CalEMA 2-925
FORENSIC MEDICAL REPORT: NONACUTE (>72 HOURS)
CHILD/ADOLESCENT SEXUAL ABUSE EXAMINATION

REQUIRED USE OF STANDARD STATE FORM:

Penal Code Section 13823.5(c) requires that every health care practitioner, who conducts a medical examination of a sexual assault or child sexual abuse victim for evidence of sexual assault or sexual abuse, must use a standard form to record findings. This form is intended to document forensic findings and, as such, is not a complete medical treatment record.

SUGGESTED USE OF THE STANDARD STATE FORMS: FOLLOW LOCAL POLICY.

CalEMA 2-923	▪ History of **acute sexual assault** (<72 hours) ▪ Examination of adults (age 18 and over) and adolescents (ages 12-17)
CalEMA 2-925	▪ History of **nonacute sexual abuse** (>72 hours) ▪ Examination of children and adolescents under age 18
CalEMA 2-930	▪ History of **acute sexual abuse or assault** (<72 hours) ▪ Examination of children under age 12
CalEMA 2-930	▪ History of **chronic sexual abuse (incest) and recent incident** (<72 hours) ▪ Examination of children and adolescents under age 18
CalEMA 2-950	▪ Examination of person(s) suspected of sexual assault or sexual abuse

Key terms for Sexual Assault or Sexual Abuse Exams	
Acute	Less than 72 hours have passed since the incident (<72 hours)
Nonacute	More than 72 hours have passed since the incident (>72 hours)
These terms are used to describe timeframes, not rigid standards. This is not to suggest that after 72 hours a complete exam should not be done. It is not unusual to detect injuries or possible trace and biological evidence after 72 hours.	

INSTRUCTIONS FOR CalEMA 2-925

These instructions contain the recommended methods for meeting the minimum legal standards established by Penal Code Section 13823.11 for performing evidential examinations.

LIABILITY AND RELEASE OF INFORMATION:

This medical report is subject to the confidentiality requirements of the Child Abuse and Neglect Reporting Act (Pen. Code 11164 or privilege), the Medical Information Act (Civ. Code Sec. 56 et seq.), the Physician-Patient Privilege (Ev. Code Sec. 990), and the Official Information Privilege (Ev. Code Sec. 1040). It can only be released to those involved in the investigation and prosecution of the case: a law enforcement officer, district attorney, city attorney, crime laboratory, child protective services worker, a child abuse and neglect team member, county licensing agency, and coroner. Records may be released to the defense counsel only through discovery of documents in the possession of a prosecuting agency or after the appropriate court process (i.e., judicial review and a court order).

Complete this report in its entirety. Use N/A (not applicable) when appropriate to show that the examiner attended to the question.	**Patient identification: This space is provided for hospitals and clinics using plastic plates for stamping identification information.**

A. GENERAL INFORMATION: Print or type the name of the facility where the examination was conducted.

1. **Enter the patient's name and identification number (if applicable).**
2. **Enter the patient's address, city, county, state, and telephone number.**
3. **Enter the patient's age, date of birth (DOB), gender, and ethnicity; date/time of arrival; and date/time of discharge.**
4. **Enter the name of the mother, stepmother, or guardian, and their address, city, county, state, and telephone numbers.**
5. **Enter the name of the father, stepfather, or guardian, and their address, city, county, state, and telephone numbers.**
6. **Enter the name(s) of siblings, gender, age, and date of birth.**

B. REPORTING AND AUTHORIZATION: Indicate jurisdiction where the incident(s) occurred.

Penal Code Section 11166 requires all professional medical personnel to report suspected child abuse, defined by Penal Code Section 11165, immediately by telephone and to submit a written report (DOJ SS 8572) within 36 hours to the local law enforcement or child protective services agency.

1. **Check the appropriate box to indicate whether a telephone report was made to a law enforcement and/or a child protective services agency. Identify the person who took the report by name, agency, identification number, and telephone number.**
2. **If the patient was accompanied by law enforcement or child protective services, enter the person's name and identifying information.**
3. **If known, identify the law enforcement and/or child protective services investigator assigned to this case.**
4. **Obtain the signature of a law enforcement and/or child protective services investigator to authorize payment for the evidential exam at public expense, the name of the agency, telephone number, date, time, and case number. If telephone authorization was obtained, enter the name of the authorizing party, identification number, and the date and time in the Telephone Authorization box.**
5. **Medical facilities with contracts or memorandums of understanding may not require separate patient authorization.**

C. CONSENT FOR EXAMINATION BY PATIENT/PARENT/GUARDIAN

- **Parental consent is not required for suspected sexual abuse examinations.**
- Family Code Section 6927 permits minors (12 to 17 years of age) to consent to medical examination, treatment, and evidence collection related to a sexual assault without parental consent. Family Code Section 6928 requires health care professionals to attempt to contact the minor's parent or legal guardian, and to note in the minor's treatment record the date and time the attempted contact was made, including whether the attempt was successful or unsuccessful. This provision **is not applicable** when the health professional reasonably believes the parent(s) or guardian committed the sexual assault on the minor.

