

State of California
California Emergency Management Agency

**FORENSIC MEDICAL REPORT:
DOMESTIC VIOLENCE EXAMINATION**

CAL EMA 2-502



For more information or assistance in completing the CAL EMA 2-502, please contact
California Clinical Forensic Medical Training Center at:
(916) 930-3080 or www.ccfmtc.org

This form is also available on the following website:
www.calema.ca.gov

**FORENSIC MEDICAL REPORT:
DOMESTIC VIOLENCE EXAMINATION**
State of California
California Emergency Management Agency
CalEMA 2-502

Confidential Document: Restricted Release

Patient Identification:

Date:

A. GENERAL INFORMATION

1. Patient's Last Name			First Name			M.I.		
2. Street Address (optional)				City	County	State	Zip Code	Telephone (optional) (Home) (Work) (Safe)
3. Age	DOB	Gender F M MTF FTM	Ethnicity (check all that apply) <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black / African American <input type="checkbox"/> American Indian / Alaskan Native <input type="checkbox"/> Hispanic / Latino <input type="checkbox"/> Native Hawaiian / Other Pacific Islander <input type="checkbox"/> Other _____					
4. Name of Facility Where Forensic Exam Performed					Address of Facility			
5. Patient Arrival		Patient Discharge		6. Exam Started		Exam Completed		
Date	Time	Date	Time	Date	Time	Date	Time	
7. Interpreter Used <input type="checkbox"/> No <input type="checkbox"/> Yes				Language Used: _____				
Name of Interpreter: _____				Telephone: _____				
Affiliation of interpreter: <input type="checkbox"/> Facility Interpreting Services				_____				
<input type="checkbox"/> Contracted Agency, specify: _____				_____				
<input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Other, specify: _____				_____				

B. MANDATORY SUSPICIOUS INJURY REPORT (Pursuant to Pen. Code §11160)

1. Name of Person Making Mandated Telephone Report to Law Enforcement Agency		Date	Time
2. Name of Person Taking Telephone Report	Name of Law Enforcement Agency	<input type="checkbox"/> CalEMA 920 Written Report Submitted	

C. RESPONDING OFFICER TO MEDICAL FACILITY

Not Applicable

Law Enforcement Officer	Name of Law Enforcement Agency	ID Number
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D. AUTHORIZATION FOR MEDICAL EVIDENTIARY EXAMINATION: Follow Local Policy

Not Applicable

Law Enforcement Officer	Name of Law Enforcement Agency	ID Number
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Telephone	Date	Time	Case Number
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E. PATIENT INFORMATION

1. I understand that hospitals and health care professionals are required by Penal Code §§11160-11161 to report to law enforcement authorities cases in which medical care is sought when injuries have been inflicted upon any person in violation of any state penal law. The report must state the name of the injured person, current whereabouts, and the type and extent of injuries. _____(initial)
2. I have been informed that victims of crime are eligible to submit crime victim compensation claims to the California Victim Compensation Program (VCP) for out-of-pocket medical expenses, psychological counseling, loss of wages, and job retraining and rehabilitation. _____(initial)
3. I have been informed about domestic violence advocacy services or a social services professional who can provide me with counseling and support. _____(initial)

F. PATIENT CONSENT

1. I understand that a forensic medical examination for evidence of domestic violence can, with my consent, be conducted by a health care professional to discover and preserve evidence of the assault. If conducted, the report of the examination and any evidence obtained will be released to law enforcement authorities. I understand that the examination may include the collection of reference specimens at the time of the examination or at a later date. I understand that I may withdraw consent at any time for any portion of the examination. _____(initial)
2. I understand that collection of evidence may include audio/visual recordings and photographing injuries and that these photographs may include the genital area. _____(initial)
3. I hereby consent to a forensic medical examination for evidence of domestic violence. _____(initial)
4. I understand that data without patient identity from this report may be collected for health and forensic purposes, and provided to health authorities and other qualified persons with a valid educational or scientific interest. _____(initial)
 Patient Parent Guardian Surrogate

Print Name _____ Signature _____ Date _____

G. DISTRIBUTION OF CalEMA 2-502 (check all that apply)

- Law Enforcement Officer - Original Crime Lab - Copy within evidence kit Medical or Agency Facility Records - Copy

