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

FORENSIC MEDICAL REPORT: DOMESTIC VIOLENCE INSTRUCTIONS

CAL OES 2-502

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

Cal OES 2-502
Forensic Medical Report: Domestic Violence Examination
Instructions

REQUIRED USE OF STANDARD STATE FORM:
Penal Code Section 11161.2 established the use of a standard form to record findings from examinations performed for suspected domestic violence. As such, this form is not a complete medical treatment record and does not supplant medical treatment records.

SUGGESTED USE OF THE STANDARD STATE FORMS: FOLLOW LOCAL POLICY

Domestic Violence	**Cal OES 2-502**	**Forensic Medical Report: Domestic Violence Examination** • Examination of persons involved in intimate partner violence including dating relationships
Elder and Dependent Adult Abuse and Neglect	**Cal OES 2-602**	**Forensic Medical Report: Elder and Dependent Adult Abuse and Neglect Examination** • Examination of persons age 65 and above • Examination of dependent adults age 18 to 64
Sexual Assault	**Cal OES 2-923**	**Forensic Medical Report: Acute (<72 hours) Adult/Adolescent Sexual Assault Examination** • History of acute sexual assault (<72 hours)

INSTRUCTIONS FOR CAL OES 2-502
These instructions contain the recommended methods for meeting the minimum legal standards established by Penal Code §11161.2. Consult the California Medical Protocol for Examination of Domestic Violence and Elder and DependentAdult Victims published by Cal OES for additional information.

LIABILITY AND RELEASE OF INFORMATION
This medical report is subject to the confidentiality requirements of the Medical Information Act (Civ. Code §56 et seq.), the Physician-Patient Privilege (Evid. Code §990), and the Official Information Privilege (Evid. Code §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, 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. Print legibly. 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

1. **Enter the patient's name.**
2. **Enter city, county, state, and zip code for demographic purposes. Street address and telephone numbers are optional due to patient safety reasons.**
3. **Enter patient's age, date of birth, gender, and ethnicity. (MTF: Male transgendered to female; FTM: female transgendered to male)**
4. **Enter the name and address of the facility where the medical/evidentiary examination is being performed.**
5. **Enter patient arrival and discharge dates/times.**
6. **Enter the exam start and completion times to track facility usage and length of exams.**
7. **Enter whether an interpreter was used, the language used, and who provided interpreting services.**

B. MANDATORY SUSPICIOUS INJURY REPORT

Penal Code §11160 - 11160.2 requires all healthcare providers to make an immediate telephone report and to submit a written report to a local law enforcement agency within two working days when medical services are provided to a patient suspected to be suffering from a wound or other physical injury inflicted when the injury is the result of assaultive or abusive conduct. Use the Cal OES 920 Suspicious Injury Report Form to submit the written report. Assaultive or abusive conduct includes, but is not limited to: Abuse of Spouse or Cohabitant (Pen. Code §273.5); Battery (Pen. Code §242); Assault with a Deadly Weapon (Pen. Code §245); and other relevant penal code sections. See California Medical Protocol for Examination of Domestic Violence and Elder and Dependent Adult Abuse and Neglect for further discussion.

1. **Record the name of the person making the telephone report to the law enforcement agency, date, and time.**
2. **Record the name of the person taking the telephone report and check whether the written report, Cal OES 920 Suspicious Injury Report Form, was submitted.**

C. RESPONDING OFFICER TO MEDICAL FACILITY

Record the name of the law enforcement officer, agency, and ID number. Check "Not Applicable" if no officer was dispatched or if officer arrived after the victim's departure.

D. AUTHORIZATION FOR MEDICAL/EVIDENTIARY EXAMINATION: Follow Local Policy

1. **Domestic violence medical/evidentiary exams are new to the field of victim and forensic medical services. As such, payment methods have not been formally established. Options include: the patient's public (Medi-Cal) or private insurance, the California Victim Compensation Program (VCP), or local law enforcement agencies. Follow local policy. See California Medical Protocol for Examination of Domestic Violence and Elder and Dependent Adult Abuse and Neglect for further discussion.**
2. **Authorization by law enforcement is not required for healthcare providers to use this form. Authorization, however, may be required if law enforcement is the designated payor.**

E. PATIENT INFORMATION

Ask the patient to read the items, initial, and sign.

