EXAM PROCESS

1. **Clean work area /Gather supplies**
   a. *prep work area where kit will be*
   b. *gather pelvic supplies*
   c. *request pelvic bed if needed*

2. **Demographic info – Payroll/Demographic Form**
   a. *name, DOB, SSN, address, account number, etc*

3. **Medical History – MD/RN report form**
   a. *medical history (pertinent)*
   b. *current medications*
   c. *allergies*
   d. *last tetanus*
   e. *contraceptive history*

4. **Consent for exam**
   a. *review each section with patient > initials*

5. **Mandated Reporting to LE**
   a. *call county dispatch to confirm jurisdiction*

6. **DFSA (if indicated)**
   a. *consent for DFSA*
   b. *collection of DFSA*

7. **Forensic questionnaire**
   a. *use quotes for spontaneous statements*
   b. *make list for DNA/injury areas to use during assessment*

8. **Forensic narrative**
   a. *detailed description of events*
   b. *per patient, "……". Exam completed per protocol according to patient condition*
   c. *include ALL information from forensic questionnaire*

9. **Head-to-toe assessment**
   a. *blacklight first if in original clothing from assault (dry stain if needed)*
   b. *HEENT (strangulation assessment if needed)*
   c. *oral swabs (step 5) LOWER gum (use penlight to assess mouth)*
   d. *oral swabs (step 6) UPPER gum*
   e. *torso assessment (anterior/posterior)*
   f. *extremity assessment (anterior/posterior)*
   g. *hand/fingernail swabs (step 7)*
   h. *underwear collection (place in bag & INSIDE kit) (step 8)*
   i. *clothing collection (place inside bags & OUTSIDE of kit) (step 9)*
   j. *dry stains (on any area of body indicated from narrative) (step 10)*
   k. *pubic hair combings (step 11)*
   l. *anal assessment – INSPECT > PHOTOGRAPH > SWAB (step 12)*
   m. *vaginal assessment – INSPECT > PHOTOGRAPH > SWAB (step 13)*
   n. *use ALS multiple times throughout exam as needed*

10. Photography

a. *parallel angles, no shadows, clear photos, broad then close up*
b. *in each photo > measuring device, pt sticker, ID label (ex: AP1)*

11. Medication Review

a. *what meds pt is a candidate for based on exam, history, allergies*

12. MD/RN Report

a. *use MD/RN report form, review CDC meds*
b. *note what meds pt will be getting at facility vs by Rx*
c. *complete DC instructions for patient > have pt sign*
d. *give pt a copy of DC info*

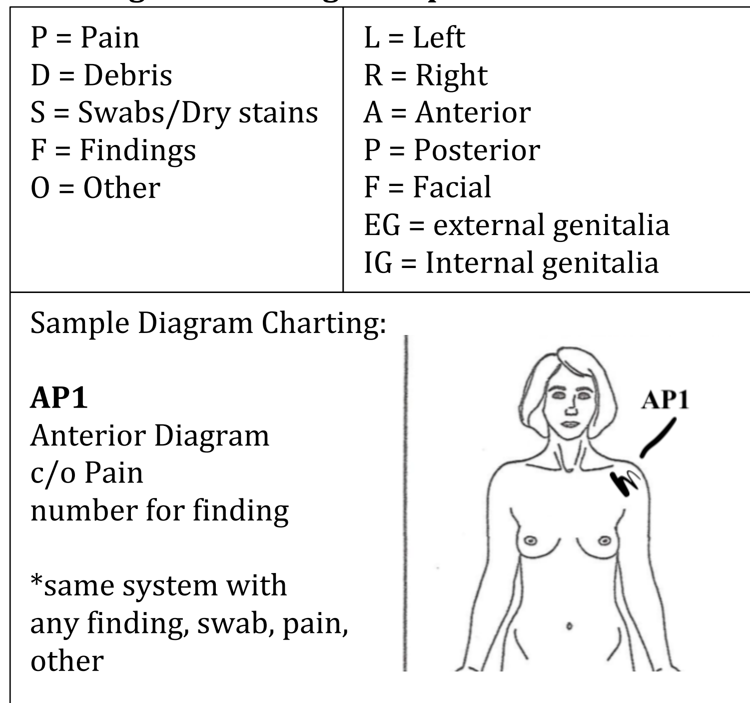
13. Documentation

a. *complete diagrams, document findings/debris/pain/swabs/other*
b. *complete detective/crime lab notes*

14. Kit Handoff & Paperwork

a. *COC – correct parcel count, times must match*
b. *docs inside kit = consent, questionnaire, narrative, diagrams, P/D/S/F/O docs*
c. *docs to LE = everything*
d. *docs to hospital = everything*
e. *docs to admin/Forcura = everything BEFORE leaving facility*

Diagram Labeling Examples:



P = Pain D = Debris S = Swabs/Dry stains F = Findings O = Other	L = Left R = Right A = Anterior P = Posterior F = Facial EG = external genitalia IG = Internal genitalia
Sample Diagram Charting: **AP1** Anterior Diagram c/o Pain number for finding *same system with any finding, swab, pain, other	

+ Finding/Debris Documentation

Document the:
size
shape
color
raised/not raised
border description
location
if photo was obtained
note any patterns to area
**important correlation info from narrative

+ Pain Documentation

Document the:
location
characteristic (burn, ache, dull, sharp, etc)
temporal (intermittent, constant)
scale (0-10)
**important correlation info from narrative

Swab Documentation

Document the:
location
ALS + or –
why you chose that area to collect
(possible touch DNA, step #, etc)