State of California
Office of Emergency Services
(www.oes.ca.gov)

FORENSIC MEDICAL REPORT: DOMESTIC VIOLENCE EXAMINATION

CAL OES 2-502

For copies of this form or assistance in completing the Cal OES 2-502, please contact
California Clinical Forensic Medical Training Center
(916) 930-3080 or
Contact Us @ www.ccfmtc.org

FORENSIC MEDICAL REPORT: DOMESTIC VIOLENCE EXAMINATION
State of California
California Office of Emergency Services
CAL OES 2-502

Confidential Document:

Patient Identification

A. GENERAL INFORMATION

1. Patient's Last Name | **First Name** | **M.I.**

2. Street Address (optional)	City	County	State	Zip Code	Telephone (optional) (Home) (Work) (Safe)

3. Age	DOB	Gender	Ethnicity (check all that apply)
		F M MTF FTM	☐ White ☐ Black / African American ☐ Hispanic / Latino ☐ Asian ☐ American Indian / Alaskan Native ☐ Native Hawaiian / Other Pacific Islander ☐ Other _____

4. Name of Facility Where Forensic Exam Performed | **Address of Facility**

5. Patient Arrival		Patient Discharge		6. Exam Started		Exam Completed	
Date	Time	Date	Time	Date	Time	Date	Time

7. Interpreter Used ☐ No ☐ Yes Language Used: _____

Name of Interpreter: _____ Telephone: _____

Affiliation of interpreter: ☐ Facility Interpreting Services
☐ Contracted Agency, specify: _____
☐ Family ☐ Friend ☐ Other, specify: _____

B. MANDATORY SUSPICIOUS INJURY REPORT (Pursuant to Pen. Code §11160)

1. Name of Person Making Mandated Telephone Report to Law Enforcement Agency | **Date** | **Time**

2. Name of Person Taking Telephone Report | **Name of Law Enforcement Agency** | ☐ **Cal OES 920 Written Report Submitted**

C. RESPONDING OFFICER TO MEDICAL FACILITY ☐ Not Applicable

Law Enforcement Officer | Name of Law EnforcementAgency | ID Number

D. AUTHORIZATION FOR MEDICAL EVIDENTIARY EXAMINATION: Follow Local Policy ☐ Not Applicable

Law Enforcement Officer | Name of Law Enforcement Agency | ID Number

Telephone | Date | Time | Case Number

E. PATIENT INFORMATION

1. I understand that hospitals and health care professionals are required by Penal Code §§11160-11161 to report to law enforcement authorities cases in which medical care is sought when injuries have been inflicted upon any person in violation of any state penal law. The report must state the name of the injured person, current whereabouts, and the type and extent of injuries. ____(initial)
2. I have been informed that victims of crime are eligible to submit crime victim compensation claims to the California Victim Compensation Program (VCP) for out-of-pocket medical expenses, psychological counseling, loss of wages, and job retraining and rehabilitation. ____(initial)
3. I have been informed about domestic violence advocacy services or a social services professional who can provide me with counseling and support. ____(initial)

F. PATIENT CONSENT

1. I understand that a forensic medical examination for evidence of domestic violence can, with my consent, be conducted by a health care professional to discover and preserve evidence of the assault. If conducted, the report of the examination and any evidence obtained will be released to law enforcement authorities. I understand that the examination may include the collection of reference specimens at the time of the examination or at a later date. I understand that I may withdraw consent at any time for any portion of the examination. ____(initial)
2. I understand that collection of evidence may include audio/visual recordings and photographing injuries and that these photographs may include the genital area. ____(initial)
3. I hereby consent to a forensic medical examination for evidence of domestic violence. ____(initial)
4. I understand that data without patient identity from this report may be collected for health and forensic purposes, and provided to health authorities and other qualified persons with a valid educational or scientific interest. ____(initial)

☐ Patient ☐ Parent ☐ Guardian ☐ Surrogate

Print Name _____ Signature _____ Date _____

G. DISTRIBUTION OF CAL OES 2-502 (check all that apply)

☐ (Law Enforcement Officer - Original ☐ Crime Lab - Copy within evidence kit ☐ Medical or Agency Facility Records - Copy

