

**HAWAII STATE
MEDICAL-LEGAL RECORD AND SEXUAL ASSAULT INFORMATION FORM**

PEDIATRIC

Date: _____ Patient Name: _____

Time In: _____ AM / PM Nickname: _____ Age: _____

Time Out: _____ AM / PM Gender Identity reported by patient: M Transgender (MTF) F Transgender (FTM) Other: _____

DOB: _____ Ethnicity: _____

Accompanied patient to exam site/relationship: _____

Present during the exam/relationship: _____

Height: _____ Temp: _____ Resp: _____
Weight: _____ Pulse: _____ B/P: _____ Glasses/Contacts: _____ Yes _____ No

Victim Rights Notification Form Provided: Signature of person completing the above information _____

THIS PORTION TO BE COMPLETED BY EXAMINER IN ATTENDANCE

HEALTH HISTORY

1A. **PAST HISTORY**

Major Illnesses / Disabilities: _____

Drug Allergies: _____

Medications: _____

Pre-existing physical injuries: _____

Pertinent medical history of anal-genital injuries, surgeries, diagnostic procedures, or medical treatment: _____

History of Hepatitis B Vaccination: _____ Yes _____ No _____ Unknown

FEMALES: IF HISTORY OF MENARCHE, USE ADULT / ADOLESCENT FORM

1B. **PATIENT HISTORY**

Is the patient able to answer question(s) pertaining to the assault? _____ Yes _____ No

If no, explain: _____

Name of person providing history: _____

Relationship to Patient: _____

Sexual penetration/contact within the past 120 hours, other than this assault: _____ Yes _____ No _____ Unable to discuss

Date / Time / Location of assault: _____

_____ Less than 120 hours since assault took place _____ Over 120 hours since assault took place

Number of perpetrator(s): _____

Name(s) and age(s) of perpetrator(s) if known: _____

Relationship of perpetrator(s) to patient: _____

BAR CODE # _____

POLICE REPORT # _____

2. Since assault, check () if patient has:

- | | | |
|--|---|---|
| <input type="checkbox"/> Drank / Eaten | <input type="checkbox"/> Brushed Teeth | <input type="checkbox"/> Defecated |
| <input type="checkbox"/> Changed Clothes | <input type="checkbox"/> Used Mouthwash | <input type="checkbox"/> Douched |
| <input type="checkbox"/> Been Swimming | <input type="checkbox"/> Vomited | <input type="checkbox"/> Removed / inserted tampon, sponge,
diaphragm (circle) |
| <input type="checkbox"/> Bathed / Showered | <input type="checkbox"/> Urinated | |

3. SUMMARY OF PRESENTING COMPLAINTS, SYMPTOMS AND HISTORY:

COMPLAINTS / HISTORY (Incident)

BAR CODE # _____

POLICE REPORT # _____

SUMMARY OF PRESENTING COMPLAINTS, SYMPTOMS AND HISTORY: (Continued)

4. ACTS DESCRIBED:

Unable to obtain detailed history because of:
 ___ developmental age ___ altered mental status

Described by: P = Patient / H = Historian				
Yes	No	Attempted	Unknown	N/A

Describe:

Penetration of genital opening by:

Penis:					
Finger:					
Foreign object:					

Describe object:

Penetration of anus by:

Penis:					
Finger:					
Foreign object:					

Describe object:

Oral contact of genitals:

Of patient's genitals by perpetrator:					
Of perpetrator's genitals by patient:					

Oral contact of anus:

Of patient's anus by perpetrator:					
Of perpetrator's anus by patient:					

Physical Contact: genitals, anus, breasts, buttocks, and/or other (circle)

If other, specify location:

Of patient by perpetrator:					
Of perpetrator by patient:					
Of perpetrator by perpetrator:					

Ejaculation:

Inside of body orifice:					
Outside of body orifice:					

Specify location:

Kissing / licking:

Specify location:					
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5. METHODS EMPLOYED BY PERPETRATOR:

Described by: P = Patient / H = Historian			
	Yes	No	Unknown
Weapons used:			
Type of weapon:			
Physical blows:			
Specify location:			
Specify what was used:			
Strangulation: If "Yes" complete Appendix A – Strangulation Supplemental			
Grabbing / grasping / holding (circle):			
Specify location:			
Physical restraints:			
Specify location:			
Specify what was used:			
Bites / suction:			
Specify location:			
Threat(s) of harm:			
To whom:			
Type of threat(s):			
Other: (Describe)			
DID PERPETRATOR:			
Claim vasectomy / sterile:			
Use a condom:			
Use a lubricant:			
Clean self after assault:			
Describe what was used:			

