

State of California  
California Emergency Management Agency

**FORENSIC MEDICAL REPORT:  
ELDER AND DEPENDENT ADULT ABUSE AND NEGLECT  
EXAMINATION**

**CAL EMA 2-602**



For more information or assistance in completing the CAL EMA 2-602, please contact  
**California Clinical Forensic Medical Training Center at:**  
**(916) 930-3080 or [www.ccfmtc.org](http://www.ccfmtc.org)**

This form is also available on the following website:  
**[www.calema.ca.gov](http://www.calema.ca.gov)**

**Forensic Medical Report: Elder and  
Dependent Adult Abuse & Neglect Examination  
State of California  
California Emergency Management Agency  
CalEMA 2-602 PART 1: INTERVIEW**

**Confidential Document: Restricted Release**

**Patient Identification:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**A. GENERAL INFORMATION**     **Elder Abuse Exam**     **Dependent Adult Abuse Exam**

1. Patient's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

2. Street Address \_\_\_\_\_ City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

3. Age \_\_\_\_\_ DOB \_\_\_\_\_ Gender  Female  Male Ethnicity  White  Black / African American  Hispanic / Latino  Asian  American Indian / Alaskan Native  Native Hawaiian / Other Pacific Islander  Other \_\_\_\_\_

4. Name and address of facility where exam performed \_\_\_\_\_ If patient transferred from another facility, name and address of facility \_\_\_\_\_

5. Patient Arrival		Patient Discharged		6. Exam Started		Exam Completed	
Date	Time	Date	Time	Date	Time	Date	Time

7. Interpreter Used  No  Yes Language Used: \_\_\_\_\_  
 Name of Interpreter: \_\_\_\_\_ Telephone: \_\_\_\_\_  
 Affiliation of interpreter:  Facility Interpreting Services  Contracted Agency, specify: \_\_\_\_\_  
 Family  Friend  Other, specify: \_\_\_\_\_

**B. MANDATORY REPORTING FOR ELDER AND DEPENDENT ADULT ABUSE**

Adult Protective Services  Ombudsman  Law Enforcement  Other: \_\_\_\_\_  Telephone Report  
 Name of Person Taking Telephone Report \_\_\_\_\_ Date \_\_\_\_\_ Name of Agency \_\_\_\_\_  Written Report Submitted  
 Name of Person Taking Telephone Report \_\_\_\_\_ Date \_\_\_\_\_ Name of Agency \_\_\_\_\_  Written Report Submitted

**C. RESPONDING PERSONNEL TO MEDICAL FACILITY**     **Law Enforcement**     **APS**     **Ombudsman**

Name	Agency	ID Number	Telephone

**D. REQUEST AND AUTHORIZATION FOR MEDICAL EVIDENTIARY EXAM: Follow local policy**     **Not Applicable**

Law Enforcement Officer    Name \_\_\_\_\_ Agency \_\_\_\_\_ ID Number \_\_\_\_\_  
 Adult Protective Services  
 Ombudsman

**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, job retraining and rehabilitation. \_\_\_\_\_(initial)

**F. PATIENT CONSENT**

1. I understand that a medical evidentiary examination for evidence of abuse and/or neglect can, with my consent, be conducted by a health care professional to discover and preserve evidence. If conducted, the report of the examination and any evidence obtained will be released to investigative 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 photographing injuries and that these photographs may include the genital area. \_\_\_\_\_(initial)

3. I hereby consent to a medical evidentiary examination for evidence of abuse and/or neglect. \_\_\_\_\_(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 for demographic and/or epidemiological studies. \_\_\_\_\_(initial)

Patient     Surrogate     Conservator     Other: \_\_\_\_\_

Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**G. DISTRIBUTION OF CalEMA 2-602** (check all that apply)

Local Law Enforcement - Original     Adult Protective Services - Copy     Crime Lab - Copy     Ombudsman - Copy     Other Agency  
 Medical Facility Records - Copy     Bureau of Medi-Cal Fraud & Elder Abuse - Copy     District Attorney - Copy    Specify: \_\_\_\_\_

