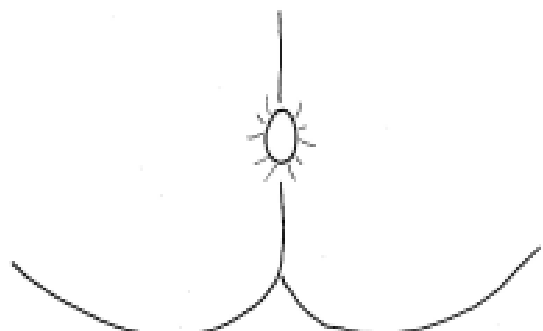


Diagram N



**LEGEND: TYPES OF FINDINGS. RECORD ALL SPECIMENS COLLECTED IN SECTION O.**

<b>AB</b> Abrasion	<b>BU</b> Burn	<b>DF</b> Deformity	<b>FB</b> Foreign Body	<b>MS</b> Moist Secretion	<b>PE</b> Petechiae	<b>SW</b> Swelling
<b>ALS</b> Alternate Light Source	<b>CS</b> Control Swab	<b>DS</b> Dry Secretion	<b>IN</b> Induration	<b>OF</b> Other Foreign Materials (describe)	<b>PS</b> Potential Saliva	<b>TB</b> Toluidine Blue®
<b>BI</b> Bite	<b>CT</b> Contusion (bruise)	<b>ER</b> Erythema (redness)	<b>IW</b> Incised Wound	<b>OI</b> Other Injury (describe)	<b>SHX</b> Sample Per History	<b>TE</b> Tenderness
<b>DE</b> Debris	<b>F/H</b> Fiber/Hair	<b>LA</b> Laceration			<b>SI</b> Suction Injury	<b>V/S</b> Vegetation/Soil

Locator #	Type	Description	Locator #	Type	Description

**M. TOXICOLOGY**

Toxicology examples must be collected as soon as possible due to the limited time frame in which they can be collected. If the assault happened within 96 hours of the examination and the answer to any of these questions is Yes or Unsure, use the DoD Toxicology Kit.

1. Loss of memory? (If yes, describe)  No  Yes

**Patient Identification**

2. Lapse of consciousness? (If yes, describe)  No  Yes  Unsure

3. Vomited? (If yes, describe. Include location and number of times.)  No  Yes

4.a. Voluntary ingestion of alcohol/drugs?  No  Yes  Unsure  
If yes:  Alcohol  Drugs

b. Involuntary ingestion of alcohol/drugs?  No  Yes  Unsure  
If yes:  Alcohol  Drugs

5. Was a clinical toxicology lab conducted?  No  Yes

6. FOR UNRESTRICTED REPORTS: Was a DoD Toxicology Kit completed?  No  Yes

**N. RECORD EXAM METHODS**

1. Direct visualization only	<input type="checkbox"/> No <input type="checkbox"/> Yes	5. Toluidine Blue Dye	<input type="checkbox"/> No <input type="checkbox"/> Yes	(If Other, describe)
2. Alternate Light Source	<input type="checkbox"/> No <input type="checkbox"/> Yes	6. Anoscopic exam	<input type="checkbox"/> No <input type="checkbox"/> Yes	
3. Digital Camera	<input type="checkbox"/> No <input type="checkbox"/> Yes	7. Vaginal speculum exam	<input type="checkbox"/> No <input type="checkbox"/> Yes	
4. Colposcope or Other Magnifier	<input type="checkbox"/> No <input type="checkbox"/> Yes	8. Other	<input type="checkbox"/> No <input type="checkbox"/> Yes	

O. OBSERVATIONS. Please describe your observations.

P. EVIDENCE COLLECTED										
		No	Yes	Time Completed						
<b>1. TOXICOLOGY KIT</b>										
Completed By		Released To								
					<b>Patient Identification</b>					
<b>2. CLOTHING</b>		No	Yes	Time Completed	Completed By		Released To			
a. Undergarments placed in evidence kit										
b. Clothing placed in bags										
<b>3. OTHER:</b>		No	Yes	Time Completed	Completed By		Released To			
a. Swabs, suspected blood										
b. Dried secretions										
c. Fiber/loose hairs										
d. Vegetation										
e. Soil/debris										
f. Swabs/suspected semen										
g. Swabs/suspected saliva										
h. Swabs/Alternate Light Source area(s)										
i. Fingernail cuttings										
j. Fingernail scrapings/swabbings										
k. Matted hair cuttings										
l. Pubic hair combings/brushings										
m. Intravaginal foreign body <i>(If yes, describe)</i>										
n. Other types <i>(If yes, describe)</i>										
<b>4. ORAL, GENITAL, RECTAL SAMPLES</b>										
	# Swabs	Time Completed	Completed By			# Swabs	Time Completed	Completed By		
a. External oral swab(s)					f. Perineal swab(s)					
b. Oral cavity swab(s)					g. Anal swab(s)					
c. Vaginal swab(s)					h. Rectal swab(s)					
d. Cervical swab(s)					i. Other <i>(If yes, describe)</i>					
e. Pubic mound swab(s)										
<b>5. REFERENCE SAMPLES</b>		No	Yes	Time Completed	Completed By		No	Yes	Time Completed	Completed By
a. Blood Card							d. Other <i>(describe)</i>			
b. Known Head Hair										
c. Known Pubic Hair										