D. PATIENT HISTORY

1. **Record the time or time frame of the incident(s) and date(s).**
   - For children, use familiar dates and time frames (holidays, birthdays, weekday or weekend, nighttime or daytime).
2. **Record the terms the patient uses for the female and male genitalia, breasts, and anus.**
3. **Record the identity of the alleged perpetrator(s) by name or nickname, approximate age, gender, ethnicity, relationship to the patient, and whether the perpetrator(s) are known or unknown to the patient.**
   - Use a numbering system to identify multiple perpetrators by name, if known, or a brief description such as the "big guy." This numbering system can be used to relate the perpetrator to the acts described by the historian and/or patient on pages 2 and 3.

E. ACTS DESCRIBED BY HISTORIAN

- **Record the acts described by the historian to the recorder of this form and additional pertinent history.**
- **For yes answers, ask if there was associated pain or bleeding and describe in the space provided.**

• Genital/vaginal contact/penetration • Anal contact/penetration	Mark the appropriate box for each method of contact/penetration. Mark "attempted" if it is reasonably clear from the interview that the perpetrator(s) intended an act but was thwarted by the patient, an intervening occurrence, or was unable to accomplish the act. If either "attempted" or "unsure" is checked, provide a description in the adjacent space. If more than one perpetrator was involved, identify each one by number on the lines adjacent to the boxes. If an object was used, describe it.
• Oral copulation of genitals • Oral copulation of anus	Mark the appropriate box. Mark "attempted" if it is reasonably clear, from the interview, that the perpetrator(s) intended an act but was thwarted by the patient, an intervening occurrence, or was unable to accomplish the act. If either "attempted" or "unsure" is checked, provide a description in the adjacent space. If more than one perpetrator was involved, identify each one by number on the lines adjacent to the boxes.
• Anal-genital fondling	Mark the appropriate box. Mark "attempted" if it is reasonably clear, from the interview, that the perpetrator(s) intended an act but was thwarted by the patient, an intervening occurrence, or was unable to accomplish the act. If either "attempted" or "unsure" is checked, provide a description in the adjacent space. If more than one perpetrator was involved, identify each one by number on the lines adjacent to the boxes.
• Non-genital acts	Mark the appropriate box. If yes, describe the act and note where it occurred on the adjacent line. Mark "attempted" if it is reasonably clear, from the interview, that the perpetrator(s) intended an act but was thwarted by the patient, an intervening occurrence, or was unable to accomplish the act. If either "attempted" or "unsure" is checked, provide a description in the adjacent space. If more than one perpetrator was involved, identify each one by number on the lines adjacent to the boxes. • **Note: Identify bites and alert law enforcement about their existence.** Bites can provide very specific evidence and they fade very quickly. Bites should be measured and photographed. Contact a forensic odontologist or law enforcement to evaluate the need for impressions. • **Note:** The term suction injury means "hickey".
• Other act(s)	If yes, describe.
• Ejaculation	Mark the appropriate box. For body surfaces, note location(s) on the diagrams. For clothing, bedding, or other surface(s), describe in the space provided. If more than one perpetrator ejaculated, identify each one by number on the lines adjacent to the boxes. If "unsure" is checked, provide a description in the adjacent space.
• Contraceptive or lubricant products	Note whether a contraceptive or a lubricant product was used. If yes, record the type or brand used, if known.
• Force or threats	If yes, describe.
• Weapons	If yes, describe.
• Pictures or videotapes	If yes, describe.
• Drugs or alcohol	Ask about the possibility of forced or coerced ingestion of alcohol or drugs. Mark the appropriate box. If yes, describe. Some drugs may be detected in urine up to 96 hours after ingestion. For ingestion of drugs, collect 100cc of urine in a clean container.
• Loss of memory • Lapse of consciousness	If yes, describe.
• Vomited after act(s)	If yes, describe.
• Behavioral changes	If yes, describe.

F. ACTS DESCRIBED BY PATIENT

Interview Methods
• Determine and use terms familiar to the patient. • Allow the patient to describe the incident(s) to the extent possible. • Follow-up questions may be necessary to ensure that all items are covered. • Avoid asking questions that may be leading or suggestive. • Gather as much information as possible from law enforcement officers and social workers to avoid redundant interviewing.