H. CURRENT ASSAULT HISTORY

1. Examination audio and/or videotaped
☐ No ☐ Yes ☐ Audio ☐ Video

2. Name of person providing history	**Relationship to Patient**

3. Date(s) of Assault	**Time/Time Frame of Assault**

Patient Identification:

4. Describe Physical Surroundings of Assault

5. Patient Description of Assault

☐ Additional attached pages

6. Assailant(s)

#1	Assailant's Name	DOB	Age	Gender	Ethnicity

Relationship to Patient: (check all that apply)
☐ Spouse ☐ Cohabitant/Domestic Partner ☐ Dating Relationship ☐ Child Together
☐ Former Spouse ☐ Former Cohabitant/Domestic Partner ☐ Former Dating Relationship ☐ Other
Current Whereabouts: ☐ Unknown ☐ In Custody ☐ Known Location

#2	Assailant's Name	DOB	Age	Gender	Ethnicity

Relationship to Patient: (check all that apply)
☐ Spouse ☐ Cohabitant/Domestic Partner ☐ Dating Relationship ☐ Child Together
☐ Former Spouse ☐ Former Cohabitant/Domestic Partner ☐ Former Dating Relationship ☐ Other
Current Whereabouts: ☐ Unknown ☐ In Custody ☐ Known Location:

7. Methods employed by assailant(s) and circumstances

	No	Yes	If yes:
Weapons	☐	☐	☐ Firearm ☐ Knife ☐ Blunt Object ☐ Other
Threatened?	☐	☐	**Describe:**
Displayed?	☐	☐	**Describe:**
Used?	☐	☐	**Describe:**
Injuries?	☐	☐	**Describe:**

Physical blows ☐ by hands ☐ by feet ☐ by head ☐ Other, describe:
☐ Grabbing ☐ Holding ☐ Pinching ☐ Slapping ☐ Punching ☐ Other, describe:
Hair pulling? ☐ No ☐ Yes ☐ If yes, describe:
Physical restraints ☐ No ☐ Yes ☐ If yes, describe:

Strangulation

One Hand		Two Hands		Forearm
	Frontal Assault		Frontal Assault	Frontal Assault
	Rear Assault		Rear Assault	Rear Assault

☐ Ligature, describe:

Bites ☐ No ☐ Yes, describe:
Burns ☐ Thermal ☐ Chemical ☐ Other
Threat(s) of harm ☐ No ☐ Yes If yes, target of threat: ☐ Patient ☐ Children ☐ Pet(s) ☐ Property ☐ Other, describe:
Describe what was said or done:

Sexual relations with assailant as part of this assault? ☐ No ☐ Unsure ☐ Yes If yes: ☐ Forced ☐ Coerced
Involuntary use of alcohol/drugs ☐ No ☐ Yes If yes: ☐ Forced ☐ Coerced ☐ Suspected
If yes: ☐ Alcohol ☐ Drugs Describe:

8. Injuries inflicted upon assailant(s) during assault ☐ No ☐ Unsure ☐ Yes, describe:

9. Post assault hygiene
☐ Bath / shower / wash ☐ Clothes change ☐ Other, describe:

I. CURRENT SYMPTOMS REPORTED BY PATIENT
(check all that apply)

Symptoms	From This Event	From Past Event(s)
Neurological		
Headache		
Dizziness		
Memory/Concentration Problems		
Lightheaded		
Visual Changes		
Hearing Changes		
Loss of Consciousness		
Numbness		
Weakness		
Other		
Psychological		
Acute Anxiety		
Depression		
Suicide Ideation		
Homicide Ideation		
Other		
Cardiorespiratory		
Voice Change		
Coughing		
Shortness of Breath		
Chest Pain		
Palpitations		
Other		
Gastrointestinal		
Sore Throat		
Difficulty Swallowing		
Nausea		
Vomiting		
Diarrhea		
Abdominal Pain		
Hematemesis		
Rectal Bleeding		
Rectal Pain		
Penis/Testicular Pain		
Other		
Urogenital		
Pelvic Pain		
Dysuria		
Vaginal Bleeding		
Vaginal Discharge		
Other		
Musculoskeletal		
Extremity Pain		
Neck Pain		
Back Pain		
Deformity		
Other		
Other		
Other		

Patient Identification:

J. PATIENT HISTORY

1. Disability ☐ No ☐ Yes

If yes: ☐ Cognitive ☐ Physical ☐ Blind ☐ Deaf/HOH ☐ Mental

2. History of prior physical assault(s) with this assailant?

☐ No ☐ Yes If yes, past injuries to patient? ☐ No ☐ Yes, describe:

3. Prior history of forced or coerced sexual relations with this assailant? ☐ No ☐ Yes, describe:

Approximate Date(s):

4. Has patient sought medical care for prior assault(s) by this assailant? ☐ No ☐ Yes

If yes, name of facility:

If yes, under what name(s)?

