

State of California  
Governor's Office of Criminal Justice Planning

**FORENSIC MEDICAL REPORT:  
NONACUTE (>72 HOURS)  
CHILD/ADOLESCENT SEXUAL ABUSE  
EXAMINATION**

**OCJP 925**



For more information or assistance in completing the OCJP 925 please contact  
University of California, Davis California Medical Training Center at:  
(916) 734-4141

This form is available on the following Web site:  
[www.ocjp.ca.gov](http://www.ocjp.ca.gov)

**FORENSIC MEDICAL REPORT: NONACUTE (<72 HOURS)  
CHILD/ADOLESCENT SEXUAL ABUSE EXAMINATION  
STATE OF CALIFORNIA  
OFFICE OF CRIMINAL JUSTICE PLANNING  
OCJP 925**

Confidential Document

Patient Identification

**A. GENERAL INFORMATION (print or type) Name of Medical Facility:**

1. Name of patient \_\_\_\_\_ Patient ID number \_\_\_\_\_

2. Address \_\_\_\_\_ City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Telephone \_\_\_\_\_

| 3. Age | DOB | Gender<br>M F | Ethnicity | Arrival Date | Arrival Time | Discharge Date | Discharge Time |
|--------|-----|---------------|-----------|--------------|--------------|----------------|----------------|
|        |     |               |           |              |              |                |                |

4. Name of :  Mother  Stepmother  Guardian Address \_\_\_\_\_ City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Telephone W: \_\_\_\_\_ H: \_\_\_\_\_

5. Name of :  Father  Stepfather  Guardian Address \_\_\_\_\_ City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Telephone W: \_\_\_\_\_ H: \_\_\_\_\_

| 6. Name(s) of Siblings | Gender<br>M F | Age | DOB | Name(s) of Siblings | Gender<br>M F | Age | DOB |
|------------------------|---------------|-----|-----|---------------------|---------------|-----|-----|
|                        |               |     |     |                     |               |     |     |
|                        |               |     |     |                     |               |     |     |

**B. REPORTING AND AUTHORIZATION Jurisdiction (city county other):**

1. Telephone report made to \_\_\_\_\_ Name \_\_\_\_\_ Agency \_\_\_\_\_ ID number \_\_\_\_\_ Telephone \_\_\_\_\_

Law Enforcement   
and/or  
Child Protective Services

2. Responding Personnel (to medical facility) \_\_\_\_\_ Name \_\_\_\_\_ Agency \_\_\_\_\_ ID number \_\_\_\_\_ Telephone \_\_\_\_\_

Law Enforcement   
and/or  
Child Protective Services

3. Assigned Investigator (if known) \_\_\_\_\_ Name \_\_\_\_\_ Agency \_\_\_\_\_ ID number \_\_\_\_\_ Telephone \_\_\_\_\_

Law Enforcement   
and/or  
Child Protective Services

4. Authorization for evidential exam requested by law enforcement or child protective services agency

I request a forensic medical examination for suspected sexual abuse at public expense.

Telephone Authorization  Law enforcement officer ID number \_\_\_\_\_  Child Protective Services

Agency: \_\_\_\_\_  
Authorizing party: \_\_\_\_\_  
ID number: \_\_\_\_\_  
Date/time: \_\_\_\_\_

Telephone \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_ Case number \_\_\_\_\_

**C. CONSENT FOR EXAMINATION BY PATIENT/PARENT/GUARDIAN** Note: Parental consent is not required for a suspected child sexual abuse examination if the child is in protective custody. Family Code Section 6927 permits minors (12 to 17 years of age) to consent to medical examination, treatment, and evidence collection for sexual assault without parental consent. See instructions regarding parental notification requirements for minors.

- I hereby consent to a forensic medical examination for evidence of sexual abuse. I understand that collection of evidence may include photographing injuries and that these photographs may include the anal-genital area (private parts). I further understand that medical providers are required to notify child protective authorities of known or suspected child abuse; and, if child abuse is found or suspected, this form and any evidence obtained will be released to a child protective agency.
- I have been informed that victims of crime are eligible to submit crime victim compensation claims to the State Victims of Crime (VOC) Restitution Fund for out-of-pocket medical expenses, psychological counseling, loss of wages, and job retraining/rehabilitation.
- I understand that data without patient identity may be collected from this report 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.