H. CURRENT ASSAULT HISTORY

1. Examination audio and/or videotaped

No Yes Audio Video

2. Name of person providing history

Relationship to Patient

3. Date(s) of Assault

Time/Time Frame of Assault

Patient Identification:

Date:

4. Describe Physical Surroundings of Assault

5. Patient Description of Assault

Additional attached pages

6. Assailant(s)

#1	Assailant's Name	DOB	Age	Gender	Ethnicity
	Relationship to Patient: (check all that apply) <input type="checkbox"/> Spouse <input type="checkbox"/> Cohabitant/Domestic Partner <input type="checkbox"/> Dating Relationship <input type="checkbox"/> Child Together <input type="checkbox"/> Former Spouse <input type="checkbox"/> Former Cohabitant/Domestic Partner <input type="checkbox"/> Former Dating Relationship <input type="checkbox"/> Other _____ Current Whereabouts: <input type="checkbox"/> Unknown <input type="checkbox"/> In Custody <input type="checkbox"/> Known Location: _____				
#2	Assailant's Name	DOB	Age	Gender	Ethnicity
	Relationship to Patient: (check all that apply) <input type="checkbox"/> Spouse <input type="checkbox"/> Cohabitant/Domestic Partner <input type="checkbox"/> Dating Relationship <input type="checkbox"/> Child Together <input type="checkbox"/> Former Spouse <input type="checkbox"/> Former Cohabitant/Domestic Partner <input type="checkbox"/> Former Dating Relationship <input type="checkbox"/> Other _____ Current Whereabouts: <input type="checkbox"/> Unknown <input type="checkbox"/> In Custody <input type="checkbox"/> Known Location: _____				

7. Methods employed by assailant(s) and circumstances

Weapons No Yes **If yes:**
 Firearm Knife Blunt Object Other _____
Threatened? No Yes **Describe:** _____
Displayed? No Yes **Describe:** _____
Used? No Yes **Describe:** _____
Injuries? No Yes **Describe:** _____

Physical blows by hands by feet by head Other, describe: _____
 Grabbing Holding Pinching Slapping Punching Other, describe: _____

Hair pulling? No Yes If yes, describe: _____

Physical restraints No Yes If yes, describe: _____

Strangulation

	One Hand	Two Hands	Forearm
	Frontal Assault	Frontal Assault	Frontal Assault
	Rear Assault	Rear Assault	Rear Assault

Ligature, describe: _____

Bites No Yes, describe: _____

Burns Thermal Chemical Other _____

Threat(s) of harm No Yes If yes, target of threat: Patient Children Pet(s) Property Other, describe: _____

Describe what was said or done: _____

Sexual relations with assailant as part of this assault? No Unsure Yes If yes: Forced Coerced

Involuntary use of alcohol/drugs No Yes If yes: Forced Coerced Suspected

If yes: Alcohol Drugs Describe: _____

8. Injuries inflicted upon assailant(s) during assault No Unsure Yes, describe: _____

9. Post assault hygiene

Bath / shower / wash Clothes change Other, describe: _____

I. CURRENT SYMPTOMS REPORTED BY PATIENT (check all that apply)		
Symptoms	From This Event	From Past Event(s)
Neurological		
Headache		
Dizziness		
Memory/Concentration Problems		
Lightheaded		
Visual Changes		
Hearing Changes		
Loss of Consciousness		
Numbness		
Weakness		
Other		
Psychological		
Acute Anxiety		
Depression		
Suicide Ideation		
Homicide Ideation		
Other		
Cardiorespiratory		
Voice Change		
Coughing		
Shortness of Breath		
Chest Pain		
Palpitations		
Other		
Gastrointestinal		
Sore Throat		
Difficulty Swallowing		
Nausea		
Vomiting		
Diarrhea		
Abdominal Pain		
Hematemesis		
Rectal Bleeding		
Rectal Pain		
Penis/Testicular Pain		
Other		
Urogenital		
Pelvic Pain		
Dysuria		
Vaginal Bleeding		
Vaginal Discharge		
Other		
Musculoskeletal		
Extremity Pain		
Neck Pain		
Back Pain		
Deformity		
Other		
Other		
Other		

