

DoD SEXUAL ASSAULT FORENSIC EXAMINATION (SAFE) REPORT

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. Chapter 55, Medical and Dental Care; DoD Directive 6495.01, Sexual Assault Prevention and Response (SAPR) Program; and DoD Instruction 6495.02, Sexual Assault Prevention and Response (SAPR) 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:					Type of Examination: <input type="checkbox"/> Victim <input type="checkbox"/> Suspect	
1a. NAME OF PATIENT <i>(Last, First, Middle Initial) (Skip if Restricted Report)</i>				b. PATIENT ID NUMBER <i>(Unrestricted Report only)</i>		
2a. ADDRESS		b. CITY	c. COUNTY	d. STATE	e. ZIP CODE	f. TELEPHONE <i>(Include Area Code)</i> (1) Home: (2) Work:
3a. AGE	b. DATE OF BIRTH <i>(YYYY/MM/DD)</i>	c. SEX (X) <input type="checkbox"/> M <input type="checkbox"/> F	d. RACE AND ETHNICITY <i>(X All That Apply)</i> <div style="display: flex; justify-content: space-between; font-size: small;"> <div>American Indian or Alaska Native</div> <div>Asian</div> <div>Black or African American</div> <div>Hispanic or Latino</div> </div> <div style="display: flex; justify-content: space-between; font-size: small;"> <div>Middle Eastern or North African</div> <div>Native Hawaiian or Pacific Islander</div> <div>White</div> <div>Other</div> </div>			
4a. ARRIVAL DATE <i>(YYYY/MM/DD)</i>		b. TIME	5a. DISCHARGE DATE <i>(YYYY/MM/DD)</i>		b. TIME	

B. NOTIFICATION AND AUTHORIZATION:

Location of Assault:		Jurisdiction:		Civilian or Foreign Assisting Agency:	
<input type="checkbox"/> On Installation <input type="checkbox"/> Off Installation		<input type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> Other			
1a. NAME OF SEXUAL ASSAULT RESPONSE COORDINATOR (SARC) <i>(Last, First, Middle Initial)</i>				<input type="checkbox"/> b. VICTIM DECLINED SARC AND SAPR VA SERVICES	c. TELEPHONE <i>(Include Area Code)</i>
2a. NAME OF SEXUAL ASSAULT FORENSIC EXAMINER <i>(Last, First, Middle Initial)</i>		b. RANK	c. TITLE		d. TELEPHONE <i>(Include Area Code)</i>
3a. NAME OF VICTIM ADVOCATE (VA) <i>(Last, First, Middle Initial)</i>				b. TELEPHONE <i>(Include Area Code)</i>	
4a. NAME OF MILITARY CRIMINAL INVESTIGATIVE OFFICER (UNRESTRICTED REPORT) <i>(Last, First, Middle Initial)</i>				b. TELEPHONE <i>(Include Area Code)</i>	
c. AGENCY			d. ID NUMBER		e. DATE <i>(YYYY/MM/DD)</i>
5a. NAME OF SERVICE DESIGNATED EVIDENCE COLLECTING OFFICER (RESTRICTED REPORT) <i>(Last, First, Middle Initial)</i>					b. TELEPHONE <i>(Include Area Code)</i>
c. AGENCY		d. ID NUMBER	e. DATE <i>(YYYY/MM/DD)</i>	f. TIME	g. RESTRICTED REPORT CONTROL NUMBER (RRCN)