**PART I: INTERVIEW  
PATIENT HISTORY**

**H. SUSPECTED TYPES OF ABUSE BEING REPORTED**

<b>1. Interview audio and/or video taped</b> <input type="checkbox"/> No <input type="checkbox"/> Yes	<b>Patient Identification:</b> _____ <b>Date:</b> _____	
<b>2. Name(s) of person(s) providing history</b>	<b>Relationship to patient</b>	<b>Telephone</b>
_____	_____	_____

<b>3. Form(s) of abuse and neglect described</b>	<b>No</b>	<b>Yes</b>	<b>Unknown</b>	<b>Describe</b>
<b>Physical Abuse</b>				
1. Physical blows and/or <input type="checkbox"/> grabbing <input type="checkbox"/> holding <input type="checkbox"/> pinching <input type="checkbox"/> pushing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Strangulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Bites	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Weapons <input type="checkbox"/> Firearm <input type="checkbox"/> Knife <input type="checkbox"/> Blunt object <input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Burns <input type="checkbox"/> Thermal <input type="checkbox"/> Chemical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Physical restraints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Chemical restraints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Poisoning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Involuntary alcohol/drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Sexual Assault</b> (Consult with law enforcement)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Financial</b>				
1. Misappropriation of money	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Property transfer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Abandonment</b>				
1. Desertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Patient left alone in unsafe circumstances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Isolation</b>				
1. False imprisonment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Patient prevented from seeing family/social contacts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Patient prevented from receiving mail/phone calls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Patient prevented from keeping appointments with medical, legal, or other service providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Abduction</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Neglect</b>				
1. Unsafe environment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Inadequate provision for heat or cooling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Malnutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
4. Dehydration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
5. Pressure ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
6. Medication not given as prescribed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
7. Failure to provide patient with glasses, walker, wheel- chair, hearing aide, dentures, or assistive devices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
8. Failure to seek physician services or follow physician orders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
9. Care plan not followed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Self-Neglect</b>				
1. Failure to live in a safe environment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Inability or failure to perform self-care tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Psychological Abuse</b>				
1. Threats of harm/intimidation If yes, target of threat: <input type="checkbox"/> patient <input type="checkbox"/> family <input type="checkbox"/> pet <input type="checkbox"/> other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
2. Harassment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
3. Emotional abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
<b>Other:</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

<b>I. ALLEGED PERPETRATOR(S)</b>						
Name(s)	Age/DOB	Gender	Ethnicity	Address	Telephone	Relationship to patient

**J. LOCATION WHERE ABUSE AND NEGLECT OCCURRED**

**PART I: INTERVIEW  
FUNCTIONAL, COGNITIVE, MENTAL HEALTH,  
AND SUBSTANCE ABUSE SCREENING**

Patient Identification:

Date:

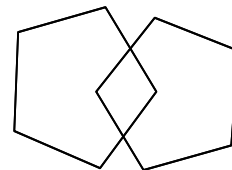
**K. FUNCTIONAL HISTORY: Indicate any limitations**

	Independent	Needs Assistance	Totally Dependent	Unknown		Independent	Needs Assistance	Totally Dependent	Unknown
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medication management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Housekeeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going to toilet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transferring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Transportation management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Continence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Handling finances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Telephoning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preparing meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Judgement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**L. DISABILITY?**  No  Yes If yes,  Cognitive  Developmental  Physical  Blind  Deaf/HOH  Mental