Patient Identification: _____ Date: _____

J. PATIENT HISTORY

1. Disability No Yes

If yes: Cognitive Physical Blind Deaf/HOH Mental

2. History of prior physical assault(s) with this assailant?

No Yes If yes, past injuries to patient? No Yes, describe:

3. Prior history of forced or coerced sexual relations with this assailant? No Yes, describe:

Approximate Date(s): _____

4. Has patient sought medical care for prior assault(s) by this assailant? No Yes

If yes, name of facility: _____

If yes, under what name(s)? _____

If yes, approximate date(s): _____

5. Obstetrical History Pregnant? No Yes Unknown

If yes, any possible problems related to current assault(s)?

No Yes, describe: _____

Any possible problems in past pregnancies related to past assault(s) by this assailant?

No Yes, describe: _____

6. Name(s) of Children/Dependent Adults Living in Household	Present During Assault(s)			Gender		DOB or Age
	No	Yes	UNK	M	F	
				M	F	
				M	F	
				M	F	
				M	F	
				M	F	

7. Voluntary Use of Alcohol/Drugs No Yes

Any voluntary alcohol use within 12 hrs prior to assault? No Yes

Any voluntary drug use within 96 hrs prior to assault? No Yes

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

List drug(s) used: _____

8. Are there other ways the patient's life has been impacted by behaviors of this assailant?

Note: For history of sexual assault (<72 hours), stop and consult with law enforcement prior to beginning physical exam to determine next steps.

K. GENERAL PHYSICAL EXAMINATION

1. Blood Pressure	Pulse	Respiration	Temp
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2. Describe general physical appearance

3. Describe general demeanor

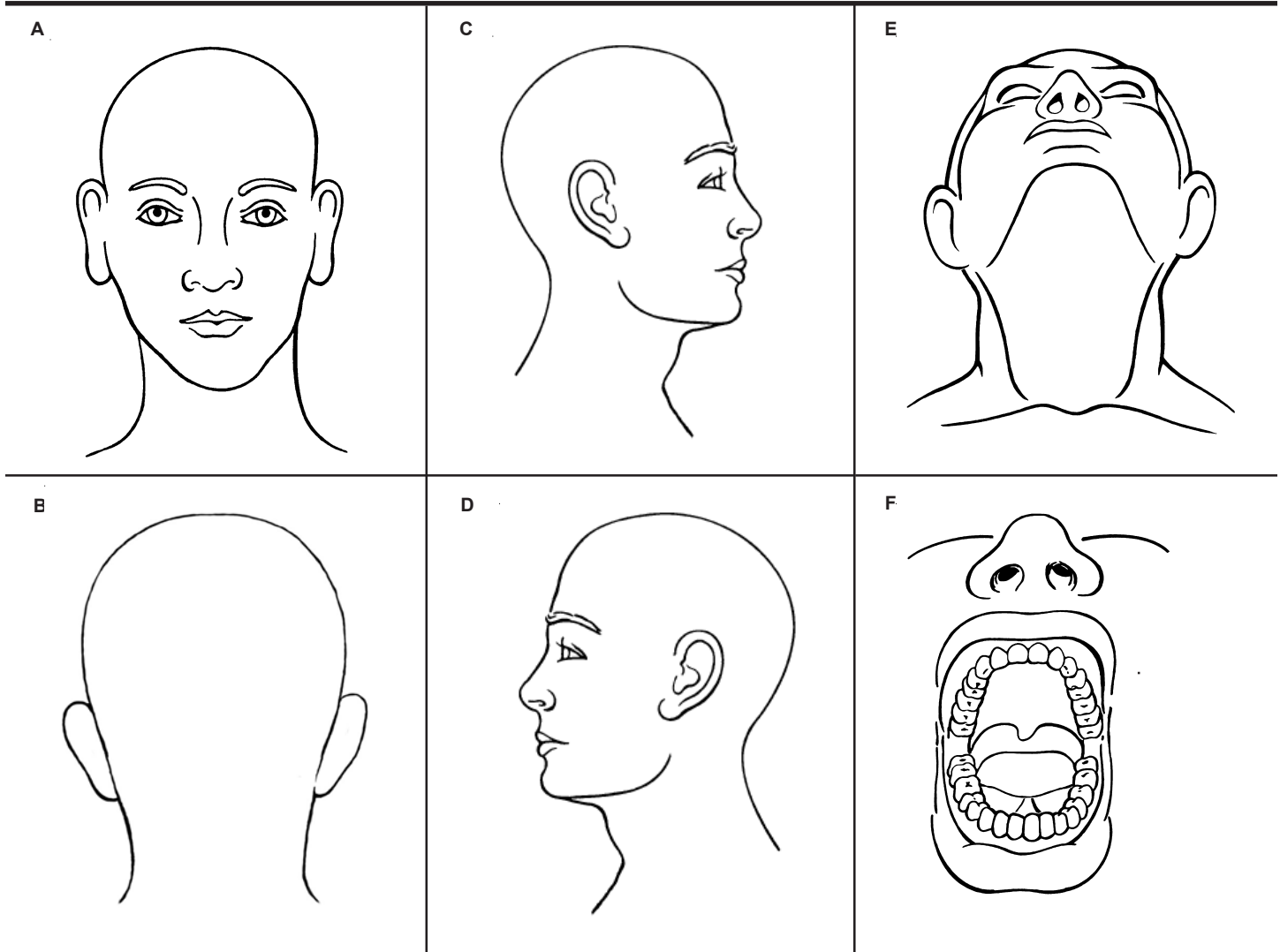
Patient Identification:

Date:

4. Describe condition of clothing upon arrival. Collect outer and under clothing if applicable. Not Applicable

5. Examine the face, head, ears, hair, scalp, neck, and mouth for injury. Document findings using photographs, diagrams, legend, and consecutive numbering system.

6. Collect dried and moist secretions, stains and foreign materials from the scalp, head and neck.



LEGEND: Types of Findings Findings No Findings Additional copies of this page attached

AB Abrasion	DS Dry Secretion	IN Induration	OI Other Injury (describe)	TA Tooth Avulsed
BI Bite	EC Ecchymosis (bruise)	IW Incised Wound	PE Petechiae	TD Tooth Decay
BU Burn	ER Erythema (redness)	LA Laceration	PS Potential Saliva	TF Tooth Fractured
CS Control Swab	FB Foreign Body	MS Moist Secretion	SI Suction Injuries	TM Tooth Missing
DE Debris	F/H Fiber/Hair	OF Other Foreign Materials (describe)	SW Swelling	V/S Vegetation/Soil
DF Deformity	FT Frenulum Torn		TE Tenderness	

Locator #	Type	Description	Locator #	Type	Description

K. GENERAL PHYSICAL EXAMINATION (continued)

7. Conduct a physical examination of body and extremities. Record findings using photographs, diagrams, legend, and a consecutive numbering system.

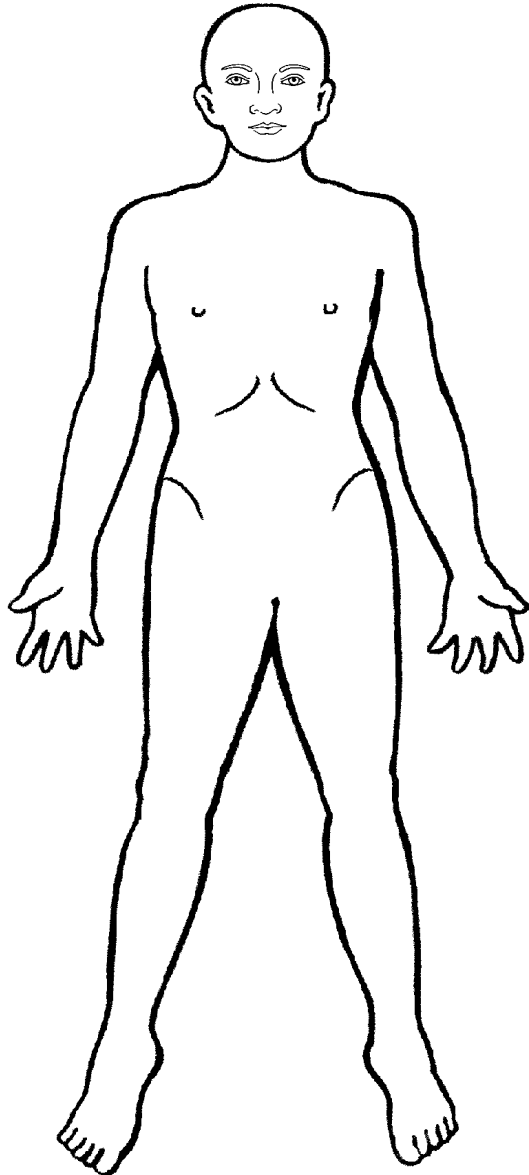
8. Collect dried and moist secretions, stains and foreign materials from body Findings No Findings