C. REPORTING INFORMATION

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 (MCIO) 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).		<i>(Initial)</i>
2. a. The Sexual Assault Response Coordinator (SARC) and/or Sexual Assault Prevention and Response Victim Advocate (SAPR VA) have explained the difference between Unrestricted and Restricted Reporting options.		<i>(Initial)</i>
b. I understand that I have the right to speak to my own attorney (Special Victims' Counsel or Victim Legal Counsel) before electing a reporting option.		<i>(Initial)</i>
c. I have elected: <input type="checkbox"/> UNRESTRICTED REPORTING <input type="checkbox"/> RESTRICTED REPORTING <i>(Only applicable to Active Duty, and Reserve and National Guard in active service or inactive duty training, adult military dependent.)</i>		<i>(Initial)</i>
3. I understand what my options are and do not have questions.		<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 such as urine and/or blood.		<input type="checkbox"/> YES <input type="checkbox"/> 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.		<input type="checkbox"/> YES <input type="checkbox"/> NO	(Initial)	
3. I understand that collection of evidence may include photographing injuries and that these photographs may include the genital area.		<input type="checkbox"/> YES <input type="checkbox"/> 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.		<input type="checkbox"/> YES <input type="checkbox"/> 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.		<input type="checkbox"/> YES <input type="checkbox"/> NO	(Initial)	
6. I hereby consent to a sexual assault medical forensic examination (SAFE).		<input type="checkbox"/> YES <input type="checkbox"/> 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 MCIO.		<input type="checkbox"/> YES <input type="checkbox"/> NO	(Initial)	
8. In cases where the military does not have jurisdiction over the offense, evidence may be turned over to a state or Federal law enforcement agency.		<input type="checkbox"/> YES <input type="checkbox"/> NO	(Initial)	
9. 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.		<input type="checkbox"/> YES <input type="checkbox"/> NO	(Initial)	
10. I understand that any evidence, including personal property, collected in an Unrestricted Report shall be retained by MCIO and not returned to me until the conclusion of all legal, adverse action, and administrative proceedings. Additionally, in a Restricted Report any personal property retained as part of the Sexual Assault Forensic Examination (SAFE) will be retained and not returned to me for a period of 5 years in accordance with legal requirements and DoD policy.		<input type="checkbox"/> YES <input type="checkbox"/> NO	(Initial)	
11a. PATIENT SIGNATURE			b. DATE (YYYY/MM/DD)	c. TIME
12. WITNESS TO PATIENT SIGNATURE				
a. SIGNATURE	b. ADDRESS (Include ZIP Code)	c. DATE (YYYY/MM/DD)	d. TIME	

E. PATIENT HISTORY				Patient Identification			
1a. NAME OF PERSON PROVIDING HISTORY <i>(Last, First, Middle Initial)</i>							
b. RELATIONSHIP TO PATIENT		c. DATE (YYYY/MM/DD)					
2. PERTINENT MEDICAL HISTORY							
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							
3. PERTINENT NON-ASSAULT RELATED HISTORY							
a. Other non-assault sexual activity within past 5 days? Do NOT record any other information regarding sexual history on this form.							
<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.							
(X and complete as applicable)							
		No	Yes	Unsure	(If Yes)		
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?							
4. POST-ASSAULT HYGIENE/ACTIVITY							
				Not Applicable if over 5 days			
(X and complete as applicable)				No	Yes		
a. Urinated						h. Brushed teeth	
b. Defecated						i. Gargled/mouthwash	
c. Genital or body wipes <i>(If yes, describe)</i>						j. Vomited	
						k. Ate or drank	
d. Douched <i>(If yes, with what)</i>						l. Used cream/ointment/lotion on body part involved in assault <i>(If yes, describe)</i>	
e. Removed/inserted						m. Changed clothing <i>(If yes, describe)</i>	
<input type="checkbox"/> Tampon <input type="checkbox"/> Diaphragm <input type="checkbox"/> Nuva ring							
f. Oral gargle/rinse						n. Changed body piercings <i>(If yes, describe)</i>	
g. Bath/shower/wash							
F. ASSAULT HISTORY							
1a. DATE OF ASSAULT(S) (YYYY/MM/DD)				2. LOCATION AND PERTINENT PHYSICAL SURROUNDINGS			
b. TIME							
3. PHYSICAL EFFECTS OF ASSAULT. 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							
4. INJURIES INFLICTED UPON THE ASSAILANT(S) DURING ASSAULT? <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

H. ACTS DESCRIBED BY PATIENT

- 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.

- If more than one assailant, identify by number.

Patient Identification

<p>6. OTHER ACT(S) <i>(Describe)</i></p>	
---	--

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

- 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.

2a. Exam Started

b. Exam Completed

Time

Time

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

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.*)

A simple line drawing of a human figure from the back, showing the spine, shoulder blades, and legs. The figure is standing with arms slightly away from the body. The drawing is minimalist, using only black outlines on a white background.

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

[illegible]

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.