F. PATIENT CONSENT

Ask the patient to read the items, initial, and sign. For patients with issues pertaining to capacity for consent, obtain consent of patient surrogate, guardian, or conservator. Consult hospital policy regarding a minor's ability to consent.

G. DISTRIBUTION OF Cal OES 2-502

Distribute original to law enforcement, one copy to the crime lab, and one copy to the medical or agency facility records.

H. CURRENT ASSAULT HISTORY

1. **Record whether an audio or video recording of the interview was performed.**
2. **Record the name of person providing the history and relationship to patient.**
   This is usually the patient. However, if the patient is unable to give the history, indicate the name and relationship of the historian to the patient.
3. **Record date(s) and time or time frame of assault.**
4. **Describe the pertinent physical surroundings of the assault(s) e.g. inside home, garage, yard, car, etc.**
5. **Record the patient's description of the assault.**
   - Describe what happened using the patient's own words.
   - Place quotation marks around the patient's comments. When interviewing, ask open-ended questions such as "What happened to you", "Tell me what happened to you", "What did he do or what did she do". Avoid WHY questions as they can suggest a judgemental perspective on the part of the interviewer. Attach additional pages, if needed.
6. **Record the assailant(s) name(s), date of birth, age, gender, ethnicity, and relationship to the patient.**
   Sometimes, there is more than one assailant.
7. **Record the methods employed by the assailant(s) and circumstances.**
   - **Weapons**
     > Record whether weapons were threatened, displayed, used, and whether there were injuries.
     > Threatened? This means that there was a verbal or a behavioral movement indicating a threat.
     > Displayed? This means that a weapon was in the perpetrator's hands or nearby. Sometimes a perpetrator will hold a weapon and set it down nearby.
     > Used? Against the patient, another person in the household, pet(s), or other.
     > Injuries? Briefly describe any injuries sustained from the weapon. This information will be recorded in more detail in the physical examination section.
   - **Strangulation**
     > Patient may not be able to directly recall if they were strangled with one hand or two from front or back. Check the boxes that describe what happened to the best of the patient's ability. More than one box may be checked.
     > Patient may know they were strangled, but cannot recall the exact mechanism. Note "patient strangled; can't recall mechanism." Be sure to describe any symptoms the patient is experiencing under the review of symptoms on page 3.
     > Describe any ligatures used.
   - **Sexual Relations**
     The patient may have had consensual or nonconsensual relations before or after the assault. If the patient describes that they were forced or coerced under threat of retaliation to themselves or others, then after the history is completed and before the physical exam, consult with a law enforcement officer as to how to proceed. The law enforcement officer may request a sexual assault medical/evidentiary exam using the Cal OES 2-923 Forensic Medical Report: Acute (<72 hours) Adult/Adolescent Sexual Assault Examination.
   - **Involuntary Use of Alcohol/Drugs.**
     Patients may report that they were forced to consume alcohol or take drugs, or they may show symptoms. Describe whether drugs or alcohol were involved and ask how they were administered. If yes, collect blood/alcohol/toxicology in accordance with local policy.
     > Cleanse the arm with a non-alcoholic solution and collect 5cc of blood in a gray stoppered evacuated vial. Label vial and envelope, and seal.
     > Up to 96 hours after suspected ingestion of drugs, collect a urine specimen (100cc) in a clean container. It is important to collect the first available sample.
     > Record whether toxicology samples where taken, and the name of the person who collected them on page 7.
8. **Record whether injuries were inflicted upon assailant(s) during assault.**
   If the patient acted defensively or fought back, check the box "Yes" if the patient is sure that injuries were inflicted; or, check the box "Unsure", if the patient is uncertain. Use the space provided to describe the injuries, possible locations on the body, and how the injuries were inflicted.
9. **Record post-assault hygiene.**

I. CURRENT SYMPTOMS REPORTED BY PATIENT

Record neurological, psychological, cardiorespiratory, gastrointestinal, urogenital, and musculoskeletal symptoms reported by patient from this event and past event(s). Check all that apply and distinguish between complaints related to this event and from past events with this assailant.