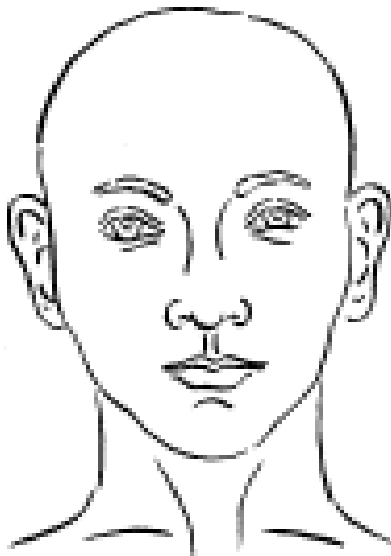
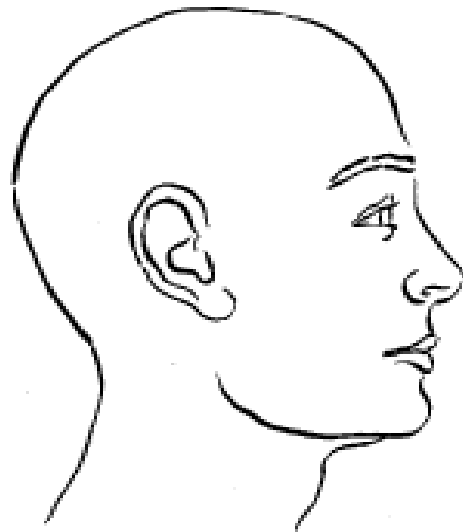
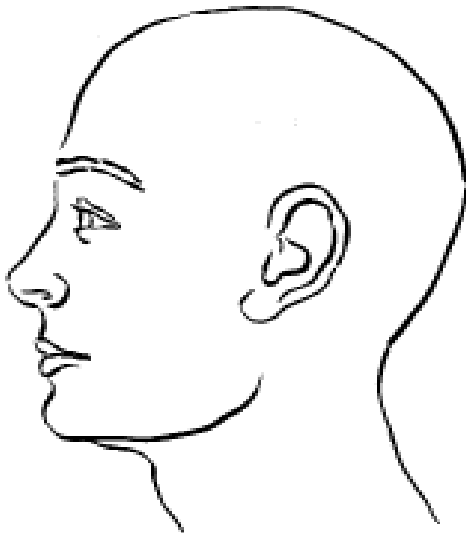
7. PHYSICAL FINDINGS OF FACE AND MOUTH: (Document location and include all signs of tenderness and trauma)

A = Abrasion
B = Bite
BR = Bruise
BU = Burn
E = Erythema

FM = Foreign Material
L = Laceration
P = Petechiae
R = Rash
S = Scar

SW = Swelling / Edema
T = Tenderness
OI = Other Injury (Describe)

Body Photos ___ Yes ___ No



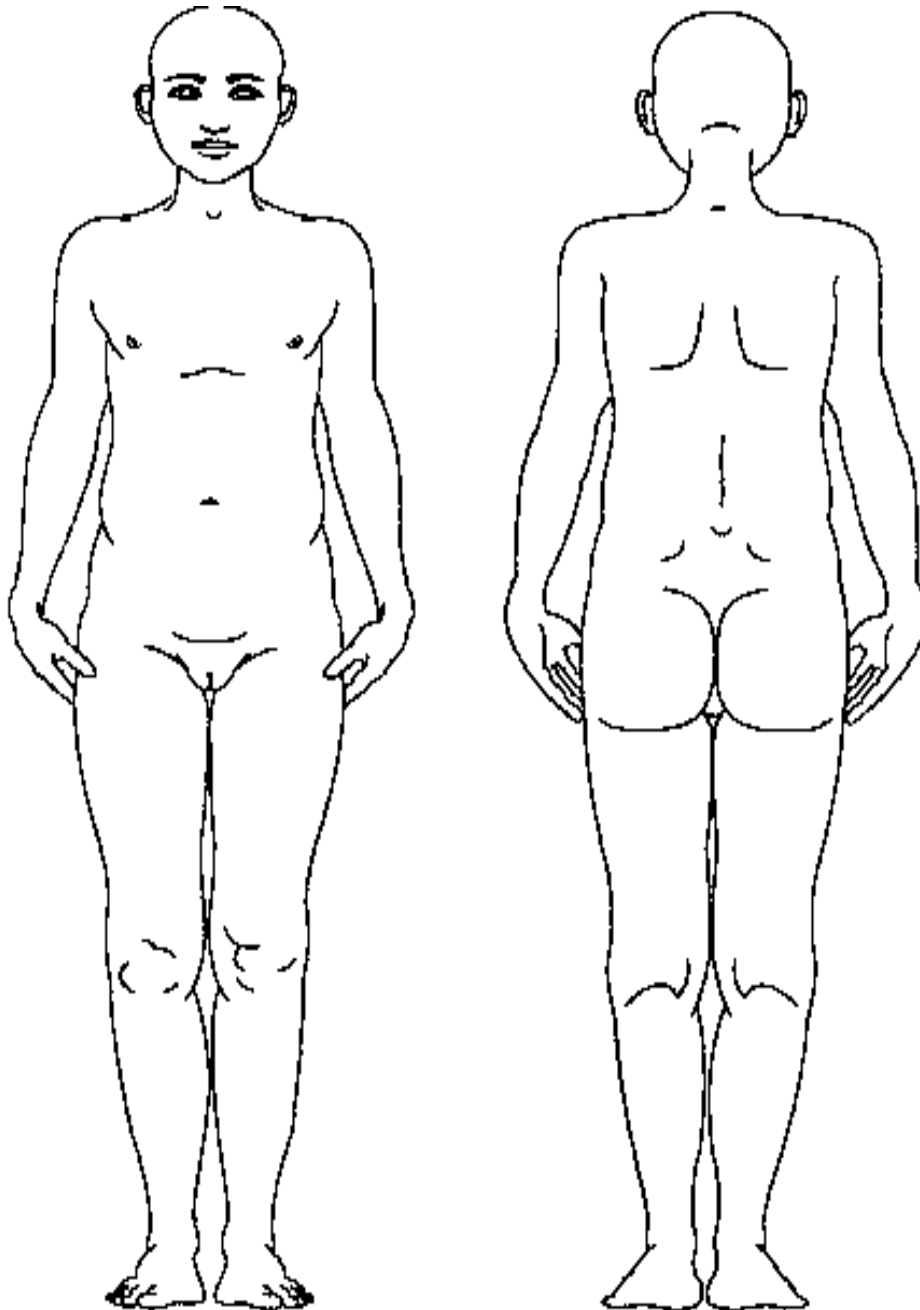
PHYSICAL FINDINGS OF FEMALE: (Document location and include all signs of tenderness and trauma)