Signature \_\_\_\_\_  Patient  Parent  Guardian

**DISTRIBUTION OF OCJP 930**

Original – Law Enforcement  Copy – Child Protective Services  Copy – Medical Facility Records

**D. PATIENT HISTORY**

| 1. Record time or time frame of the incident(s)       | Date(s) | Time or time frame |
|---|---------|--------------------|
| <input type="checkbox"/> Less than 72 hours           |         |                    |
| <input type="checkbox"/> Multiple incidents over time |         |                    |

| 2. Record patient's name for:<br>Female genitalia | 3. Alleged perpetrator(s) name(s) | Age | Gender | Ethnicity | Patient Identification           |         |
|---|-----------------------------------|-----|--------|-----------|----------------------------------|---------|
|   |                                   |     |        |           | Relationship to Patient<br>Known | Unknown |
| Male genitalia                                    | #1.                               |     | M F    |           |                                  |         |
| Breasts   | #2.                               |     | M F    |           |                                  |         |
| Anus  | #3.                               |     | M F    |           |                                  |         |

**E. ACTS DESCRIBED BY HISTORIAN**

| Name of historian | Relationship to patient | History obtained by: | Telephone | Agency | <input type="checkbox"/> Not applicable |
|-------------------|-------------------------|----------------------|-----------|--------|---|
|-------------------|-------------------------|----------------------|-----------|--------|---|