J. PATIENT HISTORY

1. **Record whether patient describes having a disability.**
2. **Record history of prior physical assault(s) with this assailant(s).**
3. **Record history of prior forced or coerced sexual relations with this assailant.**
   - Sexual relations may, at times, be consensual and at other times be forced or coerced. In the previous section, it was asked whether there were sexual relations associated with this event and, in this section, the patient is being asked about past sexual assault.
   - Record approximate date(s).
4. **Record whether previous medical care has been sought for prior assault(s) by this assailant, where these records can be obtained, and approximate date(s).**
5. **Record the obstetrical history.**
   - The intention of this section is to identify current and prior pregnancy complications that may have been related to current or past assault(s).
6. **Record the names of children to alert law enforcement that there may be additional victims and/or witnesses.**
   - By documenting the names of the children on this form, they may qualify for Victim Compensation Program (VCP) reimbursements for counseling and other expenses.
7. **Record voluntary use of alcohol and drugs.**
8. **Record general impact question. This open-ended question enables the patient to talk about other ways they have been impacted by this abusive relationship.**

Note: If a sexual assault history is described, use the Cal OES 2-923 Forensic Medical Report: Acute (<72 hours) Adult/Adolescent Sexual Assault Examination and obtain authorization from a law enforcement officer to perform the examination.

K. GENERAL PHYSICAL EXAMINATION

1. **Record vital signs.**
2. **Describe the patient's general physical appearance.**
3. **Describe the patient's general demeanor.**
   - Describe behaviors such as crying, tearfulness, withdrawn, wringing of hands, responsiveness, ability to give history, etc. Avoid the use of vague, subjective, or judgemental descriptors such as "hysterical", "spacey", etc.
4. **Describe the condition of clothing upon arrival. Collect outer and under clothing, if applicable.**
   - Coordinate with the law enforcement officer regarding clothing to be collected.
   - Wear gloves while collecting clothing.
   - Have patient disrobe on two sheets of paper placed one on top of the other on the floor. Have patient remove shoes before stepping on the paper. Shoes may be collected, if indicated, and packaged separately.
   - Package each garment in an individual paper bag, label, and seal. List every garment on page 7 of this form.
   - Carefully fold the top sheet of paper into a bindle, label, and seal. Discard the bottom sheet. Place this large bindle and all individually bagged garments into a large paper bag(s) with a chain of custody form, label, and seal.
   - Wet stains or other wet evidence require special handling. Consult local policy.
5. **Record results and findings from the physical examination.**

Physical Findings: A physical finding includes observable or palpable tissue injuries, physiologic changes, or foreign material (e.g., grass, sand, stains, dried or moist secretions, or positive fluorescence). If none are present, check "No Findings" on the legend.

   - Be observant for erythema (redness), abrasions, bruises, swelling, lacerations, fractures, bites, and burns.
   - Note areas of tenderness or induration.
   - Record size and appearance of injuries and other findings using the diagrams, the legend, and a consecutive numbering system. Describe shape, size, and color of injuries and findings.
   - Document bruises and bitemarks: See next page for additional information.
   - 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 ecchymosis
A-2	DS	Dried secretion
A-3	CS	Control swab

   - **Photograph injuries and other findings according to local policy using proper photographic techniques.**
     - > Use an appropriate light source.
     - > Use an accurate ruler or scale for size reference in the photograph.
     - > Ensure that the plane of the film is parallel to the plane of the finding.
     - > Use a camera with a macro lens and appropriate flash attachment to adequately record small or subtle injuries. Determine preference of local jurisdiction for 35mm or digital imaging.
     - > Any good quality camera may be used as long as it can be focused for undistorted, close-up photographs and it provides an accurate color rendition.
6. **Examine the face, head, ears, hair, scalp and neck for injury and foreign materials. Document findings.**
   - Give special focus to the lips, perioral region, and nares in the examination.
   - Examine the head closely for scalp trauma. Record any bruises, areas of scalp swelling, or hair loss.
   - Examine earlobes carefully for any bruising or petechiae.
   - **Strangulation History**
     - > Closely examine skin, conjunctiva, nares, and ear canals for petechiae.
     - > Examine front and back of neck.
     - > If patient is symptomatic post-strangulation (e.g., sore throat, voice change, stridor, difficulty breathing), perform indirect laryngoscopy. Provide description and/or drawings of findings of the larynx. Consider CT, MRI, or direct laryngoscopy for further evidentiary findings, if these tests are medically indicated.
     - > Auscultate lungs, make voice recordings, and document findings of chest x-ray, if medically indicated.
7. **Examine the mouth for injury, chipped or missing teeth, and foreign materials. Document findings.**
   - Give special focus to frenulum, buccal surfaces, gums, and soft palate.
   - Signs and symptoms of dentofacial trauma may include avulsed teeth, lip lacerations, tongue injuries, frenulum injuries, and jaw and facial fractures.
   - Record injuries and other findings using the diagrams and legend.
8. **Collect dried and moist secretions, stains (including blood stains, saliva from bites, suction injury [hickey], licking, and kissing), and foreign materials from the face, head, hair, scalp, neck and mouth.**
   - **Swab moist secretions** with a dry swab to avoid dilution. Label and air dry before packaging.
   - **Swab dried stains** with a swab (or multiple swabs for large stains) moistened with sterile, deionized, or distilled water. Label and air dry the evidence swab(s) before packaging. Make a control swab by swabbing an unstained area adjacent to the stain (when possible). Label, air dry, and package the control swab separately from the evidence sample.
   - **Collect** foreign materials such as fibers, sand, hair, grass, soil, and vegetation. Place in bindles and/or envelopes as appropriate for each location on the body. Label and seal.
   - **Cut** matted head or facial hairs (for males) bearing crusted material and place in a bindle. Package, label, and seal.
   - **Record** all findings on the diagrams and the legend.