1. **Record the acts disclosed by the patient and to whom.**

Each act may lead to evidence of a chargeable crime. Any penetration, however slight, of a genital or anal opening by an object or body part constitutes an act. Oral copulation only requires contact.

- For yes answers, ask if there was associated pain or bleeding. Sometimes patients report no pain, but say "tickled".
- Use quotation marks to quote relevant statements. Example: "He put his private in my pee pee".
- Document if statement(s) made by the patient were spontaneous (i.e., not in response to a question or comment).
- Patient statements not heard directly by the recorder may be included, e.g., the child told the teacher that "he put his private in my pee pee".
- Under non-genital acts, the term suction injury means "hickey".
- Lubricant: describe by name, color, odor, flavor, and container description (if known or disclosed).
- Condom or other forms of covering: describe type or brand used (if known).

2. **Describe pain and/or bleeding (using patient's exact words) and additional pertinent history.**

G. MEDICAL HISTORY

1. **Record the name of the person providing the medical history and the relationship to the patient.**
2. **Any recent (past 60 days) anal-genital injuries, surgeries, diagnostic procedures, or medical treatment that may affect the interpretation of physical findings?**
   - This information is requested to avoid confusing pre-existing lesions with injuries or findings related to the alleged abuse.
3. **Any other pertinent medical conditions that may affect the interpretation of physical findings?**
4. **Any pre-existing physical injuries?**
5. **Any previous history of physical abuse and/or neglect?**
6. **Any previous history of sexual abuse?**
7. **For adolescents, ask whether the patient has had other anal or vaginal intercourse.**

The information is needed by the medical examiner to interpret the genital findings. **Do not record any other information regarding sexual history on this form.**

   - If yes, ask whether the other intercourse occurred within the past five days. If yes, ask when.
   - If yes, ask whether ejaculation occurred. If yes, ask where. If yes, ask whether a condom was used.

8. **Record whether menstrual periods have started, the age of menarche, and the date of the last menstrual period.**
9. **Record other symptoms described by patient and/or historian.**
   - Describe onset, duration, and intensity of symptoms.
   - Use "other" category to include enuresis, encopresis, etc.

H. GENERAL PHYSICAL EXAMINATION

1. **Record vital signs.** Blood pressure, height and weight are optional.
2. **Record the date and time the examination was started and completed.**
3. **For females, record Breast Tanner Stage by checking the appropriate box.**
   1. Preadolescent
   2. Breast and papilla elevated as small mound: areolar diameter increased
   3. Breast and areola enlarged, no contour separation
   4. Areola and papilla form secondary mound
   5. Mature: nipple projections, areola part of general breast contour
4. **Describe the patient's general demeanor and any relevant spontaneous statements made during the exam.**
   - Documenting helps the examiner recall the patient's behavior and response during the exam for future reference.
5. **Conduct a physical examination. Record all findings and whether the general exam was within normal limits.**

Physical Findings: A physical finding includes observable or palpable tissue injuries, physiologic changes, or foreign materials. If none of the above are present, mark "No Findings".

- Be observant for erythema (redness), abrasions, bruises, swelling, lacerations, fractures, bites, and burns.
- Note areas of tenderness or induration.

DOCUMENTATION OF INJURIES AND FINDINGS USING DIAGRAMS AND LEGEND

- Record size and appearance of injuries and other findings using the diagrams, the legend, and a consecutive numbering system.
- Bruises: describe shape, size, and color.
- Use the legend to list and describe the injury/finding drawn on the diagram. Show the diagram letter followed by the finding number. Use the abbreviations in the legend to describe the type of finding. Example: A-1, EC 2x3cm red/purple indicates that the first finding on Diagram A is an ecchymosis (bruise) that is red/purple in color and 2x3 centimeters in size. See example below.

Locator #	Type	Description
A-1	EC	2x3 cm red/purple
A-2	AB	Abrasion

- **Photograph injuries and other findings according to local policy.**
- **Use proper forensic photographic techniques.**
  Use an appropriate light source and a scale near the finding.
  Note: The plane of the film must be parallel to the plane of the finding.