|   | No                          | Yes                           | Attempted                      | Unsure                           | N/A                      | Describe pain and/or bleeding and additional pertinent history: |
|---|-----------------------------|-------------------------------|--------------------------------|----------------------------------|--------------------------|---|
| <b>Genital/vaginal contact/penetration by:</b>  |                             |                               |                                |                                  |                          |   |
| Penis   | <input type="checkbox"/>    | <input type="checkbox"/>      | <input type="checkbox"/>       | <input type="checkbox"/>         | <input type="checkbox"/> | _____   |
| Finger  | <input type="checkbox"/>    | <input type="checkbox"/>      | <input type="checkbox"/>       | <input type="checkbox"/>         | <input type="checkbox"/> | _____   |
| Object (Describe)   | <input type="checkbox"/>    | <input type="checkbox"/>      | <input type="checkbox"/>       | <input type="checkbox"/>         | <input type="checkbox"/> | _____   |
| Associated pain?  | <input type="checkbox"/>    | <input type="checkbox"/>      |                                | <input type="checkbox"/>         | <input type="checkbox"/> | _____   |
| Associated bleeding?  | <input type="checkbox"/>    | <input type="checkbox"/>      |                                | <input type="checkbox"/>         | <input type="checkbox"/> | _____   |
| <b>Anal contact/penetration by:</b>   |                             |                               |                                |                                  |                          |   |
| Penis   | <input type="checkbox"/>    | <input type="checkbox"/>      | <input type="checkbox"/>       | <input type="checkbox"/>         | <input type="checkbox"/> | _____   |
| Finger  | <input type="checkbox"/>    | <input type="checkbox"/>      | <input type="checkbox"/>       | <input type="checkbox"/>         | <input type="checkbox"/> | _____   |
| Object (Describe)   | <input type="checkbox"/>    | <input type="checkbox"/>      | <input type="checkbox"/>       | <input type="checkbox"/>         | <input type="checkbox"/> | _____   |
| Associated pain?  | <input type="checkbox"/>    | <input type="checkbox"/>      |                                | <input type="checkbox"/>         | <input type="checkbox"/> | _____   |
| Associated bleeding?  | <input type="checkbox"/>    | <input type="checkbox"/>      |                                | <input type="checkbox"/>         | <input type="checkbox"/> | _____   |
| <b>Oral copulation of genitals:</b>   |                             |                               |                                |                                  |                          |   |
| Of patient by assailant   | <input type="checkbox"/>    | <input type="checkbox"/>      | <input type="checkbox"/>       | <input type="checkbox"/>         | <input type="checkbox"/> | _____   |
| Of assailant by patient   | <input type="checkbox"/>    | <input type="checkbox"/>      | <input type="checkbox"/>       | <input type="checkbox"/>         | <input type="checkbox"/> | _____   |
| <b>Oral copulation of anus:</b>   |                             |                               |                                |                                  |                          |   |
| Of patient by assailant   | <input type="checkbox"/>    | <input type="checkbox"/>      | <input type="checkbox"/>       | <input type="checkbox"/>         | <input type="checkbox"/> | _____   |
| Of assailant by patient   | <input type="checkbox"/>    | <input type="checkbox"/>      | <input type="checkbox"/>       | <input type="checkbox"/>         | <input type="checkbox"/> | _____   |
| <b>Anal/genital fondling:</b>   |                             |                               |                                |                                  |                          |   |
| Of patient by assailant   | <input type="checkbox"/>    | <input type="checkbox"/>      | <input type="checkbox"/>       | <input type="checkbox"/>         | <input type="checkbox"/> | _____   |
| Of assailant by patient   | <input type="checkbox"/>    | <input type="checkbox"/>      | <input type="checkbox"/>       | <input type="checkbox"/>         | <input type="checkbox"/> | _____   |
| <b>Non-genital act(s)?</b>  |                             |                               |                                |                                  |                          |   |
| If yes: <input type="checkbox"/> Fondling <input type="checkbox"/> Licking <input type="checkbox"/> Kissing <input type="checkbox"/> Suction Injury <input type="checkbox"/> Biting |                             |                               |                                |                                  |                          |   |
| Other acts? (Describe)  | <input type="checkbox"/>    | <input type="checkbox"/>      | <input type="checkbox"/>       | <input type="checkbox"/>         | <input type="checkbox"/> | _____   |
| Did ejaculation occur?  | <input type="checkbox"/>    | <input type="checkbox"/>      |                                | <input type="checkbox"/>         | <input type="checkbox"/> | _____   |
| If yes, note location(s):   |                             |                               |                                |                                  |                          |   |
| <input type="checkbox"/> Mouth <input type="checkbox"/> Vagina <input type="checkbox"/> Body surface <input type="checkbox"/> On bedding  |                             |                               |                                |                                  |                          |   |
| <input type="checkbox"/> Anus/Rectum <input type="checkbox"/> On clothing <input type="checkbox"/> Other  |                             |                               |                                |                                  |                          |   |
| Contraceptive or lubricant products? <input type="checkbox"/> No <input type="checkbox"/> Yes   |                             |                               |                                |                                  |                          |   |
| If yes, note type/brand: <input type="checkbox"/> Foam <input type="checkbox"/> Jelly <input type="checkbox"/> Lubricant <input type="checkbox"/> Condom                            |                             |                               |                                |                                  |                          |   |
| Were force or threats used?   | <input type="checkbox"/> No | <input type="checkbox"/> Yes  | <input type="checkbox"/> Force | <input type="checkbox"/> Threats |                          | _____   |
| Were weapons used?  | <input type="checkbox"/> No | <input type="checkbox"/> Yes  |                                |                                  |                          | _____   |
| If yes, describe: _____   |                             |                               |                                |                                  |                          |   |
| Were pictures/videotapes taken <input type="checkbox"/> or shown <input type="checkbox"/> ?   | <input type="checkbox"/> No | <input type="checkbox"/> Yes  |                                |                                  |                          | _____   |
| If yes, note type(s): <input type="checkbox"/> Pictures <input type="checkbox"/> Videotapes   |                             |                               |                                |                                  |                          |   |
| Were drugs <input type="checkbox"/> or alcohol <input type="checkbox"/> used?   | <input type="checkbox"/> No | <input type="checkbox"/> Yes* |                                |                                  |                          | _____   |
| Loss of memory?   | <input type="checkbox"/> No | <input type="checkbox"/> Yes* |                                |                                  |                          | _____   |
| Lapse of consciousness?   | <input type="checkbox"/> No | <input type="checkbox"/> Yes* |                                |                                  |                          | _____   |
| Vomited after act(s)?   | <input type="checkbox"/> No | <input type="checkbox"/> Yes  |                                |                                  |                          | _____   |
| Behavioral changes in patient?  | <input type="checkbox"/> No | <input type="checkbox"/> Yes  |                                |                                  |                          | _____   |

\*Collection of toxicology samples (<96 hours) is recommended according to local policy.