K. GENERAL PHYSICAL EXAMINATION (continued)

9. Conduct a physical examination of the trunk and extremities and record findings using Diagrams G and H for anterior and posterior located findings and Diagrams I and J on the next page for medial or lateral located findings.

Documenting bruises:

- Describe shape, size, and color of bruises
- Bruises evolve and change color in an unpredictable sequence. Determination of the age of bruising can only be done in the broadest of time frames. Use caution in the identification of bruises of different ages, and describe color and character in detail.
- Photograph bruises to document injuries and to assist in the identification of the object that inflicted the injury.
- Deep tissue injuries may not be seen or felt initially, but note any tenderness.
- Arrange or recommend to the law enforcement agency to have follow-up photographs taken in 1-2 days after the bruising develops more fully.

Documenting bite marks:

- Photograph bite marks. Individuals can be identified by the size and shape of their bite marks. Properly taken photographs of bite marks can assist in the identification of the person who inflicted the injury.
- DNA of the person who inflicted the injury may be recovered from saliva remaining at the bite mark site. Swab the general area of trauma with a swab moistened with sterile, deionized, or distilled water. Label and air dry swab(s) prior to packaging.
- Collect a control swab by swabbing an unbitten atraumatic area adjacent to the suspected saliva stain. Label, air dry, and package the control swab separately from the evidence sample.
- Casting bite marks:
  - > If the bite has perforated, broken, or left indentations in the skin, a cast of the mark may be indicated. The impressions left in the skin from a bite mark fade very quickly. If casting is indicated, it must be performed expeditiously.
  - > A forensic dentist should be consulted in these cases. The procedure for consulting such experts varies among jurisdictions. Consult with the law enforcement agency having jurisdiction over the case.
  - > Bite marks may not be obvious immediately following an assault, but may become more apparent with time.
  - > Recommend to the law enforcement agency to arrange for follow-up inspection within 1-2 days and to have additional photographs taken.

10. Collect dried and moist secretions, stains (including blood stains, saliva from bites, suction injury [hickey], licking, and kissing), and foreign materials from the body.

- **Swab moist secretious** with a dry swab to avoid dilution. Label and air dry before packaging.
- **Swab dried stains** with a swab (or multiple swabs for large stains) moistened with sterile, deionized, or distilled water. Label and air dry the evidence swab(s) before packaging. Make a control swab by swabbing an unstained area adjacent to the stain (when possible). Label, air dry, and package the control swab separately from the evidence sample.
- **Collect** foreign materials such as fibers, sand, hair, grass, soil, and vegetation. Place in bindles and/or envelopes as appropriate for each location on the body. Label and seal.
- **Record** all findings on the diagrams and the legend.

11. Collect fingernail scrapings or cuttings, if indicated by history.

- Use clean toothpicks or manicure sticks to collect scrapings from under the fingernails. Place scrapings from each hand into separate containers or bindles, then place into envelopes. Label (indicating right or left hand) and seal; OR,
- Use a clean fingernail cutter or scissors to cut the fingernails, and place the cuttings from each hand into separate containers or bindles. Package and label as above.