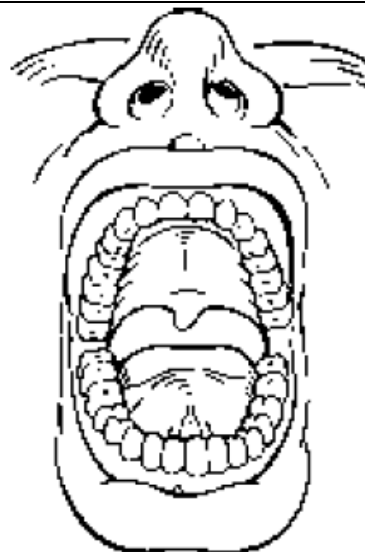
☐ Findings ☐ No Findings Observed

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. Gently comb or brush head hair to collect foreign material. Do not pluck or pull hair. (Known head hairs are no longer routinely collected. Known hairs are collected from the individual for comparisons to questioned hairs.)****Diagram C****Diagram D****Diagram E****Diagram F****LEGEND: TYPES OF FINDINGS. RECORD ALL SPECIMENS COLLECTED IN SECTION O.**

AB Abrasion	BU Burn	DF Deformity	FB Foreign Body	MS Moist Secretion	PE Petechiae	SW Swelling
ALS Alternate Light Source	CS Control Swab	DS Dry Secretion	IN Induration	OF Other Foreign Materials (describe)	PS Potential Saliva	TB Toluidine Blue®
BI Bite	CT Contusion (bruise)	ER Erythema (redness)	IW Incised Wound	OI Other Injury (describe)	SHX Sample Per History	TE Tenderness
	DE Debris	F/H Fiber/Hair	LA Laceration		SI Suction Injury	V/S 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"/> Perineal 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. Gently comb or brush pubic hair to collect foreign material. Do not pluck or pull hair. (Known pubic hairs are no longer routinely collected. Known hairs are collected from the individual for comparisons to questioned hairs.) If there is no pubic hair, conduct an external swab of pubic mound and 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.).

☐ Findings ☐ 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.

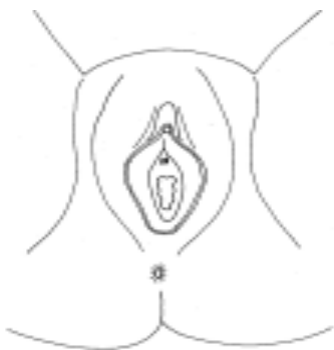
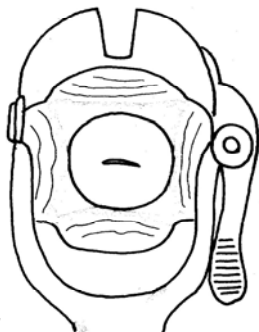
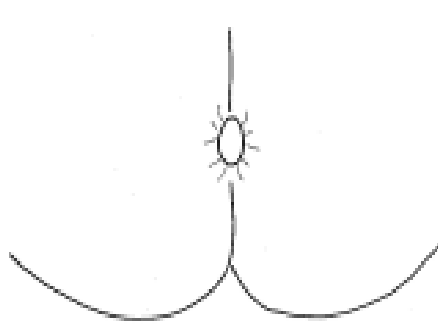
a. Rectal exam done: ☐ Yes ☐ Not applicable

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

b. Rectal bleeding: ☐ No ☐ Yes

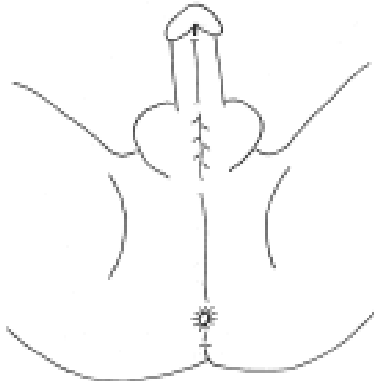
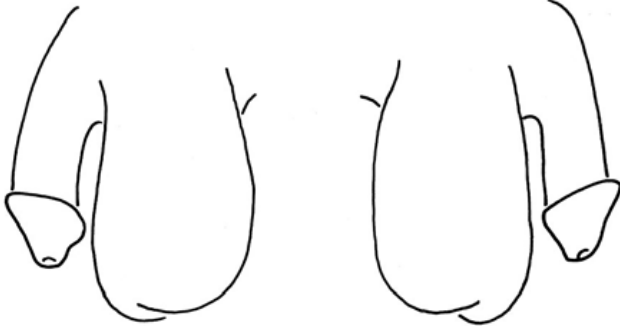
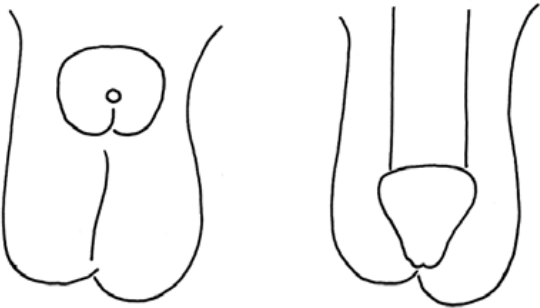
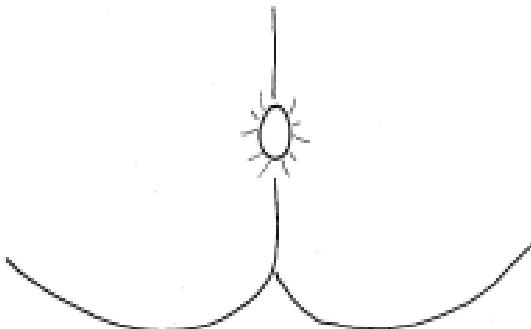
c. Was an anoscopic exam done? ☐ No ☐ Yes