## H. GENERAL PHYSICAL EXAMINATION

Record all findings using diagrams, legend, and a consecutive numbering system.

|  |    |       |      |      |                            |                            |                            |                            |                            |      |
|--|----|-------|------|------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|------|
| 1.   | BP | Pulse | Resp | Temp | Height                     | Weight                     | 2. Exam Started            |                            | Exam Completed             |      |
|  |    |       |      |      |                            |                            | Date                       | Time                       | Date                       | Time |
| 3. Female Tanner Stage – Breast  |    |       |      |      | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |      |
| 4. Describe general demeanor and relevant statements made during exam.                                       |    |       |      |      |                            |                            |                            |                            |                            |      |
| 5. Conduct a physical examination. <input type="checkbox"/> Findings <input type="checkbox"/> No Findings    |    |       |      |      |                            |                            |                            |                            |                            |      |
| General exam within normal limits: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, describe: |    |       |      |      |                            |                            |                            |                            |                            |      |

Patient Identification

Diagram A

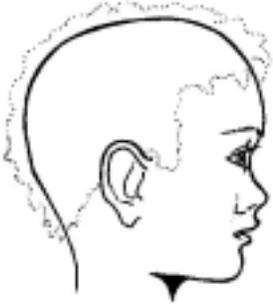


Diagram B

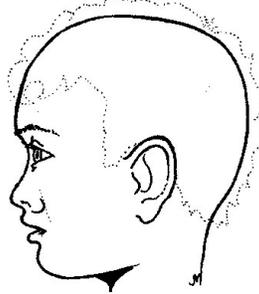


Diagram C

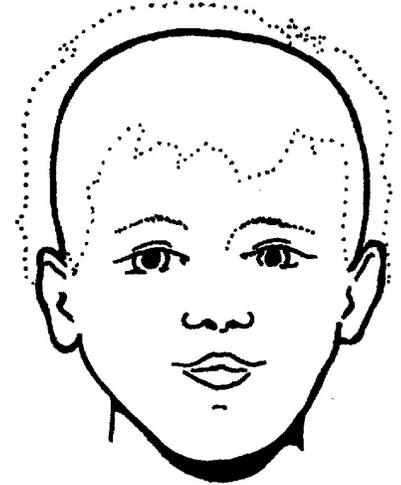


Diagram D

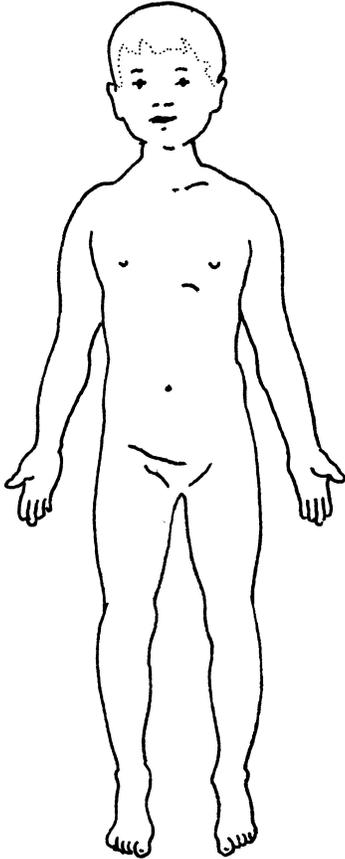


Diagram E

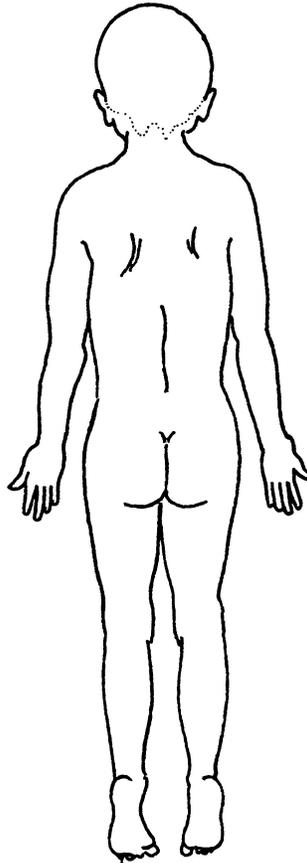
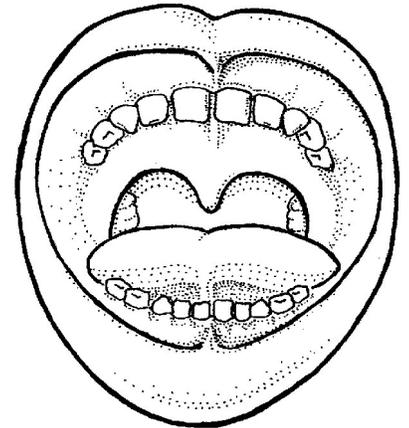