If yes, approximate date(s):

5. Obstetrical History Pregnant? ☐ No ☐ Yes ☐ Unknown

If yes, any possible problems related to current assault(s)?

☐ No ☐ Yes, describe:

Any possible problems in past pregnancies related to past assault(s) by this assailant?

☐ No ☐ Yes, describe:

6. Name(s) of Children/Dependent Adults Living in Household	Present During Assault(s)			Gender	DOB or Age
	No	Yes	UNK		
				M F	
				M F	
				M F	
				M F	
				M F	

7. Voluntary Use of Alcohol/Drugs ☐ No ☐ Yes

Any voluntary alcohol use within 12 hrs prior to assault? ☐ No ☐ Yes

Any voluntary drug use within 96 hrs prior to assault? ☐ No ☐ Yes

Any voluntary drug ☐ or alcohol ☐ use between time of assault and forensic exam? ☐ No ☐ Yes

List drug(s) used:

8. Are there other ways the patient's life has been impacted by behaviors of this assailant?

Note: For history of sexual assault (<72 hours), stop and consult with law enforcement prior to beginning physical exam to determine next steps.

K. GENERAL PHYSICAL EXAMINATION

1. Blood Pressure	Pulse	Respiration	Temp

2. Describe general physical appearance

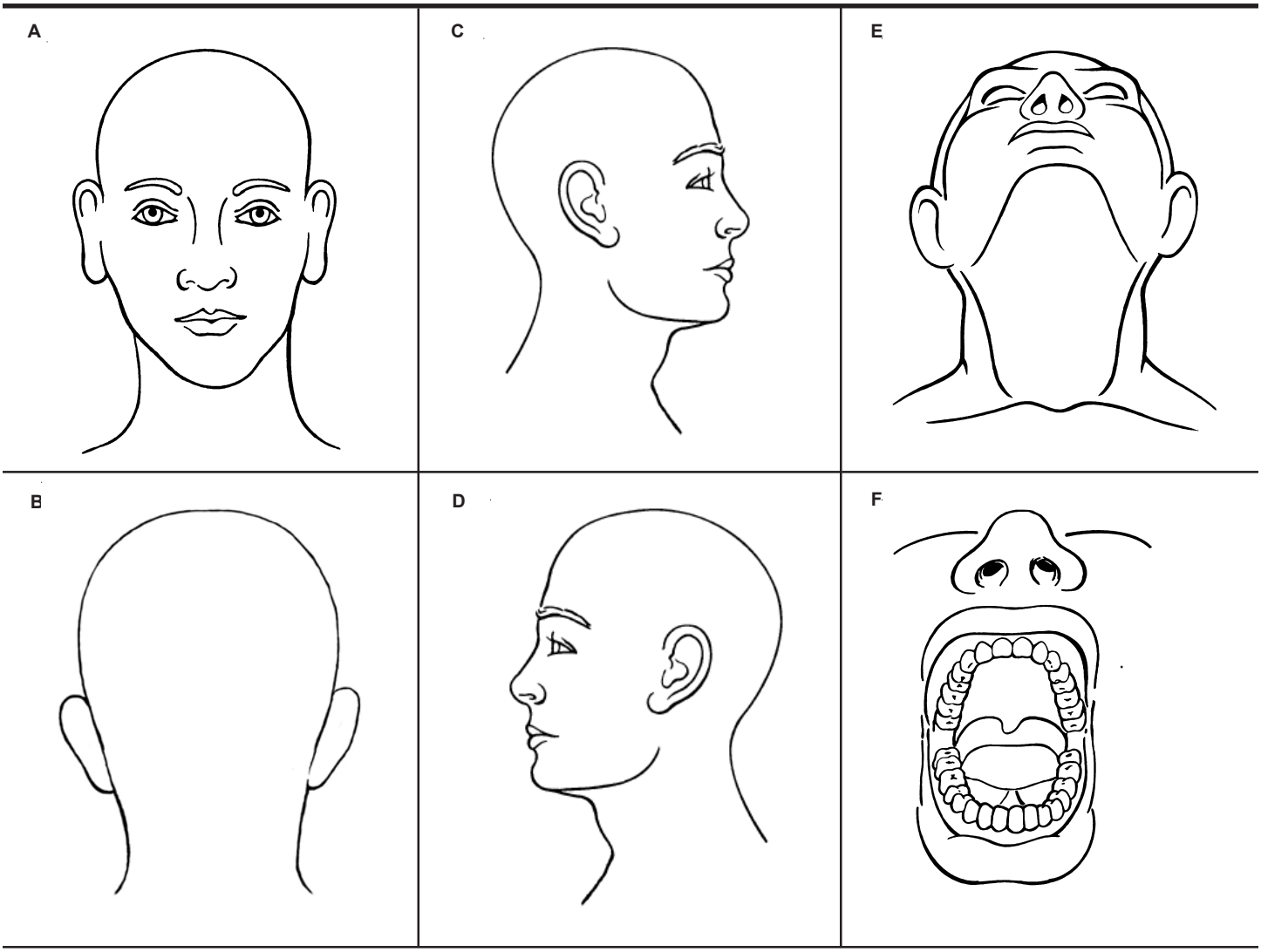
3. Describe general demeanor