**M. COGNITIVE ASSESSMENT - MINI-MENTAL STATE EXAM (Score one point for each correct answer)**

Max. Points	Patient Score	Orientation
5	( )	What is the (year) (season) (date) (day) (month)?
5	( )	Where are we (state) (county) (town/city) (building) (floor)?
		<b>Registration</b>
3	( )	Ask patient to name three common objects (e.g., "apple," "table," "penny") _____ Take one second to say each. Then ask the patient to repeat all three after you have said them. Give one point for each correct answer. Then repeat them until he/she learns all three. Count trials and record. Trials: ( )
		<b>Attention and Calculation</b>
5	( )	Spell "world" backwards. The score is the number of letters in the correct order. (D__L__R__O__W__)
		<b>Recall</b>
3	( )	Ask for the three objects repeated above. Give one point for each correct answer. (Note: recall cannot be tested if all three objects were not remembered during registration.)
		<b>Language</b>
2	( )	Name a "pencil" and a "watch."
1	( )	Repeat the following: "no if's, and's, or but's."
3	( )	Follow a three-state command: "Take a paper in your right hand, fold it in half and put it on the floor."
1	( )	Read and obey the following: "Close your eyes"
1	( )	Write a sentence
1	( )	Copy this design
		<b>Scoring</b> Number of years of education: _____
30	( )	Total
	( )	Age/education corrected score (see instructions)



**N. MENTAL HEALTH AND SUBSTANCE ABUSE SCREENING**

Ask the patient:	No	Yes
1. Do you feel your life is empty?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you often feel sad?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you feel "pretty worthless" the way you are now?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you had recent thoughts of suicide?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have a history of substance abuse?	<input type="checkbox"/>	<input type="checkbox"/>

**O. INTERVIEWER FOR PART I**

Signature	
Printed Name	ID No./License No.
Agency/Facility	
Telephone	Date

**PART II: MEDICAL ASSESSMENT**

**P. ABUSE AND NEGLECT RELATED MEDICAL HISTORY**

**Patient Identification:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**1. Date(s) of abuse and/or neglect**

**Time/time frame of abuse and/or neglect**

**2. Description of abuse and/or neglect:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**3. Past history of abuse?**  No  Yes  Unknown **When?** \_\_\_\_\_

**Reported?**  No  Yes  Unknown **Where?** \_\_\_\_\_

**4. Any recent (60 days) surgeries, diagnostic procedures, psychiatric or medical treatment that may affect the interpretation of current physical or cognitive findings?**  No  Yes  Unknown **If yes, describe** \_\_\_\_\_

\_\_\_\_\_

**5. Any other pertinent medical condition(s) that may affect the interpretation of current physical findings?**

No  Yes  Unknown **If yes, describe:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**6. Any pre-existing physical injuries?**  No  Yes  Unknown **If yes, describe:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**7. Name(s) of current/prior health care providers**

**Address**

**Telephone**

_____	_____	_____
_____	_____	_____
_____	_____	_____

**8. Current use of medication(s)**  No  Yes  Unknown

**Dose/frequency**

**Time of last dose**

Aspirin

Nonsteroidal anti-inflammatory drugs

Coumadin

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**9. Abuse and/or neglect related cognitive change(s)?**

No Yes Unknown

Loss of memory?

Change in level of consciousness?

Recent consumption of alcohol?

If yes, collection of toxicology samples is recommended according to local policy.

Blood  Urine

Other

## PART II: MEDICAL ASSESSMENT

### Q. GENERAL PHYSICAL EXAMINATION

1. Describe general physical appearance and hygiene.

2. Describe general demeanor/behavior during exam.

Patient Identification: \_\_\_\_\_

Date: \_\_\_\_\_

3. Describe condition of clothing. Collect, if indicated. \_\_\_\_\_

4. Describe condition of glasses, dentures, hearing aides, wheelchairs, canes, walkers, etc. Collect, if indicated. \_\_\_\_\_

5. Status of nutrition No Yes Describe

Adequately nourished   \_\_\_\_\_

Cachexia   \_\_\_\_\_

Temporal wasting   \_\_\_\_\_

**Status of hydration:**

Adequate hydration   \_\_\_\_\_

Dry mucous membranes   \_\_\_\_\_

Poor skin turgor   \_\_\_\_\_

### 6. Pain Scale

**For verbal patients:**  
Patient's self-rated pain status: \_\_\_\_\_

1-10 \_\_\_\_\_

Location(s) of pain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**For nonverbal patients:**