A = Abrasion
B = Bite
BR = Bruise
BU = Burn
E = Erythema

FM = Foreign Material
L = Laceration
P = Petechiae
R = Rash
S = Scar

SW = Swelling / Edema
T = Tenderness
OI = Other Injury (Describe)

Body Photos ___ Yes ___ No



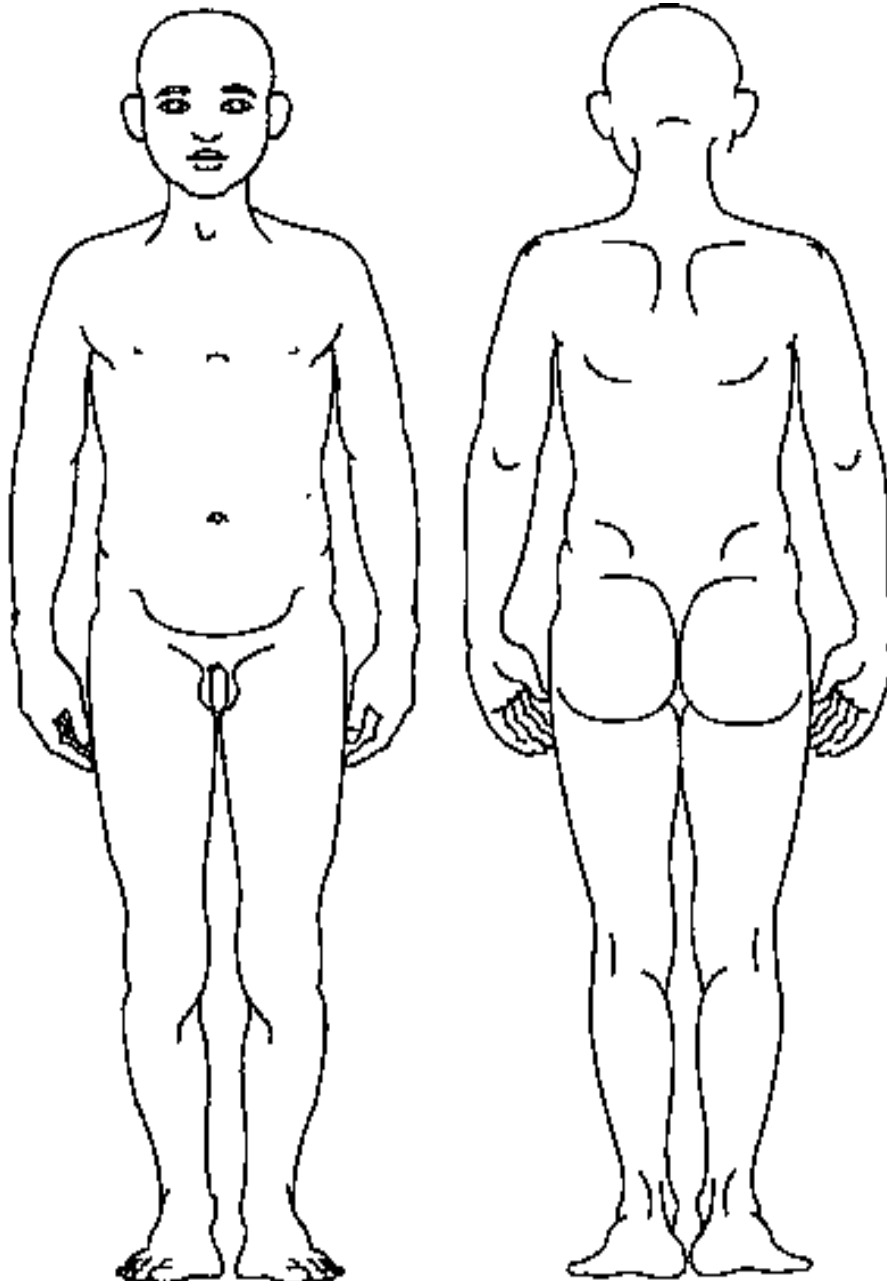
PHYSICAL FINDINGS OF MALE: (Document location and include all signs of tenderness and trauma)