Diagram F



### LEGEND: Types of Findings

|                                  |                                |                               |                                   |                                 |                                  |                            |
|----------------------------------|--------------------------------|-------------------------------|-----------------------------------|---------------------------------|----------------------------------|----------------------------|
| <b>AB</b> Abrasion               | <b>BU</b> Burn                 | <b>DI</b> Discharge           | <b>HC</b> Hymenal Cleft           | <b>OSC</b> Other Skin Condition | <b>PGW</b> Possible Genital Wart | <b>SW</b> Swelling         |
| <b>AHT</b> Absent Hymenal Tissue | <b>CV</b> Congenital Variation | <b>EC</b> Ecchymosis (bruise) | <b>IN</b> Induration              | <b>OT</b> Other                 | <b>SH</b> Submucosal Hemorrhage  | <b>TE</b> Tenderness       |
| <b>AL</b> Anal Laxity            | <b>DE</b> Debris               | <b>ER</b> Erythema (redness)  | <b>LA</b> Laceration              | <b>PW</b> Perianal Wart         | <b>SI</b> Suction Injury         | <b>VL</b> Vesicular Lesion |
| <b>BI</b> Bite                   | <b>DF</b> Deformity            | <b>FB</b> Foreign Body        | <b>OI</b> Other Injury (describe) | <b>PE</b> Petechiae             |                                  |                            |

| Locator # | Type | Description | Locator # | Type | Description |
|-----------|------|-------------|-----------|------|-------------|
|           |      |             |           |      |             |
|           |      |             |           |      |             |
|           |      |             |           |      |             |
|           |      |             |           |      |             |

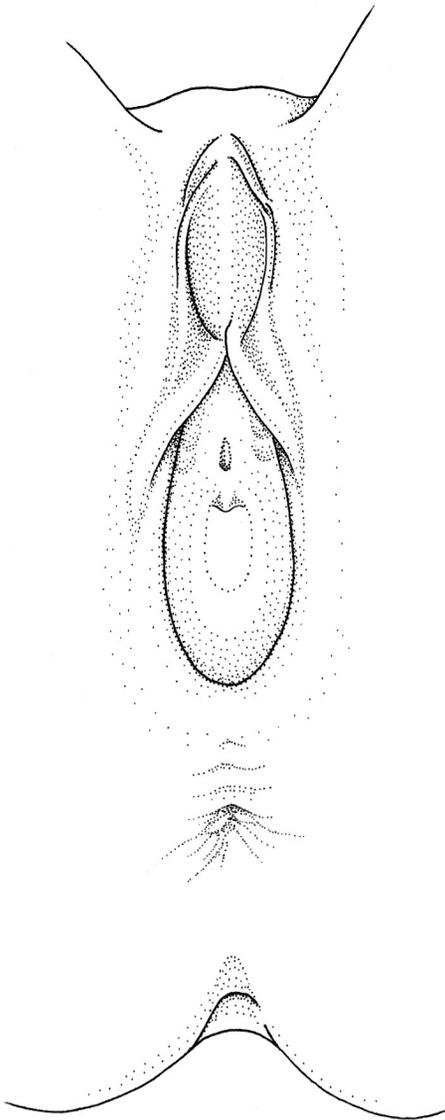
**I. EXAMINATION OF THE EXTERNAL GENITALIA AND PERINEAL AREA**

Record all findings using diagrams, legend, and a consecutive numbering system.