9. Collect fingernail scrapings/cuttings according to local policy Done Not Applicable

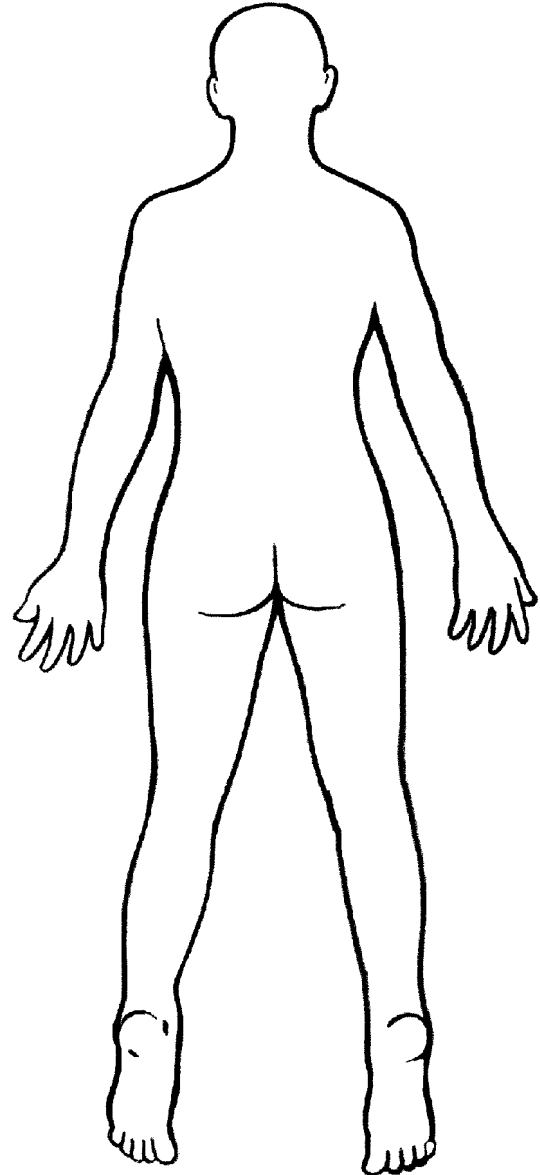
Patient Identification:

Date:

G



H



LEGEND: Types of Findings Findings No Findings Additional copies of this page attached

- | | | | |
|------------------------|-------------------------------|--|----------------------------|
| AB Abrasion | DS Dry Secretion | IW Incised Wound | PE Petechiae |
| BI Bite | EC Ecchymosis (bruise) | LA Laceration | PS Potential Saliva |
| BU Burn | ER Erythema (redness) | MS Moist Secretion | SI Suction Injuries |
| CS Control Swab | FB Foreign Body | OF Other Foreign Materials (describe) | SW Swelling |
| DE Debris | F/H Fiber/Hair | OI Other Injury (describe) | TE Tenderness |
| DF Deformity | IN Induration | | VS Vegetation/Soil |