A = Abrasion
B = Bite
BR = Bruise
BU = Burn
E = Erythema

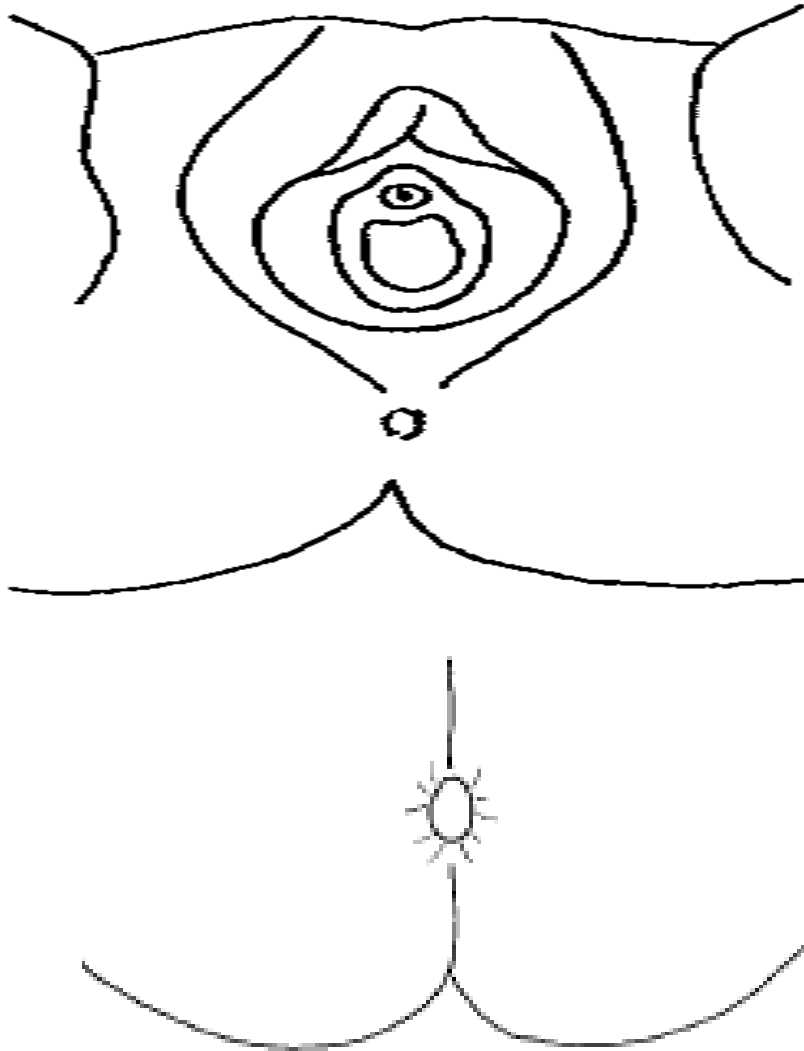
FM = Foreign Material
L = Laceration
P = Petechiae
R = Rash
S = Scar

SW = Swelling / Edema
T = Tenderness
OI = Other Injury (Describe)

Body Photos ___ Yes ___ No



8. PHYSICAL EXAMINATION OF FEMALE – Include all signs of tenderness, trauma, discharge and scars. Illustrate signs of trauma and document sites of fluorescence.



Genital/ Anogenital Photographs _____ Yes _____ No

If yes, complete documentation on page 12

Genital/ Anogenital Photographs with Toluidine Blue _____ Yes _____ No

Additional Comments: _____

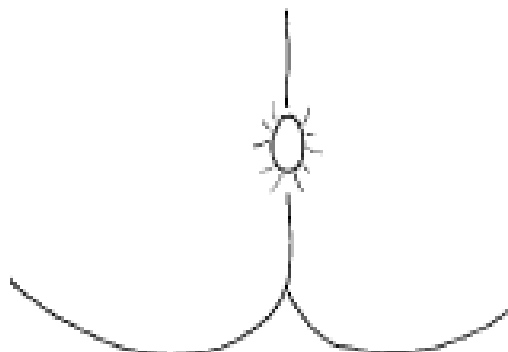
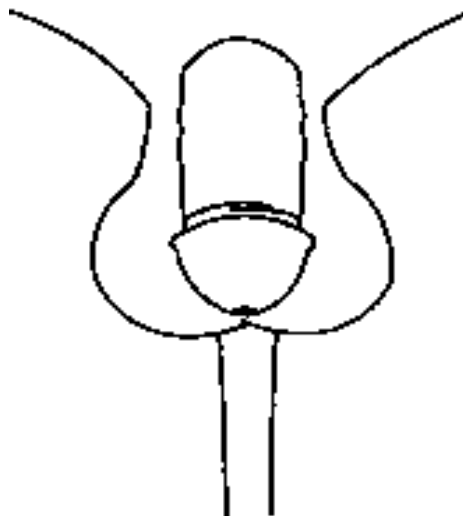
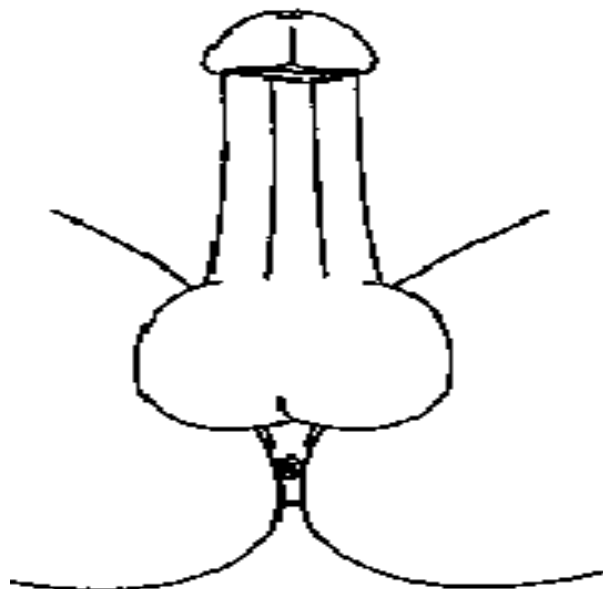
Fluorescence

Alternate Light Source _____ Yes _____ No

Was fluorescence observed _____ Yes _____ No

List sites: _____

PHYSICAL EXAMINATION OF MALE – Include all signs of tenderness, trauma, discharge and scars.
Illustrate signs of trauma and document sites of fluorescence.