1. Use a colposcope or employ other means of magnification.
2. Examine the genital structures.
  - See page 5 of instructions for diagrams of the genital structures.
  - Use exam techniques described in instructions.
  - Diagram the position that best illustrates your findings.

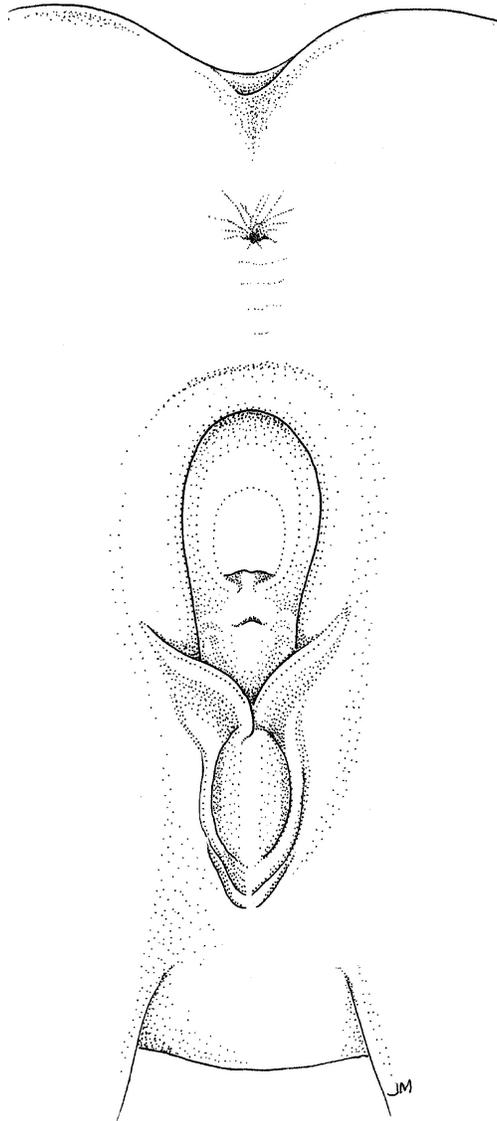
Patient Identification

Diagram G



Supine

Diagram H



Knee-Chest

Diagram I

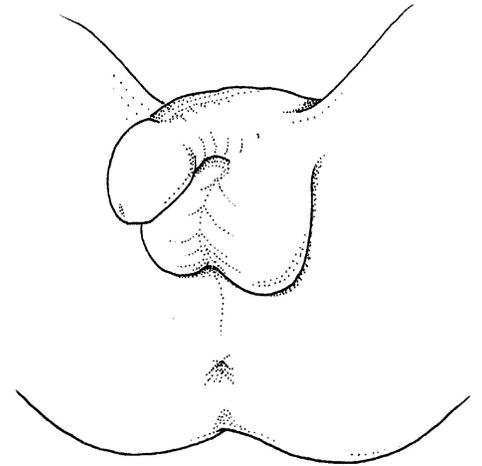
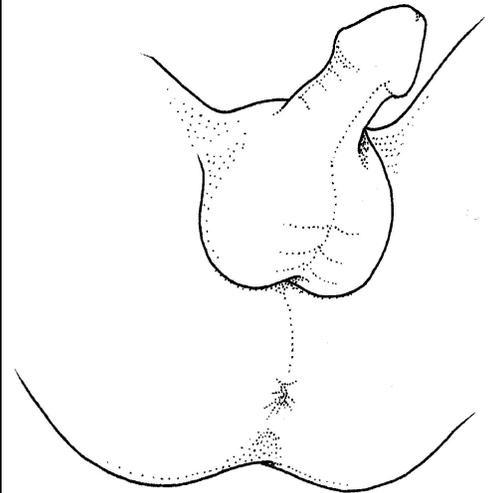