0  
NO HURT



1  
HURTS  
LITTLE BIT



2  
HURTS  
LITTLE MORE



3  
HURTS  
EVEN MORE



4  
HURTS  
WHOLE LOT



5  
HURTS  
WORST

Observed evidence of pain: \_\_\_\_\_

### 7. Vital Signs

Blood pressure lying \_\_\_\_\_ Sitting \_\_\_\_\_ Standing \_\_\_\_\_ Temperature \_\_\_\_\_

Pulse lying \_\_\_\_\_ Sitting \_\_\_\_\_ Respiration(s) \_\_\_\_\_ Oxygen Saturation \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Prior weight \_\_\_\_\_ Date of prior weight \_\_\_\_\_

### 8. Conduct a general physical exam and record findings.

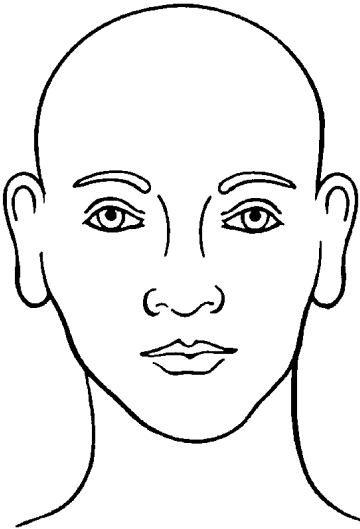


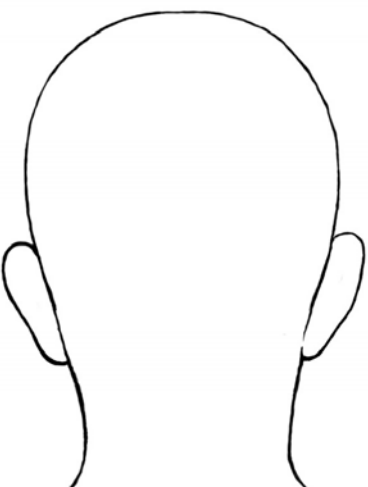
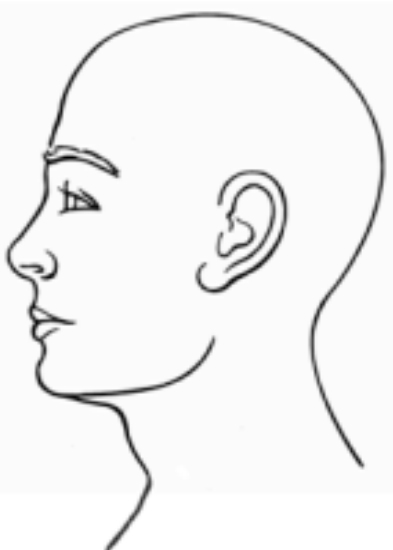
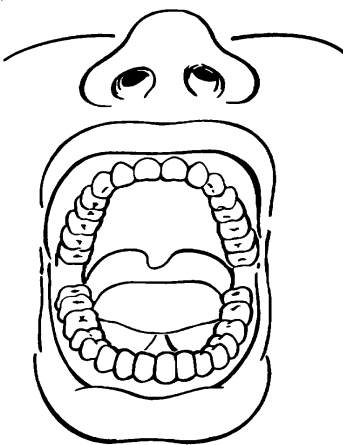
	WNL	ABN	Not Examined	See Diagrams	Describe Abnormal Findings
Skin					
Head					
Eyes					
Ears					
Nose					
Mouth/pharynx					
Teeth					
Neck					
Thorax					
Back					
Breasts					
Cardiac					
Pulmonary					
Abdomen					
Rectal					
Genitalia					
Musculoskeletal					
Neurological					
Including gait					

**PART II: MEDICAL ASSESSMENT**  
**R. GENERAL PHYSICAL EXAMINATION**

Examine the face, head, hair, scalp, neck and mouth for injury and foreign materials. Measure all findings. Record all findings using photographs, diagrams, legend, and a consecutive numbering system.