Genital/ Anogenital Photographs

___ Yes

___ No

If yes, complete documentation on page 12

Genital/ Anogenital Photographs with Toluidine Blue

___ Yes

___ No

Additional Comments: _____

Fluorescence

Alternate Light Source

___ Yes

___ No

Was fluorescence observed

___ Yes

___ No

List sites: _____

9. ANAL-GENITAL CHART:

FEMALE / MALE GENERAL

Tanner Stage													
Female:						Male:							
Breast	1	2	3	4	5	Genitals	1	2	3	4	5		
Pubic Hair	N/A	1	2	3	4	5	Pubic Hair	N/A	1	2	3	4	5
			WNL		ABN		Not Examined		Describe				
Inguinal adenopathy													
Medial aspect of thighs													
Perineum													
Vulvovaginal discharge													
Urethral discharge													
Anal discharge													

FEMALE	WNL	ABN	Not Examined	Describe
Labia majora				
Clitoris				
Labia minora				
Periurethral tissue/urethral meatus				
Hymen				
Posterior fourchette				
Fossa navicularis				
Vagina				
Cervix				
Other (describe):				

Genital exam position used: (check all that apply):

____ Supine Lithotomy ____ Supine Frog-legged ____ Supine Knee Chest ____ Prone Knee Chest

MALE	WNL	ABN	Not Examined	Describe
Penis Circumcised ____ Yes ____ No				
Urethral Meatus (e.g., discharge, redness)				
Scrotum				
Testes				
Other (describe):				

FEMALE / MALE ANUS	WNL	ABN	Not Examined	Describe
Buttocks				
Perianal skin				
Anal verge / folds / rugae				
Anal tone (e.g., spasm, laxity)				
Rectal ampulla				
Other (describe):				

Genital Exam done with: _____ Direct Visualization _____ Digital Imaging System
 Method of exam for anal tone: _____ Observation _____ Digital Exam
 Anal exam position used: _____ Supine _____ Prone _____ Lateral recumbent

10. EXAMINATION FINDINGS:

Physical examination reveals:

_____ Physical Findings

_____ No Physical Findings

SUMMARY OF PHYSICAL FINDINGS:

____ Oral trauma

____ Genital trauma

____ Anal Trauma

____ Other physical trauma

PHOTOGRAPHY:

_____ Yes

_____ No

HAWAII STATE SEXUAL ASSAULT EVIDENCE COLLECTION KIT USED:

_____ Yes

_____ No

FOLLOW – UP:

Check (✓) if applicable:

_____ Return for follow-up exam with private health provider or gynecologist

When: _____

_____ Referral for further STI testing if not treated

_____ Follow-up by Department of Human Services – Child Welfare Services (DHS-CWS)

_____ Referral for counseling given

_____ Other: _____

Examiner's Signature

Examiner's Time In: _____ AM / PM

Examiner's Name (Please Print)

Examiner's Time Out: _____ AM / PM

Address and phone number where you can be reached:

Address: _____

Phone: _____

LABORATORY SPECIMENS

Check (√) if Done:

___ Urine Test for Pregnancy: ___ Positive ___ Negative ___ Pending

___ Gonorrhea: ___ Endocervical ___ Vaginal ___ Rectal ___ Penile ___ Oral ___ Urine

___ Chlamydia: ___ Endocervical ___ Vaginal ___ Rectal ___ Penile ___ Urine

___ Herpes: Specify Site: _____

___ Complete Urinalysis

___ Drug Screening

___ HIV Protocol (only to be offered to 13 yrs old and older for exposure within 72 hours)

___ Other: (Specify) _____

WET MOUNT

Wet Mount slide prepared: ___ Yes ___ No

Slide interpreted by examiner: ___ Yes ___ No

 Motile sperm observed: ___ Yes ___ No

 Non-motile sperm observed: ___ Yes ___ No

 Monilia observed ___ Yes ___ No

 Trichomonas observed: ___ Yes ___ No

Note: Presumptive treatment for children who have been sexually assaulted or abused can be considered but it is not widely recommended. If the examiner chooses to treat, the following is recommended:

	Medication Administered / Dispensed By: (Initials)	Info Given for Medication By: (Initials)
<u>PLAN</u>		
1. Pregnancy prophylaxis (Emergency Contraception) – FEMALES		
a) <input type="checkbox"/> _____	Ulipristal (Ella) 30mg p.o. single dose (Physician has informed patient of possible risks and side effects of such Rx if pregnancy were to occur)	_____
b) <input type="checkbox"/> _____	Levonorgestrel (Plan B One-Step) 1.5mg p.o. single dose (Physician has informed patient of possible risks and side effects of such Rx if pregnancy were to occur)	_____
c) <input type="checkbox"/> _____	Not given (patient declined)	
<input type="checkbox"/> _____	Not given (contraindicated)	
Reason: _____		

<u>PLAN</u>		
2. Sexually Transmitted Disease prophylaxis / treatment (FOR CHILDREN LESS THAN 45 kg)		
Routine Treatment		
a) <input type="checkbox"/> _____	Ceftriaxone 125 mg i.m. single dose	_____
<input type="checkbox"/> _____	PLUS Erythromycin Base 50 mg/kg/day Orally divided into 4 doses daily for 14 days	_____
b) <input type="checkbox"/> _____	Not given (await culture results)	
<input type="checkbox"/> _____	Not given (patient declined)	
<input type="checkbox"/> _____	Not given (other) specify _____	