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

Diagram G**Diagram H****Diagram I****Diagram J****LEGEND: TYPES OF FINDINGS. RECORD ALL SPECIMENS COLLECTED IN SECTION O.**

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

Locator #	Type	Description	Locator #	Type	Description

<p>L. GENITAL EXAMINATION - MALE</p> <p>- Record all findings, including tenderness and pain, using diagrams, legend, and a consecutive numbering system.</p> <p>- If injuries are described or if remarkable findings or possible trauma are observed, please photograph.</p>																																																							
<p>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.)</p> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Findings <input type="checkbox"/> No Findings Observed </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div> <input type="checkbox"/> Abdomen <input type="checkbox"/> Foreskin <input type="checkbox"/> Shaft <input type="checkbox"/> Glans <input type="checkbox"/> Thighs <input type="checkbox"/> Urethral meatus <input type="checkbox"/> Scrotum <input type="checkbox"/> Testes </div> </div>	<p>Patient Identification</p>																																																						
<p>2. Circumcised: <input type="checkbox"/> No <input type="checkbox"/> 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. <input type="checkbox"/> Findings <input type="checkbox"/> No Findings Observed</p>																																																							
<p>4. Gently comb or brush pubic hair to collect foreign material. Do not pluck or pull hair. (Known pubic hairs are no longer routinely collected. Known hairs are collected from the individual for comparisons to questioned hairs.) If there is no pubic hair, conduct an external swab at base of penis.</p>																																																							
<p>5. If indicated by assault history, collect the following swabs: 2 penile and 2 scrotal.</p>																																																							
<p>6. Examine the buttocks and perineum (if indicated by history). If there are findings, describe (including location). (If available and appropriate, consider the use of toluidine blue dye.)</p> <p>a. Findings from buttocks, anus, or perineum. <input type="checkbox"/> Yes <input type="checkbox"/> None Observed</p> <p>b. Collect dried and moist secretions, and foreign materials. <input type="checkbox"/> Findings <input type="checkbox"/> No Findings Observed</p>																																																							
<p>7. Collect 2 anal swabs.</p>																																																							
<p>8. Conduct a rectal exam (using anoscope if possible) if rectal injury is suspected or if there is any sign of rectal bleeding.</p> <p>a. Rectal exam done? <input type="checkbox"/> Yes <input type="checkbox"/> No e. If exam was done, describe findings:</p> <p>b. Rectal bleeding: <input type="checkbox"/> Yes <input type="checkbox"/> None Observed</p> <p>c. Was an anoscopic exam done? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. If exam was done, what position was used? <input type="checkbox"/> Supine <input type="checkbox"/> Other (describe)</p>																																																							
<p>Diagram K</p> 	<p>Diagram L</p> 																																																						
<p>Diagram M</p> 	<p>Diagram N</p> 																																																						
<p>LEGEND: TYPES OF FINDINGS. RECORD ALL SPECIMENS COLLECTED IN SECTION O.</p>																																																							