Patient Identification: \_\_\_\_\_

Date: \_\_\_\_\_

A 	C 	E 
B 	D 	F 

**LEGEND: Types of Findings**     Findings     No Findings

<b>AB</b> Abrasion	<b>DM</b> Dry Mucous Membranes	<b>F/H</b> Fiber/Hair	<b>LA</b> Laceration	<b>PU</b> Pressure Ulcer (indicate State I, II, III, IV)
<b>AL</b> Alopecia	<b>DF</b> Deformity	<b>FB</b> Foreign Body	<b>OF</b> Other Foreign Materials (describe)	<b>SC</b> Scratch
<b>BI</b> Bite	<b>DS</b> Dry Secretion	<b>FR</b> Fracture	<b>OI</b> Other Injury (describe)	<b>ST</b> Skin Tears
<b>BU</b> Burn	<b>EC</b> Ecchymosis (bruise) color	<b>IN</b> Induration	<b>PE</b> Petechiae	<b>TD</b> Tooth Decay
<b>DE</b> Debris	<b>ED</b> Edema	<b>INF</b> Infestation	<b>PI</b> Pattern Injury	<b>UI</b> Urinary Soiling
<b>DEN</b> Denture	<b>ER</b> Erythema (redness)	<b>IW</b> Incised Wound		
	<b>FI</b> Fecal Soiling			

Locator #	Type	Description	Locator #	Type	Description

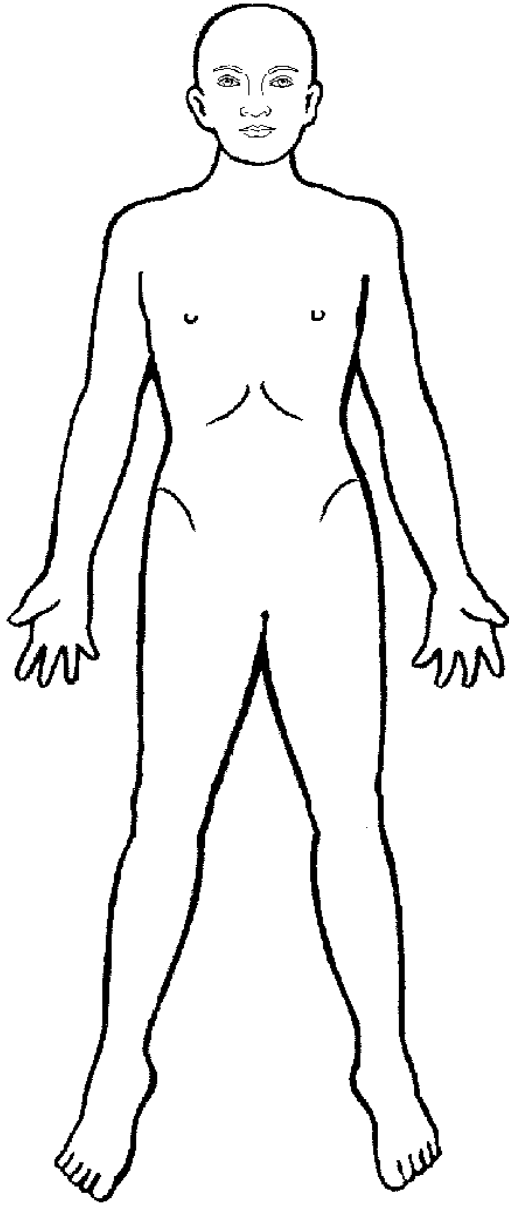
**R. GENERAL PHYSICAL EXAMINATION (cont.)**

Conduct physical examination of body and extremities. Record all findings using diagrams, legend and a consecutive numbering system. Measure all applicable findings.