Sexually transmitted disease prophylaxis / treatment
(FOR CHILDREN GREATER THAN 45 kg)

a) <input type="checkbox"/> _____	Routine Treatment	
<input type="checkbox"/> _____	Ceftriaxone 500 mg. i.m. single dose	_____
<input type="checkbox"/> _____	PLUS Azithromycin 1 gm p.o. single dose	_____
b) <input type="checkbox"/> _____	Not given (await culture results)	
<input type="checkbox"/> _____	Not given (patient declined)	

3. HIV Prophylaxis – (FOR 13 YRS OF AGE & OLDER ONLY)

a) Truvada 200 / 300 mg / 1 p.o. everyday #5

Isentress 400 mg / 1 p.o. twice a day # 10

b) Not given (patient declined)

Not given (other) specify

4. Hepatitis B Vaccination

a) Given

b) Not given (already vaccinated)

Not given (contraindicated)

Not given (patient declined)

Not given (other) specify

5.

Comfort Kit Medication

a) Acetaminophen liquid, 160 mg/tsp.
15 mg/kg (maximum dose = 650 mg) single dose
Take _____ mg p.o.

Administered / Dispensed / Prescribed By (Signature)

Date

Print Name

APPENDIX A: NON-FATAL STRANGULATION / SUFFOCATION SUPPLEMENTAL FORM

Patient Name: _____

Strangulation / Suffocation is a serious event that can occur in the context of sexual assaults. Many times strangulation / suffocation presents **NO VISIBLE INJURIES**. It is important to ask about strangulation / suffocation in all sex assault cases, and document positive disclosure or any signs and symptoms.

NOTE:

- Strangulation is impeding the normal breathing or circulation of the blood by applying pressure on the throat or the neck with any part of the body or ligature;
- Suffocation is impeding normal breathing by blocking the nose and mouth; or applying pressure to the chest.

Was the patient strangled? No Yes

How many times did strangulation occur? _____

Why/how did the strangulation stop? _____

How did strangulation occur? (Check all that apply)

Right hand Left hand Both hands Unknown Chokehold maneuver

Other (describe) _____

What is the measurement of the patient's neck circumference? _____

Describe mannequin demonstration (where applicable)

Was the patient suffocated? No Yes

How many times did suffocation occur? _____

Why/how did the suffocation stop?

Pressure on: Nose and Mouth? No Yes Chest? No Yes (describe) _____

Was the patient shaken during the incident?

No Yes (describe) _____

Was the patient's head pounded against any object during the incident?

No Yes (describe) _____

Was the assailant wearing any jewelry on hands or wrists?

Unknown No Yes (describe) _____

Describe what the pressure felt like during strangulation and/or suffocation:

What was the patient thinking during the strangulation and/or suffocation?

What did the assailant say before, during, or after the strangulation and/or suffocation?

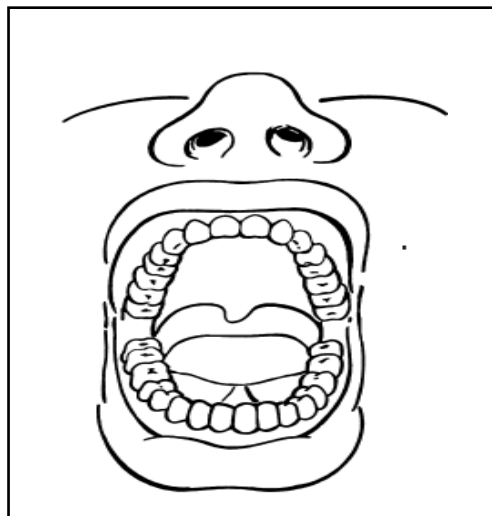
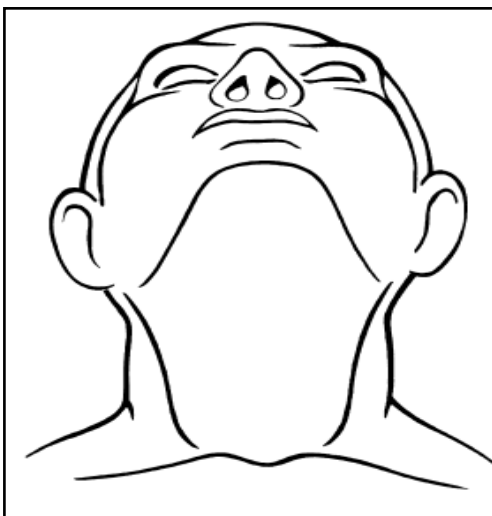
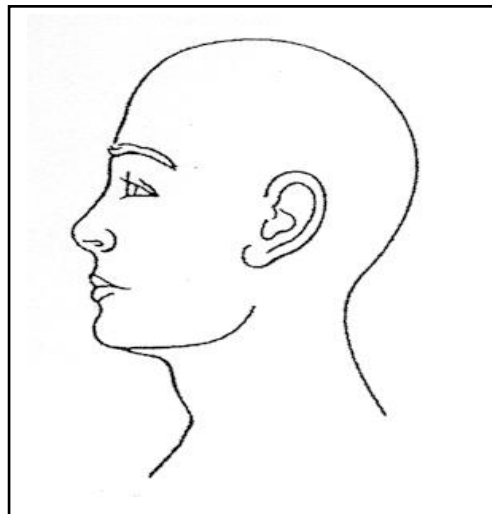
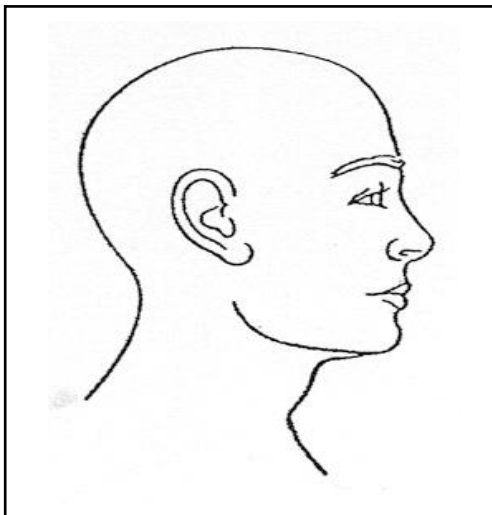
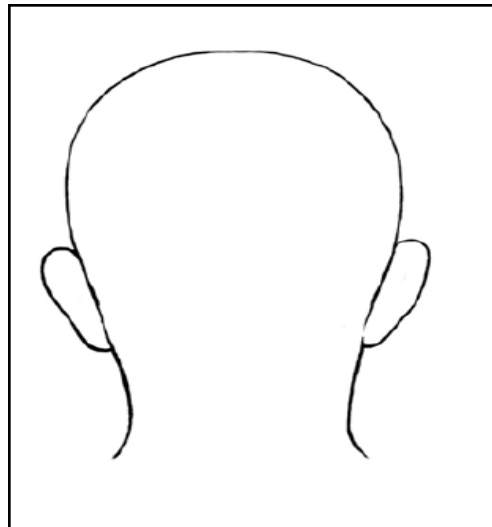
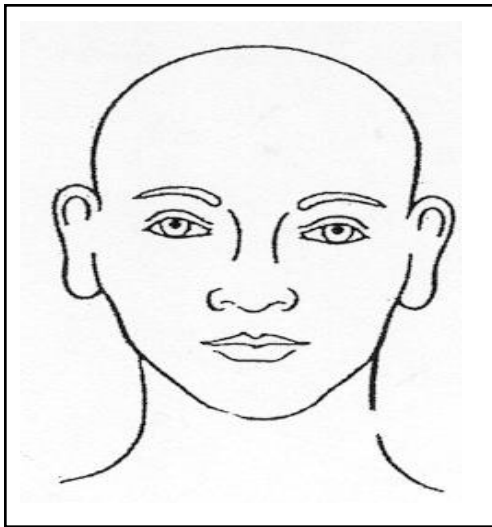
What was the assailant's demeanor during strangulation and/or suffocation? _____