Diagram J



Penis

**LEGEND: Types of Findings**

|                                  |                                |                               |                              |                                   |                                  |                            |
|----------------------------------|--------------------------------|-------------------------------|------------------------------|-----------------------------------|----------------------------------|----------------------------|
| <b>AB</b> Abrasion               | <b>BU</b> Burn                 | <b>DI</b> Discharge           | <b>HC</b> Hymenal Cleft      | <b>OSC</b> Other Skin Condition   | <b>PGW</b> Possible Genital Wart | <b>SW</b> Swelling         |
| <b>AHT</b> Absent Hymenal Tissue | <b>CV</b> Congenital Variation | <b>EC</b> Ecchymosis (bruise) | <b>IN</b> Induration         | <b>OT</b> Other                   | <b>SH</b> Submucosal Hemorrhage  | <b>TE</b> Tenderness       |
| <b>AL</b> Anal Laxity            | <b>DE</b> Debris               | <b>ER</b> Erythema (redness)  | <b>LA</b> Laceration         | <b>OI</b> Other Injury (describe) | <b>PW</b> Perianal Wart          | <b>VL</b> Vesicular Lesion |
| <b>BI</b> Bite                   | <b>DF</b> Deformity            | <b>FB</b> Foreign Body        | <b>GT</b> Granulation Tissue | <b>PE</b> Petechiae               | <b>SI</b> Suction Injury         |                            |

| Locator # | Type | Description | Locator # | Type | Description |
|-----------|------|-------------|-----------|------|-------------|
|           |      |             |           |      |             |
|           |      |             |           |      |             |
|           |      |             |           |      |             |
|           |      |             |           |      |             |
|           |      |             |           |      |             |

**J. ANAL-GENITAL FINDINGS**

**1. Exam method:**  
 Direct visualization  Colposcope  Other magnification

**2. General Female/Male**      WNL      ABN      Describe  
 Inguinal adenopathy                  \_\_\_\_\_  
 Perineum                  \_\_\_\_\_

**3. Genital Tanner Stage**    1     2     3     4     5

**4. Female Genitalia**

Exam positions/methods:    Separation      Traction      Knee chest  
 Supine                    
 Prone                    
 Saline/water     Moistened swab     Catheter     Other: \_\_\_\_\_

|  | WNL                      | ABN                      | Describe                |
|--|--------------------------|--------------------------|-------------------------|
| Labia majora   | <input type="checkbox"/> | <input type="checkbox"/> |                         |
| Labia minora   | <input type="checkbox"/> | <input type="checkbox"/> |                         |
| Clitoral hood  | <input type="checkbox"/> | <input type="checkbox"/> |                         |
| Perihymenal tissues (vestibule)                                      | <input type="checkbox"/> | <input type="checkbox"/> |                         |
| Hymen <input type="checkbox"/> Supine <input type="checkbox"/> Prone | <input type="checkbox"/> | <input type="checkbox"/> |                         |
| Record morphology:   |                          |                          |                         |
| <input type="checkbox"/> Annular                                     |                          |                          | _____                   |
| <input type="checkbox"/> Crescentic                                  |                          |                          | _____                   |
| <input type="checkbox"/> Imperforate                                 |                          |                          | _____                   |
| <input type="checkbox"/> Septate                                     |                          |                          | _____                   |
| Fossa navicularis  | <input type="checkbox"/> | <input type="checkbox"/> |                         |
| Posterior fourchette   | <input type="checkbox"/> | <input type="checkbox"/> |                         |
| Vagina (pubertal adolescents)  | <input type="checkbox"/> | <input type="checkbox"/> |                         |
| Cervix (pubertal adolescents)  | <input type="checkbox"/> | <input type="checkbox"/> |                         |
| Discharge <input type="checkbox"/> No <input type="checkbox"/> Yes   |                          |                          | If yes, describe: _____ |

**Patient Identification**

**5. Male Genitals**      WNL      ABN      Describe

Penis                  \_\_\_\_\_  
 Circumcised      
 Uncircumcised   
 Foreskin                  \_\_\_\_\_  
 Glans Penis                \_\_\_\_\_  
 Penile Shaft                \_\_\_\_\_  
 Urethral meatus                  \_\_\_\_\_  
 Scrotum                  \_\_\_\_\_  
 Testes                  \_\_\_\_\_  
 Discharge     No     Yes    If yes, describe: \_\_\_\_\_