Patient Identification:

4. Describe condition of clothing upon arrival. Collect outer and under clothing if applicable. ☐ Not Applicable

5. Examine the face, head, ears, hair, scalp, neck, and mouth for injury. Document findings using photographs, diagrams, legend, and consecutive numbering system.

6. Collect dried and moist secretions, stains and foreign materials from the scalp, head and neck.



LEGEND: Types of Findings ☐ Findings ☐ No Findings ☐ Additional copies of this page attached

AB Abrasion	**DS** Dry Secretion	**IN** Induration	**OI** Other Injury (describe)	**TA** Tooth Avulsed
BI Bite	**EC** Ecchymosis (bruise)	**IW** Incised Wound	**PE** Petechiae	**TD** Tooth Decay
BU Burn	**ER** Erythema (redness)	**LA** Laceration	**PS** Potential Saliva	**TF** Tooth Fractured
CS Control Swab	**FB** Foreign Body	**MS** Moist Secretion	**SI** Suction Injuries	**TM** Tooth Missing
DE Debris	**F/H** Fiber/Hair	**OF** Other Foreign Materials (describe)	**SW** Swelling	**V/S** Vegetation/Soil
DF Deformity	**FT** Frenulum Torn		**TE** Tenderness	

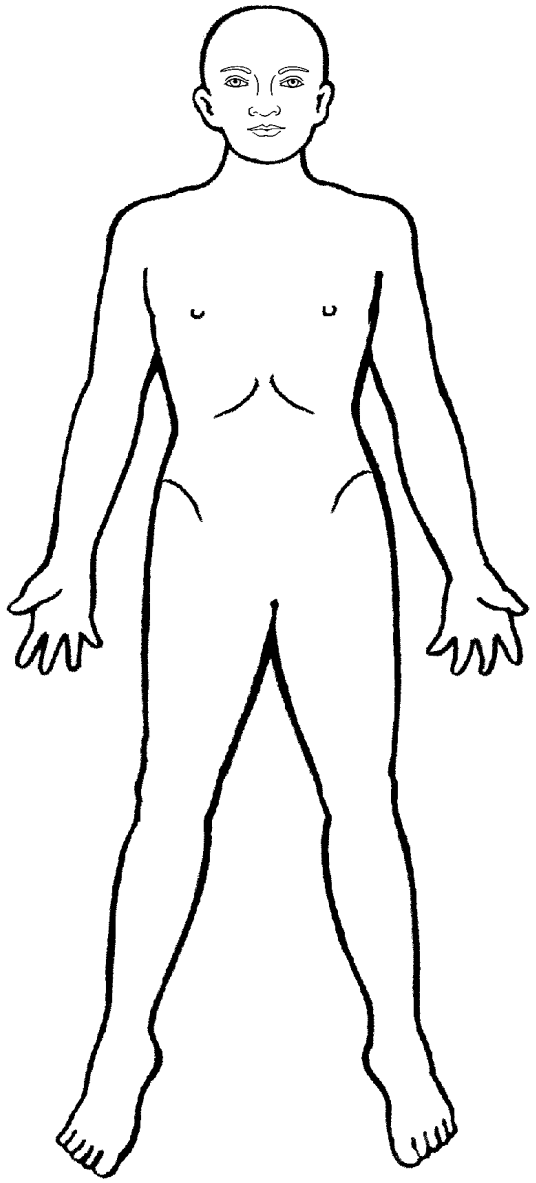
Locator #	Type	Description	Locator #	Type	Description