Locator #	Type	Description	Locator #	Type	Description

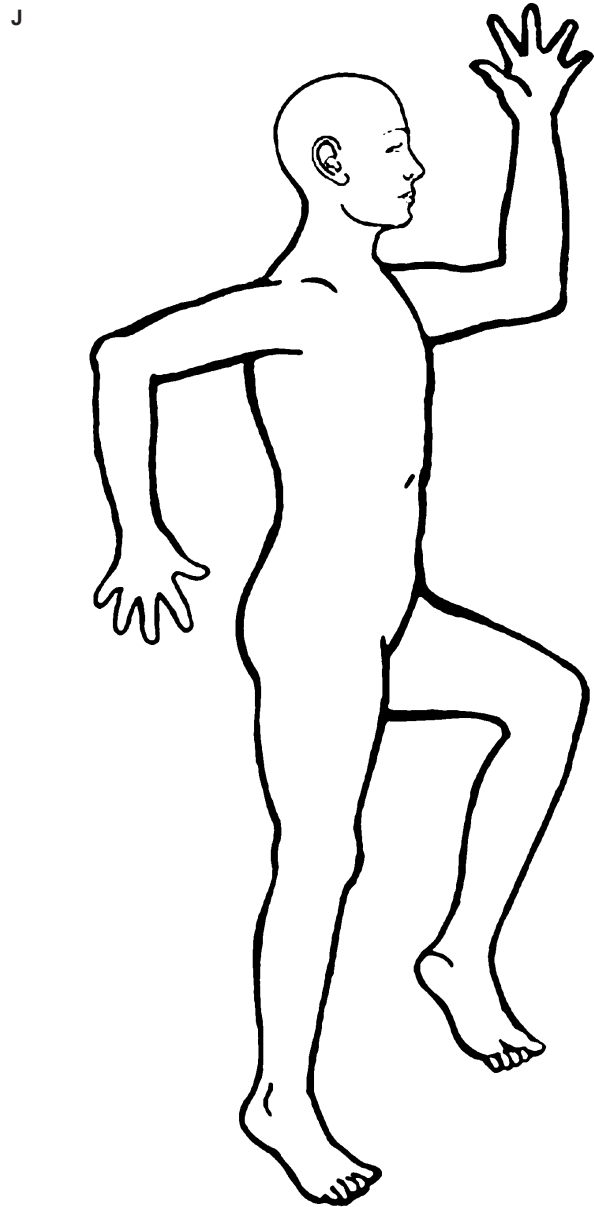
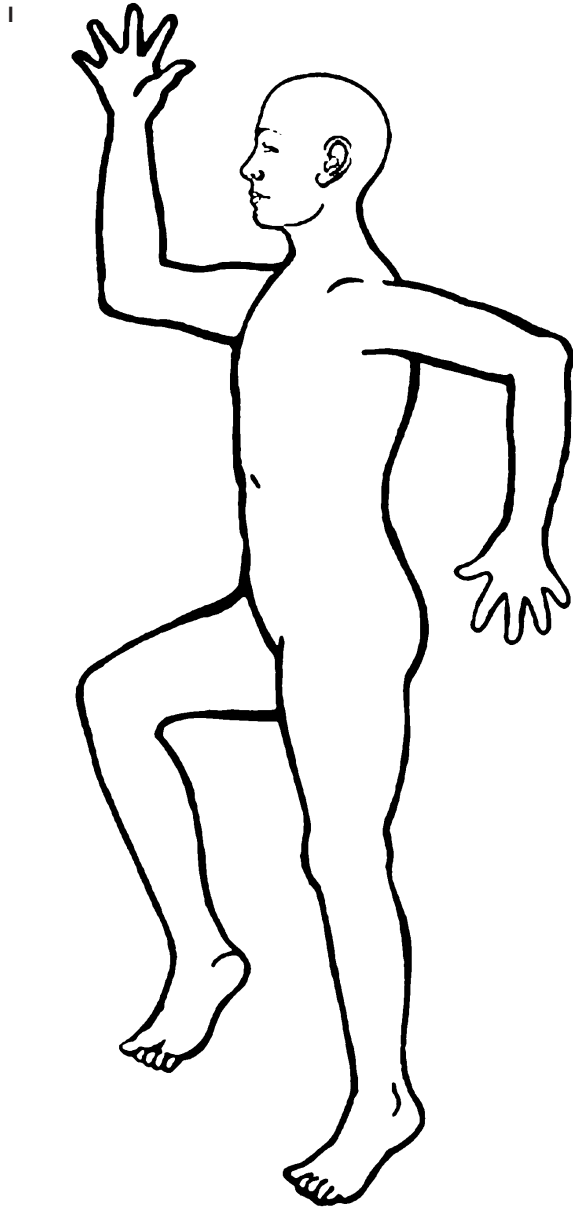
K. GENERAL PHYSICAL EXAMINATION (continued)