<table border="0" style="width: 100%; font-size: small;"> <tr> <td>AB Abrasion</td> <td>BU Burn</td> <td>DF Deformity</td> <td>FB Foreign Body</td> <td>MS Moist Secretion</td> <td>PE Petechiae</td> <td>SW Swelling</td> </tr> <tr> <td>ALS Alternate Light Source</td> <td>CS Control Swab</td> <td>DS Dry Secretion</td> <td>IN Induration</td> <td>OF Other Foreign Materials (describe)</td> <td>PS Potential Saliva</td> <td>TB Toluidine Blue®</td> </tr> <tr> <td>BI Bite</td> <td>CT Contusion (bruise)</td> <td>ER Erythema (redness)</td> <td>IW Incised Wound</td> <td>OI Other Injury (describe)</td> <td>SHX Sample Per History</td> <td>TE Tenderness</td> </tr> <tr> <td></td> <td>DE Debris</td> <td>F/H Fiber/Hair</td> <td>LA Laceration</td> <td></td> <td>SI Suction Injury</td> <td>V/S Vegetation/Soil</td> </tr> </table>		AB Abrasion	BU Burn	DF Deformity	FB Foreign Body	MS Moist Secretion	PE Petechiae	SW Swelling	ALS Alternate Light Source	CS Control Swab	DS Dry Secretion	IN Induration	OF Other Foreign Materials (describe)	PS Potential Saliva	TB Toluidine Blue®	BI Bite	CT Contusion (bruise)	ER Erythema (redness)	IW Incised Wound	OI Other Injury (describe)	SHX Sample Per History	TE Tenderness		DE Debris	F/H Fiber/Hair	LA Laceration		SI Suction Injury	V/S Vegetation/Soil																										
AB Abrasion	BU Burn	DF Deformity	FB Foreign Body	MS Moist Secretion	PE Petechiae	SW Swelling																																																	
ALS Alternate Light Source	CS Control Swab	DS Dry Secretion	IN Induration	OF Other Foreign Materials (describe)	PS Potential Saliva	TB Toluidine Blue®																																																	
BI Bite	CT Contusion (bruise)	ER Erythema (redness)	IW Incised Wound	OI Other Injury (describe)	SHX Sample Per History	TE Tenderness																																																	
	DE Debris	F/H Fiber/Hair	LA Laceration		SI Suction Injury	V/S Vegetation/Soil																																																	
<table border="1" style="width: 100%; border-collapse: collapse; font-size: x-small;"> <thead> <tr> <th>Locator #</th> <th>Type</th> <th>Description</th> <th>Locator #</th> <th>Type</th> <th>Description</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>		Locator #	Type	Description	Locator #	Type	Description																																																
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? <i>(If yes, describe)</i> <div style="float: right;"> <input type="checkbox"/> No <input type="checkbox"/> Yes </div>		Patient Identification	
2. Lapse of consciousness? <i>(If yes, describe)</i> <div style="float: right;"> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unsure </div>			
4.a. Voluntary ingestion of alcohol/drugs? <div style="float: right;"> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unsure </div> If yes: <input type="checkbox"/> Alcohol <input type="checkbox"/> Drugs		3. Vomited? <i>(If yes, describe. Include location and number of times.)</i> <div style="float: right;"> <input type="checkbox"/> No <input type="checkbox"/> Yes </div>	
4.b. Involuntary ingestion of alcohol/drugs? <div style="float: right;"> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unsure </div> If yes: <input type="checkbox"/> Alcohol <input type="checkbox"/> Drugs		5. Was a clinical toxicology lab conducted? <input type="checkbox"/> No <input type="checkbox"/> Yes	
6. FOR UNRESTRICTED REPORTS: Was a DoD Toxicology Kit completed? <input type="checkbox"/> No <input type="checkbox"/> 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 <i>(If Other, describe)</i>
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. FINDINGS. Please describe your findings.			

1. TYPE OF CAMERA

2. DISPOSITION OF FILM/DISK

3. PHOTO LIST

[illegible]

S. PERSONNEL INVOLVED - Print names.

3. SPECIMENS LABELED AND SEALED BY	Telephone (Include Area Code)	4. ASSISTED BY	Telephone (Include Area Code)
---	-------------------------------	-----------------------	-------------------------------

1. TOXICOLOGY KIT GIVEN TO:

3. ITEMS RETURNED TO PATIENT (describe)

Given to:

1. SIGNATURE

3. AGENCY

5. TELEPHONE (Include Area Code)	
----------------------------------	--

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: MCIO agent should mail kit with Form 1323, "Toxicology Request Form" (found at: www.afip.org) to:

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
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)*