K. GENERAL PHYSICAL EXAMINATION (continued)

7. **Conduct a physical examination of body and extremities. Record findings using photographs, diagrams, legend, and a consecutive numbering system.**
8. **Collect dried and moist secretions, stains and foreign materials from body** ☐ Findings ☐ No Findings
9. **Collect fingernail scrapings/cuttings according to local policy** ☐ Done ☐ Not Applicable

Patient Identification:

G



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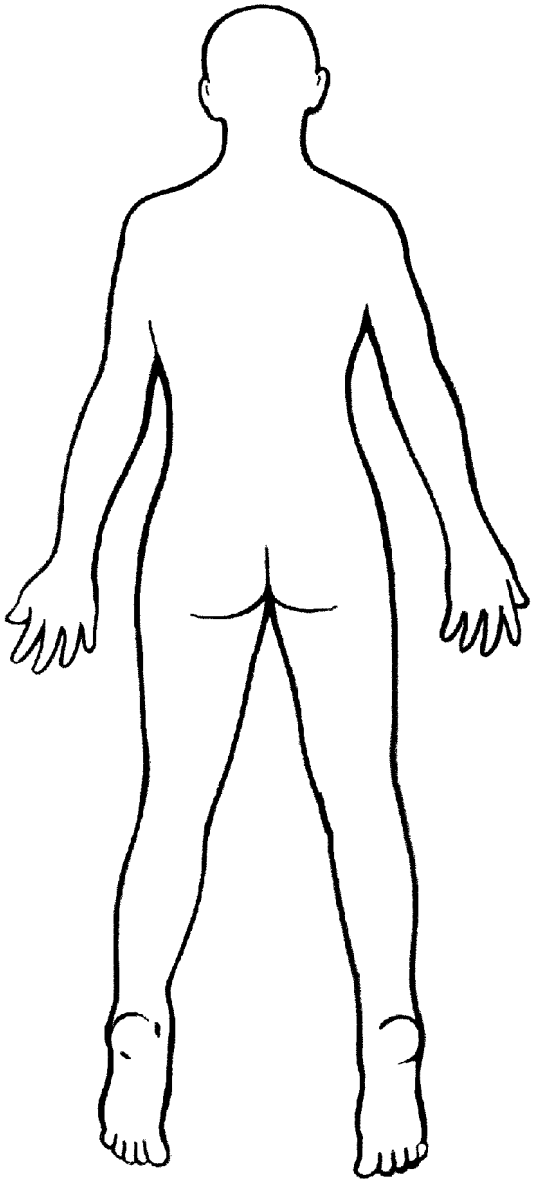


LEGEND: Types of Findings ☐ **Findings** ☐ **No Findings** ☐ **Additional copies of this page attached**

AB Abrasion	**DS** Dry Secretion	**IW** Incised Wound	**PE** Petechiae
BI Bite	**EC** Ecchymosis (bruise)	**LA** Laceration	**PS** Potential Saliva
BU Burn	**ER** Erythema (redness)	**MS** Moist Secretion	**SI** Suction Injuries
CS Control Swab	**FB** Foreign Body	**OF** Other Foreign Materials (describe)	**SW** Swelling
DE Debris	**F/H** Fiber/Hair		**TE** Tenderness
DF Deformity	**IN** Induration	**OI** Other Injury (describe)	**VS** Vegetation/Soil