**6. Female/Male Anus and Rectum**

Exam positions      Observation      Observation with traction  
 Supine              
 Supine knee chest              
 Prone knee chest              
 Lateral recumbent              
 Exam methods:     Moistened swab     Toluidine blue dye  
                           Anoscopy                                     Other: \_\_\_\_\_

|                  | WNL                      | ABN                      | Describe: |
|------------------|--------------------------|--------------------------|-----------|
| Buttocks         | <input type="checkbox"/> | <input type="checkbox"/> | _____     |
| Perianal skin    | <input type="checkbox"/> | <input type="checkbox"/> | _____     |
| Anal verge/folds | <input type="checkbox"/> | <input type="checkbox"/> | _____     |
| Rectum           | <input type="checkbox"/> | <input type="checkbox"/> | _____     |

Anal dilation     No     Yes    If yes:     Immediate     Delayed  
 Stool present in rectal ampulla     No     Yes     Undetermined

**K. FINDINGS AND INTERPRETATION**

**1. Anal-Genital Findings**  
 Normal anal-genital exam  
 Abnormal anal-genital exam  
 Indeterminate anal-genital exam

**2. Assessment of Anal-Genital Findings**  
 Consistent with history  
 Inconsistent with history  
 Limited/Insufficient history

**3. Interpretation of Anal-Genital Findings**  
 Normal exam: can neither confirm nor negate sexual abuse  
 Non specific: may be caused by sexual abuse or other mechanisms  
 Sexual abuse is highly suspected  
 Definite evidence of sexual abuse and/or sexual contact.

**4.  Need further consultation/investigation**

**5.  Lab results or photo review pending (may alter assessment)**

**6. Additional comments regarding findings, interpretations, and recommendations.**

**L. MEDICAL LAB TESTS PERFORMED**

| STD Cultures   | GC                                | Chlamydia                      | Other                              | Describe: | Collected by: |
|----------------|-----------------------------------|--------------------------------|------------------------------------|-----------|---------------|
| Oral           | <input type="checkbox"/>          | <input type="checkbox"/>       | <input type="checkbox"/>           | _____     | _____         |
| Vestibular     | <input type="checkbox"/>          | <input type="checkbox"/>       | <input type="checkbox"/>           | _____     | _____         |
| Vaginal        | <input type="checkbox"/>          | <input type="checkbox"/>       | <input type="checkbox"/>           | _____     | _____         |
| Cervical       | <input type="checkbox"/>          | <input type="checkbox"/>       | <input type="checkbox"/>           | _____     | _____         |
| Rectal         | <input type="checkbox"/>          | <input type="checkbox"/>       | <input type="checkbox"/>           | _____     | _____         |
| Penile         | <input type="checkbox"/>          | <input type="checkbox"/>       | <input type="checkbox"/>           | _____     | _____         |
| Wet mount      | <input type="checkbox"/>          | <input type="checkbox"/>       | <input type="checkbox"/>           | _____     | _____         |
| Serology       | Syphilis <input type="checkbox"/> | HIV <input type="checkbox"/>   | Hepatitis <input type="checkbox"/> | _____     | _____         |
| Pregnancy test | Blood <input type="checkbox"/>    | Urine <input type="checkbox"/> |                                    | _____     | _____         |
| Other test(s)  |                                   |                                |                                    | _____     | _____         |

**M. TOXICOLOGY SAMPLES**

Urine Toxicology     No     Yes      Collected by: \_\_\_\_\_

**N. PHOTO DOCUMENTATION METHODS**

|                 | No                       | Yes                      | Colposcope/35mm          | Macrolens/35mm           | Colposcope/Videocamera   | Other Optics             | Photographed by: |
|-----------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|------------------|
| <b>Body</b>     | <input type="checkbox"/> | _____            |
| <b>Genitals</b> | <input type="checkbox"/> | _____            |

**O. PRINT NAMES OF PERSONNEL INVOLVED**

|                          |                           |                   |                               |                    |
|--------------------------|---------------------------|-------------------|-------------------------------|--------------------|
| <b>History taken by:</b> | <b>Exam performed by:</b> | <b>Telephone:</b> | <b>Signature of Examiner:</b> | <b>License No.</b> |
| _____                    | _____                     | _____             | _____                         | _____              |