I. EXAMINATION OF THE EXTERNAL GENITALIA AND THE PERINEAL AREA

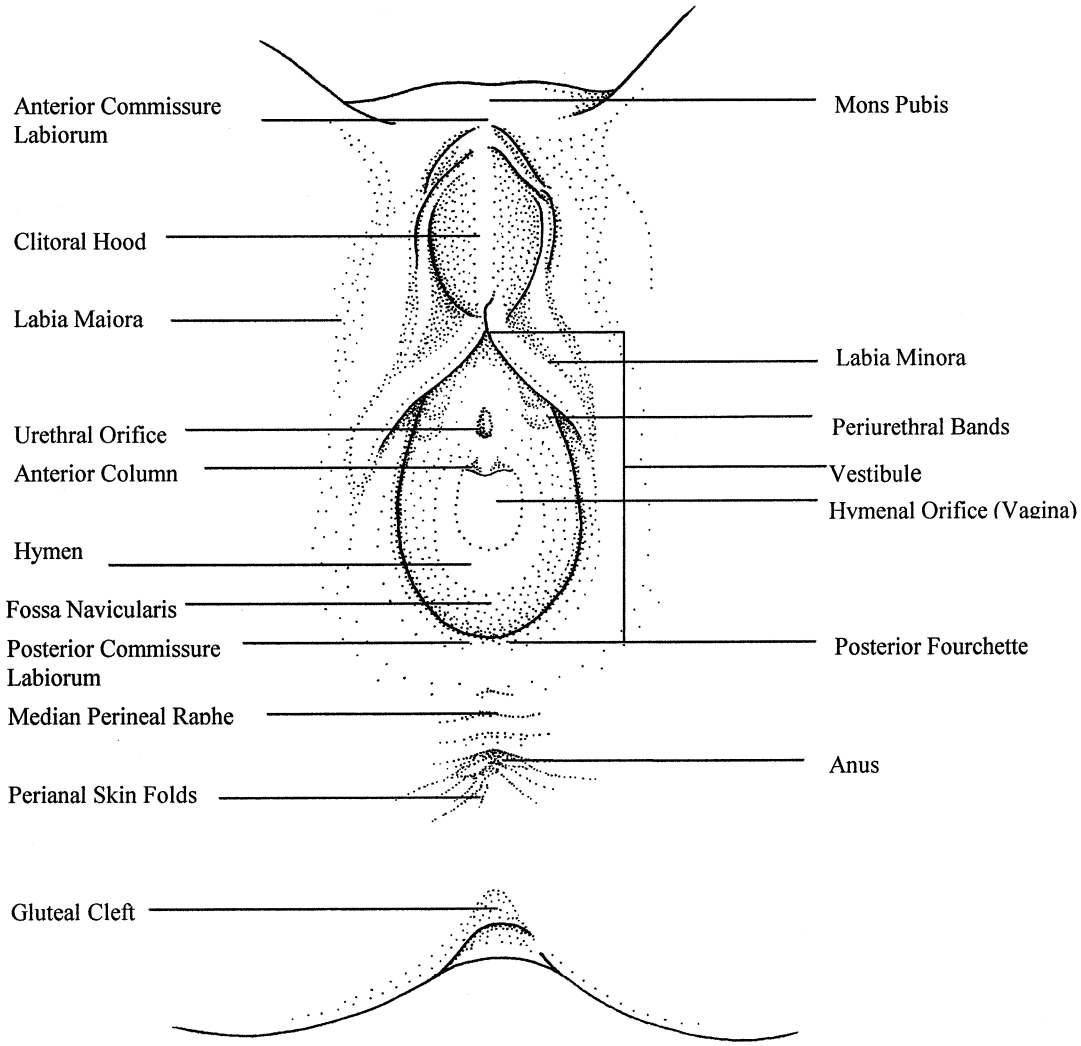
1. **Use a colposcope, if available, or employ other means of magnification.**
2. **Examine the genital structures. Diagram the position that best illustrates your findings.**

Examination positions and methods used:	
Knee chest: **Prone:** child rests on knees with upper chest on the examination table in a lordotic (swayback) posture **Supine:** child rests on back with flexed knees brought to chest	**Saline/water**: used to float/separate the hymenal tissue that may be rolled or overlapping upon itself
Traction: labia majora are grasped between the thumbs and index fingers and gently pulled toward the examiner	**Moistened swab**: used to reposition hymenal tissue **Always use a moistened swab to reduce discomfort**
Separation: labia majora are gently separated in a lateral and downward direction exposing the structures within the vestibule	**Speculum exams: Never done on prepubertal females**

- Record size and appearance of injuries and other findings using the diagrams, legend, and a consecutive numbering system.
- Use the legend to help identify and describe the findings drawn on the diagrams. Example: D-5 LA 1.5 centimeters means Diagram D finding #5 is a laceration, 1.5 centimeters long.
- Describe genital findings as the face of a clock with the top of a genital diagram being 12 o'clock and the bottom of a genital diagram being 6 o'clock.
- Photograph injuries and other findings according to local policy.