Locator #	Type	Description	Locator #	Type	Description

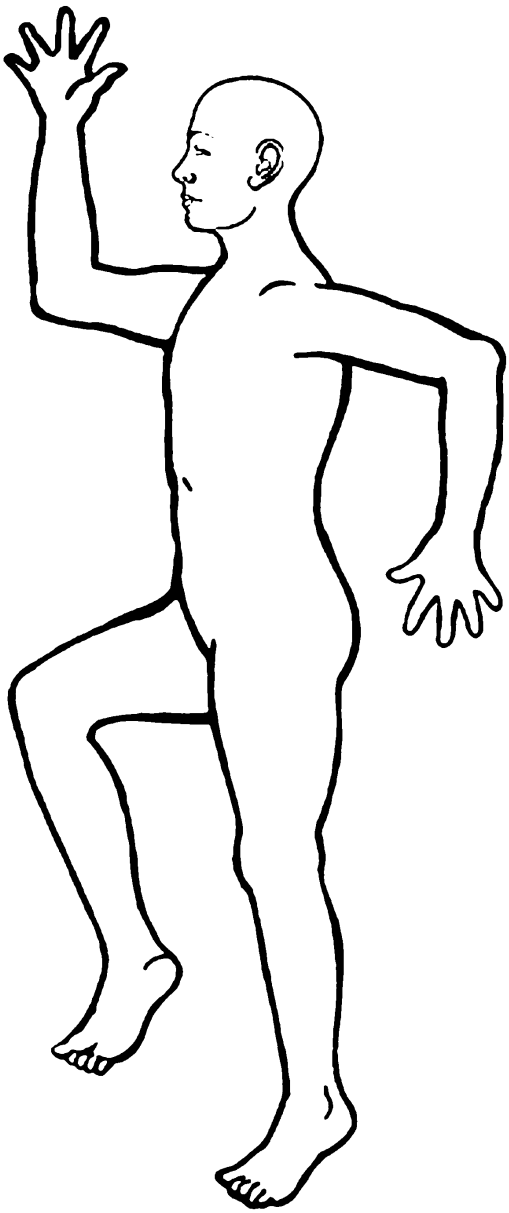
K. GENERAL PHYSICAL EXAMINATION (continued)

10. Use diagrams I and J to record findings to lateral or medial aspect of trunk or extremities. Record findings.
11. If genital injuries sustained, use pages 6 and 7 from Cal OES 2-923 Forensic Medical Report: Acute Adult/ Adolescent Sexual Assault Examination form to document findings.

Are Cal OES 2-923 pages 6 & 7 attached? ☐ Yes ☐ No ☐ Not applicable

Patient Identification:

I



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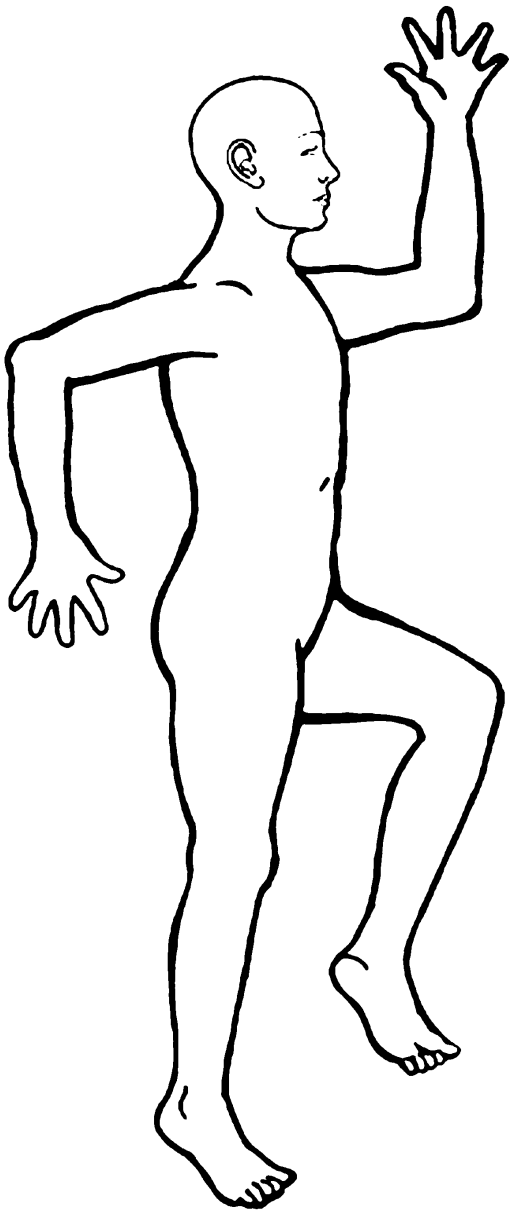