# DoD SEXUAL ASSAULT FORENSIC EXAMINATION REPORT

## PART II - DoD TOXICOLOGY KIT - FOR UNRESTRICTED REPORTS ONLY

### BLOOD AND URINE SPECIMEN COLLECTION INSTRUCTIONS

**Notes:**

- (A) This kit is to be used in conjunction with a DoD Medical Forensic Examination Kit when the patient indicates that there was memory loss, lapse of consciousness, involuntary or voluntary ingestion of drugs or alcohol, or if toxicology testing is otherwise indicated.
- (B) Collect **both** blood and urine specimens in all cases.
- (C) Urine samples should be collected from the victim as soon as possible due to the short window of detection for many of the drugs (including alcohol) involved in sexual assault.
- (D) Based on timing of evidence pick up, refrigerate the sealed kit. However, if you are in a deployed or natural disaster environment that does not have refrigeration, it will be unlikely to preserve specimen.

**STEP 1:** Fill out the information requested on the Victim Information Form (next page).

### BLOOD SPECIMEN COLLECTION

**Note:** Blood specimen collection must be performed only by a physician, registered nurse or trained phlebotomist.

**STEP 2:** Cleanse the blood collection site with the alcohol-free prep pad provided. Following normal hospital/clinic procedure, collect blood using two 10 ml blood collection tubes with 100 mg of sodium fluoride and 20 mg of potassium oxalate. Allow blood tubes to fill to maximum volume.

**Notes:**

- (A) Immediately after blood collection, assure proper mixing of anticoagulant powder by slowly and completely inverting the blood tube at least five times. **Do NOT shake!**
- (B) Discard venipuncture needle(s) and prep pads as recommended by OSHA guidelines. **Do NOT** place the venipuncture needle(s) or prep pads in the specimen collection box.

**STEP 3:** Fill out all information requested on two of the three Specimen Security Seals provided. Then remove backing from the two Specimen Seals. Affix center of seals to the blood tube rubber stoppers, and press ends of seals down sides of the blood tubes, then place both filled and sealed blood tubes in specimen holder.

### URINE SPECIMEN COLLECTION

**STEP 4:** Have subject void directly into the urine specimen bottle provided. A minimum of 60 ml is required.

**STEP 5:** After specimen is collected, replace cap and tighten down to prevent leakage.

**STEP 6:** Fill out the information requested on the remaining Specimen Security Seal. Affix center of seal to the bottle cap and press ends of seal down sides of bottle, then place urine bottle in specimen holder.

**STEP 7:** Place specimen holder inside the zip lock bag, then squeeze out excess air and close the bag. Place specimen holder in kit box.

**Note:** Do not remove liquid absorbing sheet from specimen bag.

**STEP 8:** Place DoD Toxicology Kit Victim Information form in Toxicology Kit. Retain a copy of the form with the SAFE Report.

**STEP 9:** Close kit box and affix kit box shipping seal where indicated.

**STEP 10:** Fill out all information requested on kit box top under "For Hospital Personnel".

**STEP 11:** Hand sealed kit to investigating agent.

**Note:** If the officer is not present at this time, place sealed kit in secure and refrigerated area, and hold for pickup by investigating officer. Work with law enforcement/investigating agent to ensure the **CHAIN OF CUSTODY IS MAINTAINED**.

MCIO or investigating agent should mail kit with Form 1323, Toxicological Request Form (found at: [www.afip.org](http://www.afip.org)) to:

**Armed Forces Medical Examiner**  
Division of Forensic Toxicology  
Bldg 1102  
1413 Research Boulevard  
Rockville, MD 20850

**EFFECTIVE 1 DEC 2011:**  
**Armed Forces Medical Examiner**  
Division of Forensic Toxicology  
Bldg 115  
Purple Heart Drive  
Dover AFB, DE 19902

**DoD TOXICOLOGY KIT  
VICTIM INFORMATION FORM  
FOR UNRESTRICTED REPORTS ONLY**

**Patient Identification**

1. VICTIM'S NAME (*Last, First, Middle Initial*)

2. VICTIM'S DATE OF BIRTH (*YYYY/MM/DD*)

3a. DATE OF SPECIMEN COLLECTION (*YYYY/MM/DD*)

b. TIME

4. IS VICTIM A SMOKER?

Yes  No

5. IS VICTIM TAKING ANY PRESCRIPTION DRUGS?

Yes  No

a. IF YES, NAME OF DRUG(S)

b. DATE DRUG(S) LAST TAKEN (*YYYY/MM/DD*)

c. TIME

6. IS VICTIM TAKING ANY OVER-THE-COUNTER DRUGS?

Yes  No

a. IF YES, NAME OF DRUG(S)

b. DATE DRUG(S) LAST TAKEN (*YYYY/MM/DD*)

c. TIME

7. WHY IS DRUG SCREEN BEING REQUESTED?

8. PERSON COLLECTING SAMPLE

a. NAME (*Last, First, Middle Initial*)

b. TITLE

c. DATE (*YYYY/MM/DD*)

**DoD TOXICOLOGY KIT  
VICTIM INFORMATION FORM  
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