FEMALE GENITALIA WITH LABELS: SUPINE VIEW

Diagrams of female and male genitalia with definitions are provided in Appendix N of the Protocol.



J. ANAL-GENITAL FINDINGS

1. **Record examination method used.**
2. **General female/male: inguinal adenopathy and perineum. Describe any abnormal findings.**
3. **Record Genital Tanner Stage by checking the appropriate box.**
   1. No or fine vellus (peach fuzz) hair
   2. Sparse, long straight pigmented hair
   3. Increased density, dark coarse curly hair
   4. Abundant hair, sparing medial thighs
   5. Abundant hair, spreading to medial thighs
4. **Female Genitalia**
   - Record examination positions and methods used.
   - Describe any abnormal or unusual findings.
   - Hymen: note exam position/orientation in which findings are reported.
   - Pubertal adolescents: If a speculum is used for an adolescent exam, describe the cervix.

Record morphology of the hymen:		Terms relating to the hymen:	
annular:	circumferential	**estrogenized:**	influenced by estrogen, hymen takes on thickened, redundant, pale appearance
crescentic:	attachments at about the 11 and 1 o'clock positions without tissue being present between the two attachments	**fimbriate/denticular:**	multiple projections and indentations along edge
imperforate:	no opening	**narrow/wide rim:**	viewed in the coronal plane-from edge of hymen to muscular portion(attachment) of the vaginal opening
septate:	bisected by a band of hymenal tissue creating two or more orifices	**membrane thickness:**	relative amount of tissue between internal and external surfaces of the hymenal membrane

5. **Male Genitals:** Describe unusual and abnormal findings.
   - Record if circumcised or uncircumcised.
   - Note any unusual findings of the urethral meatus, shaft, scrotum, and testes.
6. **Female/Male Anus and Rectum:**
   - Record examination positions, methods, and observations.
   - Examination position options: supine, prone, or lateral recumbent (lying on side with hips and knees flexed).
   - Use lateral traction on the buttocks or the knee-chest position with lateral traction on the buttocks to conduct the examination.
   - If an anoscopic examination is medically indicated, document under examination methods. Sedation or anesthesia is recommended for the prepubertal child.
   - Indicate if anal dilatation is immediate or delayed. If anus dilates, record if stool is present in the rectal ampulla.

K. RECORD FINDINGS AND INTERPRETATION

- **Findings and interpretations are based on both the patient history available at the time and the medical examination.**
- **A normal exam does not indicate that sexual abuse did not occur.**
- **A medical exam is only one part of a complete investigation.**

1. **Anal-Genital Findings**
   - Normal anal-genital exam
   - Abnormal anal-genital exam
   - Indeterminate anal-genital exam (Example: erythema)
2. **Assessment of Anal-Genital Findings**
   - Check the box to indicate whether the findings are consistent or inconsistent with the history given, or whether history was limited or insufficient.
3. **Interpretation of Anal-Genital Findings**

Findings:	Examples:
• Normal exam: can neither confirm nor negate sexual abuse	• Normal findings and variations of normal
• Non-specific: may be caused by sexual abuse or other mechanisms	• Erythema (redness) of the anogenital tissues
• Sexual abuse is highly suspected	• Condyloma acuminata on a 9 year old without history of prior condylomata
• Definite evidence of sexual abuse and/or sexual contact	• Nonperinatal culture proven *Neisseria gonerrhoeae* • Pregnancy

4. **Need further consultation/investigation.**

Examples:	• Examiner may not have seen this type of finding before
	• No history to account for examiner's findings of larger than "normal" hymenal diameter

5. **Check if lab results or photo review are pending.**
6. **Record additional comments regarding findings, interpretations, and recommendations; or, use to describe variations of normal congenital abnormalities.**

L. RECORD MEDICAL LAB TESTS PERFORMED

- Consider abuse history, patient's medical history, and exam findings to determine tests needed.
- Pregnancy testing should be considered for all females Tanner Stage 3 and above, irrespective of menarche.
- Additional tests performed depend upon clinical assessment (i.e. urinalysis, biopsy, cultures, viral titers, etc.).

M. TOXICOLOGY SAMPLES

If indicated by history of drug and/or alcohol use, lapse of memory, or lapse of consciousness **and** it is <96 hours, collect a urine toxicology sample.

N. RECORD PHOTO DOCUMENTATION METHODS

O. PRINT NAMES OF PERSONNEL INVOLVED. OBTAIN SIGNATURE AND LICENSE NUMBER OF EXAMINER.