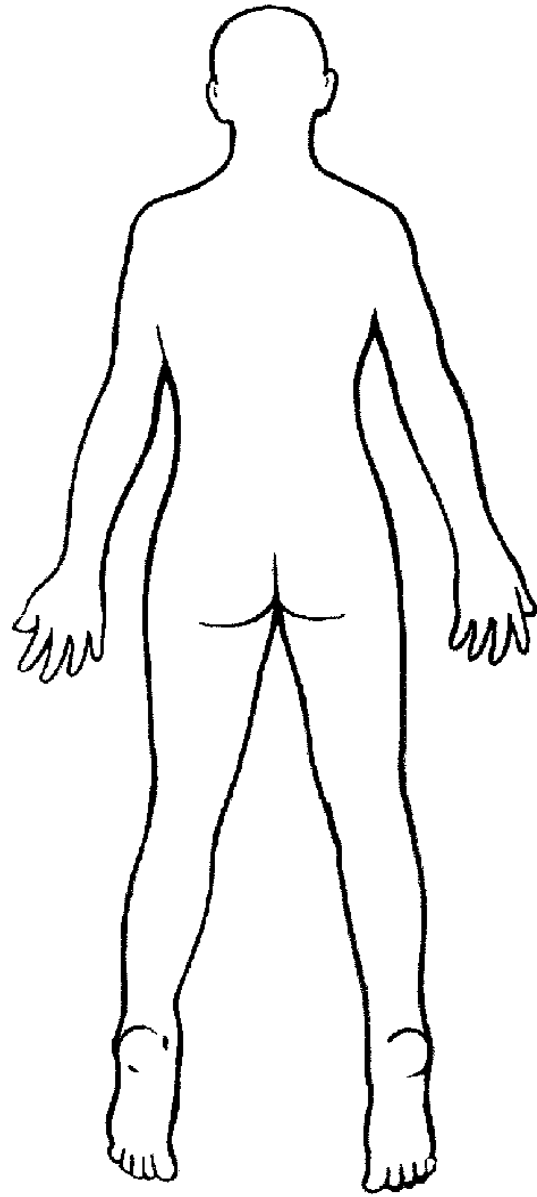
Patient Identification:

Date:

G



H



**LEGEND: Types of Findings**     Findings     No Findings

<b>AB</b> Abrasion	<b>DF</b> Deformity	<b>F/H</b> Fiber/Hair	<b>LA</b> Laceration	<b>PU</b> Pressure Ulcer (indicate State I, II, III, IV)
<b>AL</b> Alopecia	<b>DS</b> Dry Secretion	<b>FB</b> Foreign Body	<b>OF</b> Other Foreign Materials (describe)	<b>SC</b> Scratch
<b>BI</b> Bite	<b>EC</b> Ecchymosis (bruise) color	<b>FR</b> Fracture	<b>OI</b> Other Injury (describe)	<b>ST</b> Skin Tears
<b>BU</b> Burn	<b>ED</b> Edema	<b>IN</b> Induration	<b>PE</b> Petechiae	<b>UI</b> Urinary Soiling
<b>DE</b> Debris	<b>ER</b> Erythema (redness)	<b>INF</b> Infestation	<b>PI</b> Pattern Injury	
<b>DM</b> Dry Mucous Membranes	<b>FI</b> Fecal Soiling	<b>IW</b> Incised Wound		