Signs/Symptoms of Strangulation and/or Suffocation

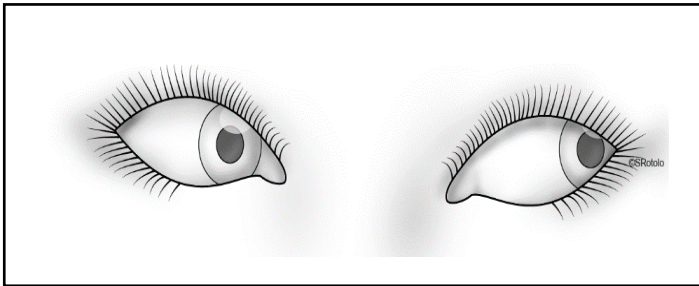
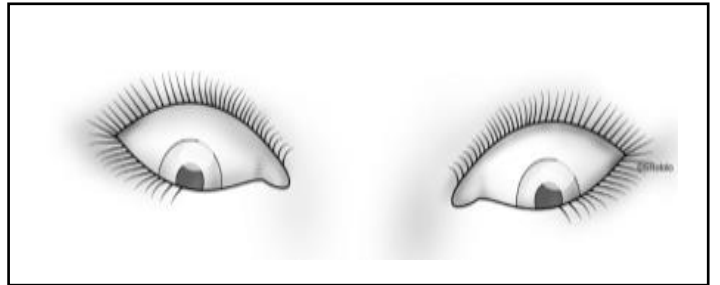
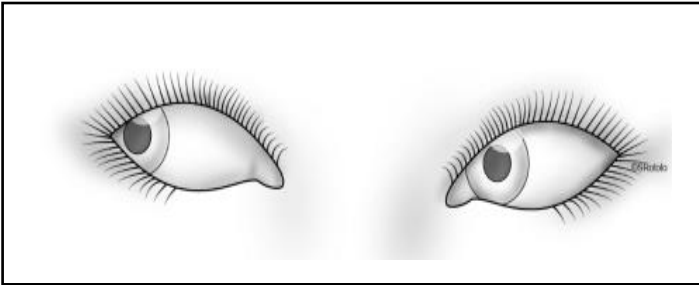
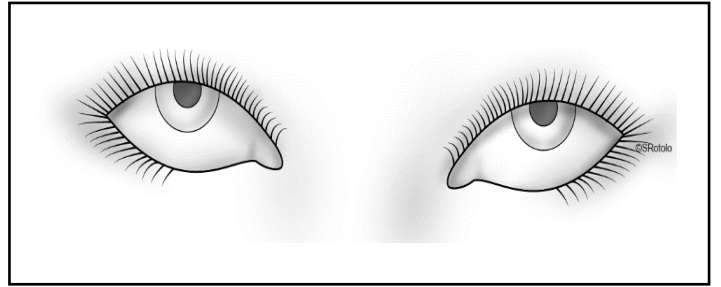
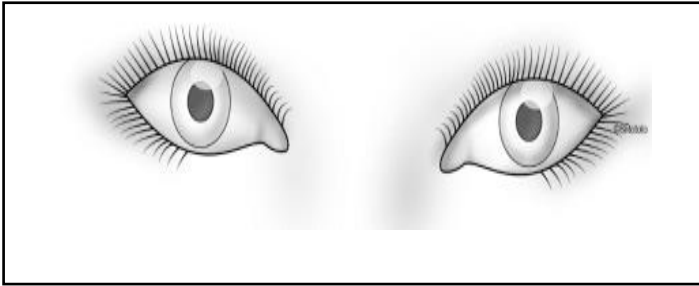
The following signs/symptoms should be asked about, assessed for and documented in writing, with body mapping, and by photo-imaging (if applicable). **Check ALL that apply.**