LEGEND: Types of Findings ☐ Findings ☐ No Findings ☐ Additional copies of this page attached

AB Abrasion	**DS** Dry Secretion	**IW** Incised Wound	**PE** Petechiae
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DE Debris	**F/H** Fiber/Hair		**TE** Tenderness
DF Deformity	**IN** Induration	**OI** Other Injury (describe)	**VS** Vegetation/Soil

Locator #	Type	Description	Locator #	Type	Description

L. EVIDENCE COLLECTED AND SUBMITTED TO CRIME LAB

1. Clothing Collected ☐ No ☐ Yes	Clothing Placed in Evidence Kit	Clothing Placed in Paper Bag
Bra ☐		
Dress/skirt ☐		
Jacket/sweater ☐		
Nylons ☐		
Pants/shorts ☐		
Shirt/top ☐		
Shoes (1 or 2) ☐		
Socks (1 or 2) ☐		
Underwear ☐		
Undershirt ☐		
Other ☐		

2. Foreign Materials Collected

	N/A	No	Yes	Collected by:
Swabs/suspected blood	☐	☐	☐	
Dried secretions	☐	☐	☐	
Fiber/loose hairs	☐	☐	☐	
Soil/debris/vegetation	☐	☐	☐	
Swabs/suspected saliva	☐	☐	☐	
Foreign body	☐	☐	☐	
Fingernail scrapings	☐	☐	☐	
Control swabs	☐	☐	☐	

Other, describe: _____

3. Laboratory Results Additional Page ☐ Yes ☐ No

Pregnancy ☐ Positive ☐ Negative

Additional Labs: ☐ No ☐ Yes, specify: _____

4. X-Ray/Imaging Results Additional Page ☐ Yes ☐ No

☐ No ☐ Yes, specify: _____

5. Toxicology Samples

	N/A	No	Yes	Time	Collected by:
Blood Alcohol / Toxicology	☐	☐	☐		
Urine Toxicology	☐	☐	☐		

6. Reference Samples ☐ Blood ☐ Saliva ☐ Buccal ☐ N/A

Collected by: _____

7. Photo Documentation

☐ No ☐ Yes

35mm	Digital	Instant	Other
☐	☐	☐	☐ _____

Photography by: _____ # Rolls/images _____

Recommend follow-up photographs to be taken in 1-2 days

☐ No ☐ Yes ☐ Not applicable

8. Voice recording for strangulation injuries

☐ **No** ☐ **Yes** **If yes:** ☐ **Audio** ☐ **Audiovideo**

If yes, obtained by: ☐ Examiner ☐ Law Enforcement

M. SUMMARY OF KEY FINDINGS

_____

Patient Identification:

N. PERTINENT ISSUES AFFECTING EXAMINATION

_____

O. PERSONNEL INVOLVED

	Name (print clearly)	Phone
History taken by:		
Physical exam performed by:		
Specimens labeled and sealed by:		
Assisted by: ☐ N/A		
Additional narrative by: ☐ N/A		
Signature of Examiner	Date	License Number

P. DISTRIBUTION OF EVIDENCE

	Released To
Clothing (items not placed in evidence kit)	
Evidence Kit	
Reference samples	
Toxicology samples	
Recording(s) ☐ Audio ☐ Audiovideo	

Q. DISPOSITION AND FOLLOW UP

☐ Discharged ☐ Admitted ☐ Follow Up Exam Scheduled

☐ Cross Reporting to: ☐ CPS ☐ APS ☐ N/A

☐ Referral to domestic violence advocacy services

☐ Safety plan discussed with patient

☐ Referral to counseling, drug, and alcohol treatment services

☐ Referral to Victim Witness Assistance Program

☐ Referral for Protective Order **OR** EPO. ☐ PO or EPO Granted

R. SIGNATURE OF OFFICER

I have received the evidence indicated above:

Printed Name ID Number

Signature

Agency Telephone