Locator #	Type	Description	Locator #	Type	Description

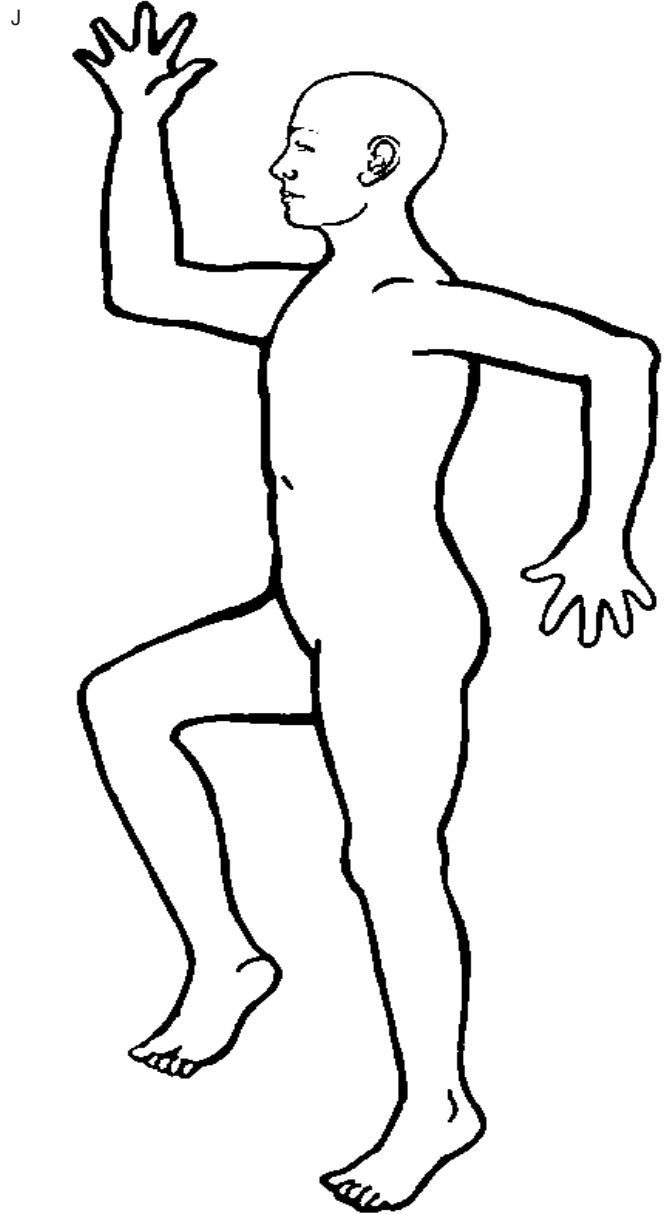
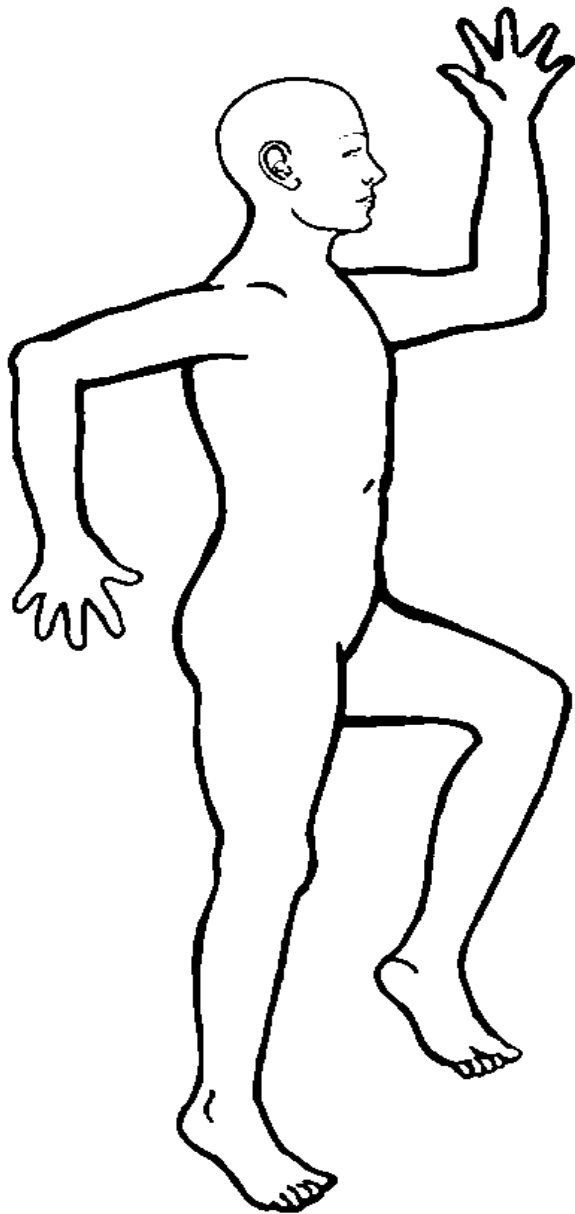
**R. GENERAL PHYSICAL EXAMINATION (cont.)**

Use diagrams I and J to record findings to lateral or medial aspect of trunk and/or extremities. Record all findings using photographs, diagrams, legend and a consecutive numbering system. Measure all applicable findings.