<p>Head/Scalp</p> <ul style="list-style-type: none"> <input type="checkbox"/> Petechiae on scalp <input type="checkbox"/> Pulled hair <input type="checkbox"/> Contusions / bump <input type="checkbox"/> Cuts / abrasions <input type="checkbox"/> Other _____ <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting 	<p>Face</p> <ul style="list-style-type: none"> <input type="checkbox"/> Red, flushed <input type="checkbox"/> Petechiae (Red Spots) <input type="checkbox"/> Scratch marks <input type="checkbox"/> Cuts / abrasions <input type="checkbox"/> Other _____ 	<p>Eyes & Eyelids</p> <ul style="list-style-type: none"> <input type="checkbox"/> Bloody red eyeball <input type="checkbox"/> Petechiae eyeball <ul style="list-style-type: none"> <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Petechiae eyelid <ul style="list-style-type: none"> <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Ptosis <ul style="list-style-type: none"> <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Other _____ 	<p>Nose</p> <ul style="list-style-type: none"> <input type="checkbox"/> Bloody nose <input type="checkbox"/> Broken nose <input type="checkbox"/> Petechiae <input type="checkbox"/> Cuts / abrasions <input type="checkbox"/> Other _____ 	
<p>Ears</p> <ul style="list-style-type: none"> <input type="checkbox"/> Petechiae <ul style="list-style-type: none"> <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bleeding from ear <ul style="list-style-type: none"> <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Auditory changes <input type="checkbox"/> Cuts / abrasions <input type="checkbox"/> Other _____ 	<p>Mouth</p> <ul style="list-style-type: none"> <input type="checkbox"/> Swollen tongue <input type="checkbox"/> Swollen lips <input type="checkbox"/> Cut / abrasions <input type="checkbox"/> Petechiae <input type="checkbox"/> Bruising <input type="checkbox"/> Other _____ 	<p>Neck/Under Chin</p> <ul style="list-style-type: none"> <input type="checkbox"/> Redness <input type="checkbox"/> Scratch marks <input type="checkbox"/> Cuts / abrasions <input type="checkbox"/> Bruises <input type="checkbox"/> Neck pain _____ (Pain scale 0–10) <input type="checkbox"/> Swelling <input type="checkbox"/> Ligature marks <input type="checkbox"/> Subcutaneous emphysema <input type="checkbox"/> Fingernail impressions <input type="checkbox"/> Other _____ 	<p>Shoulders</p> <ul style="list-style-type: none"> <input type="checkbox"/> Redness <input type="checkbox"/> Scratch marks <input type="checkbox"/> Bruise(s) <input type="checkbox"/> Cuts / abrasions <input type="checkbox"/> Other _____ 	
<p>Chest</p> <ul style="list-style-type: none"> <input type="checkbox"/> Redness <input type="checkbox"/> Scratch marks <input type="checkbox"/> Cuts / abrasions <input type="checkbox"/> Bruises <input type="checkbox"/> Subcutaneous emphysema <input type="checkbox"/> Other _____ 	<p>Behavioral</p> <ul style="list-style-type: none"> <input type="checkbox"/> Agitation <input type="checkbox"/> Combative <input type="checkbox"/> Anxiety <input type="checkbox"/> Memory disruption <input type="checkbox"/> Confusion <input type="checkbox"/> Other _____ 	<p>Neurological</p> <ul style="list-style-type: none"> <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Involuntary urination <input type="checkbox"/> Involuntary defecation <input type="checkbox"/> Seizures <input type="checkbox"/> Headache _____ (Pain scale 0–10) <input type="checkbox"/> Dizziness <input type="checkbox"/> Faintness <input type="checkbox"/> Tinnitus <input type="checkbox"/> Visual changes <input type="checkbox"/> "Saw Stars" or Spots <input type="checkbox"/> Other _____ 	<p>Throat/Voice</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dysphagia <input type="checkbox"/> Odynophagia (painful swallowing) <input type="checkbox"/> Dysphasia <input type="checkbox"/> Aphasia <input type="checkbox"/> Drooling or inability to swallow <input type="checkbox"/> Throat pain _____ (Pain scale 0–10) <input type="checkbox"/> Raspy voice/hoarseness <input type="checkbox"/> Coughing <input type="checkbox"/> Change in voice pitch <input type="checkbox"/> Other _____ 	<p>Respiratory</p> <ul style="list-style-type: none"> <input type="checkbox"/> Stridor <input type="checkbox"/> Hoarseness <input type="checkbox"/> Trouble catching breath <input type="checkbox"/> Hyperventilation <input type="checkbox"/> Respiratory Distress <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Other _____

Please indicate all injuries checked above on the body maps below.



Please indicate all injuries checked above on the body maps below



Notes