10. Use diagrams I and J to record findings to lateral or medial aspect of trunk or extremities. Record findings.

11. If genital injuries sustained, use pages 6 and 7 from CalEMA 2-923 Forensic Medical Report: Acute Adult/Adolescent Sexual Assault Examination form to document findings. Are CalEMA 2-923 pages 6 & 7 attached? Yes No Not applicable

Patient Identification:

Date:



LEGEND: Types of Findings Findings No Findings Additional copies of this page attached

- | | | | |
|------------------------|-------------------------------|--|----------------------------|
| AB Abrasion | DS Dry Secretion | IW Incised Wound | PE Petechiae |
| BI Bite | EC Ecchymosis (bruise) | LA Laceration | PS Potential Saliva |
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| DE Debris | F/H Fiber/Hair | OI Other Injury (describe) | TE Tenderness |
| DF Deformity | IN Induration | | VS Vegetation/Soil |

Locator #	Type	Description	Locator #	Type	Description

L. EVIDENCE COLLECTED AND SUBMITTED TO CRIME LAB

1. Clothing Collected <input type="checkbox"/> No <input type="checkbox"/> Yes	Clothing Placed in Evidence Kit	Clothing Placed in Paper Bag
Bra <input type="checkbox"/>		
Dress/skirt <input type="checkbox"/>		
Jacket/sweater <input type="checkbox"/>		
Nylons <input type="checkbox"/>		
Pants/shorts <input type="checkbox"/>		
Shirt/top <input type="checkbox"/>		
Shoes (1 or 2) <input type="checkbox"/>		
Socks (1 or 2) <input type="checkbox"/>		
Underwear <input type="checkbox"/>		
Undershirt <input type="checkbox"/>		
Other <input type="checkbox"/>		

2. Foreign Materials Collected

	N/A	No	Yes	Collected by:
Swabs/suspected blood <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dried secretions <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fiber/loose hairs <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Soil/debris/vegetation <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swabs/suspected saliva <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Foreign body <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fingernail scrapings <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Control swabs <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other, describe: _____				

3. Laboratory Results Additional Page Yes No
Pregnancy Positive Negative
Additional Labs: No Yes, specify: _____

4. X-Ray/Imaging Results Additional Page Yes No
 No Yes, specify: _____

5. Toxicology Samples N/A No Yes Time Collected by:

Blood Alcohol / Toxicology <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urine Toxicology <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

6. Reference Samples Blood Saliva Buccal N/A
Collected by: _____

7. Photo Documentation
 No Yes **35mm Digital Instant Other**

Photography by: _____ # Rolls/images _____
Recommend follow-up photographs to be taken in 1-2 days
 No Yes Not applicable

8. Voice recording for strangulation injuries
 No Yes If yes: Audio Audiovideo
If yes, obtained by: Examiner Law Enforcement

M. SUMMARY OF KEY FINDINGS

Patient Identification: _____ Date: _____

N. PERTINENT ISSUES AFFECTING EXAMINATION

O. PERSONNEL INVOLVED

Name (print clearly)	Phone
History taken by: _____	
Physical exam performed by: _____	
Specimens labeled and sealed by: _____	
Assisted by: <input type="checkbox"/> N/A	
Additional narrative by: <input type="checkbox"/> N/A	
Signature of Examiner _____	Date _____ License Number _____

P. DISTRIBUTION OF EVIDENCE

	Released To
Clothing (items not placed in evidence kit)	
Evidence Kit	
Reference samples	
Toxicology samples	
Recording(s) <input type="checkbox"/> Audio <input type="checkbox"/> Audiovideo	

Q. DISPOSITION AND FOLLOW UP

Discharged Admitted Follow Up Exam Scheduled
 Cross Reporting to: CPS APS N/A
 Referral to domestic violence advocacy services
 Safety plan discussed with patient
 Referral to counseling, drug, and alcohol treatment services
 Referral to Victim Witness Assistance Program
 Referral for Protective Order OR EPO. PO or EPO Granted

R. SIGNATURE OF OFFICER

I have received the evidence indicated above:
Printed Name _____ ID Number _____
Signature _____
Agency _____ Telephone _____