*Note: 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.*

Patient Identification:

Date:



**LEGEND: Types of Findings**     Findings     No Findings

<b>AB</b> Abrasion	<b>DF</b> Deformity	<b>F/H</b> Fiber/Hair	<b>LA</b> Laceration	<b>PU</b> Pressure Ulcer (indicate State I, II, III, IV)
<b>AL</b> Alopecia	<b>DS</b> Dry Secretion	<b>FB</b> Foreign Body	<b>OF</b> Other Foreign Materials (describe)	<b>SC</b> Scratch
<b>BI</b> Bite	<b>EC</b> Ecchymosis (bruise) color	<b>FR</b> Fracture	<b>OI</b> Other Injury (describe)	<b>ST</b> Skin Tears
<b>BU</b> Burn	<b>ED</b> Edema	<b>IN</b> Induration	<b>PE</b> Petechiae	<b>UI</b> Urinary Soiling
<b>DE</b> Debris	<b>ER</b> Erythema (redness)	<b>INF</b> Infestation	<b>PI</b> Pattern Injury	
<b>DM</b> Dry Mucous Membranes	<b>FI</b> Fecal Soiling	<b>IW</b> Incised Wound		

Locator #	Type	Description	Locator #	Type	Description

**PART II: MEDICAL ASSESSMENT  
SUMMARY OF FINDINGS**

**Patient Identification:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**S. EVIDENCE COLLECTED AND SUBMITTED TO CRIME LAB**

1. Clothing Collected	No	Yes	Placed in Evidence Kit	Placed in Paper Bag
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		

**T. CLINICAL STUDIES**

Laboratory Results:	No	Yes	Pending	Additional Page
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes
X-ray/Imaging Results:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes

2. Foreign Materials	N/A	No	Yes	Collected by:
Swabs/suspected blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dried secretions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fibers/loose hairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Soil/debris/vegetation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swabs/suspected saliva	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Foreign body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fingernail scrapings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Control swabs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Toxicology Samples	No	Yes	Pending	Time	Collected by
Toxicology screen Results:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Blood alcohol/toxicology Results:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Urine toxicology Results:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

**Reference Samples**  
 No  Yes  Blood  Saliva

**U. PHOTO DOCUMENTATION**

No  Yes  35 mm  Digital  Instant  Other Optics  
 Photography by: \_\_\_\_\_ # Rolls/Images \_\_\_\_\_  
 Retained  Released to: \_\_\_\_\_  
 Recommend follow-up photographs to be taken in 1-2 days  No  Yes  Not applicable

**V. DISTRIBUTION OF EVIDENCE**

	Released to:
Clothing (items not placed in evidence kit)	
Evidence Kit	
Reference Samples	
Toxicology Samples	
Recordings <input type="checkbox"/> Audio <input type="checkbox"/> Audiovideo	

**W. VOICE RECORDING FOR STRANGULATION INJURIES**

No  Yes If yes:  Audio  Audiovideo If yes, obtained by:  Examiner  Law Enforcement

**X. SUMMARY AND INTERPRETATION OF FINDINGS:** \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

If patient expires, contact medical examiner/coroner for an autopsy.  No, not applicable  Yes

**Y. FOLLOW UP**

Family/friend contact name	Telephone	Follow-up Exam Needed (specify reason):
Location/address of patient following examination	Telephone	

Z. EXAMINER for Part II	SIGNATURE OF LAW ENFORCEMENT OFFICER
Signature of Examiner _____ Printed name _____	<b>I have received the evidence indicated above</b>
Signature of Supervising Physician, if applicable _____	Signature of Officer _____ Printed Name _____
Title _____ License Number _____	ID Number _____
Medical Facility _____ Date _____	Agency: _____
Address _____ Telephone _____	Telephone _____
	Date: _____