K. GENERAL PHYSICAL EXAMINATION (continued)

12. **Use Diagrams I and J to record findings (injuries, secretions, foreign materials) to lateral and medial aspect of trunk or extremities as per previous instructions.**

13. **If genital injuries are sustained, use pages 6 and 7 from the Cal OES 2-923 Forensic Medical Report: Acute Adult/Adolescent Sexual Assault Examination form to document findings. These forms can be downloaded from http://www.caloes.ca.gov.**
    - Check **Yes or No** if these pages are attached; or, check not applicable.

L. RECORD ALL EVIDENCE COLLECTED AND SUBMITTED TO THE CRIME LABORATORY

All swabs and slides must be air dried prior to packaging (Pen. Code §13823.11). Air dry in a stream of cool air for 60 minutes. Only place samples from one patient at a time in the swab drying box. Wipe or spray the swab drying box with 10% bleach before each use.

Labeling requirements: Swabs, bindles, and small containers must be individually labeled with the patient's name and sample source. Containers for these individual items must be labeled with the name of the patient, date of collection, description of the evidence including location from which it was taken, and signature or initials of the person who collected the evidence. Include the legend locator number, if the legend was used to document the location from which the evidence was located. Package containers in an Assault Evidence Collection Kit, or bag. Record all evidence transfers, also known as the chain of custody.

1. **Record all item(s) of clothing collected and whether it was placed in an evidence kit or paper bags. Handle wet clothing according to local procedure.**
2. **Record all foreign materials collected and the name of the person who collected them.**
3. **Record laboratory results including a pregnancy test, if performed.**
   Note if a blood or urine test was done.
4. **Record results from x-ray/imaging studies, if performed.**
   Note results of all imaging including direct or indirect laryngoscopy for strangulation.
5. **Toxicology samples**
   - Collect samples for blood alcohol/toxicology at the discretion of the examiner and/or law enforcement officer in accordance with local policy.
   - Cleanse the arm with a non-alcoholic solution and collect 5cc of blood in a gray stoppered evacuated vial. Label vial and envelope, and seal.
   - Up to 96 hours after suspected ingestion of drugs, collect a urine specimen (100cc) in a clean container. It is important to collect the first available sample.
   - Record whether toxicology samples where taken, and the name of the person who collected them.
6. **Reference Samples**
   Policies pertaining to whether reference samples are collected at the time of the exam or later vary by jurisdiction. If collected at the time of the exam, ALWAYS collect after the evidence samples. For those jurisdictions not performing conventional serology, a buccal swab can be taken in place of the blood reference sample. Consult your local crime laboratory.

   Blood:
   - Collect blood sample in lavender and/or yellow stoppered evacuated vials as specified by local policy.
   - A blood card is optional in some jurisdictions.
   - Label vial(s) and envelope(s) and seal.

   Buccal (inner cheek) swabs:
   - Collect as a DNA reference sample.
   - Rub two swabs gently but firmly along the inside of the cheek in a rotating motion to ensure even sampling.
   - Air dry, package, label, and seal.

   Saliva:
   - **Note:** If a saliva reference sample is required by the local crime laboratory, collect it whether or not an oral assault occurred.
   - Collect sample by placing two swabs in the mouth and allowing them to saturate.
   - Air dry, package, label, and seal.
7. **Record photo documentation**
   - Document whether or not photographs were taken, type of camera used, name of photographer, number of rolls/images used, and whether follow-up photographs are recommended.
   - Documentation must clearly link the patient's identity to the specific photographs of injuries and/or findings. For example, include a picture of the patient identification on the roll or use a databack camera which can be programmed with the patient's identification number.
8. **A voice recording of strangulation injuries can be important. Note whether the recording is obtained by law enforcement or the examiner.**

M. RECORD SUMMARY OF KEY FINDINGS

Use an abbreviated list such as: fractured R orbit; bruises to face; dried secretions to back; leaves in hair

N. RECORD ANY PERTINENT ISSUES AFFECTING THE EXAMINATION.

Note interruptions or problems with equipment. Write "NONE" if there were none.

O. RECORD NAMES OF ALL PERSONNEL INVOLVED.

- Print information clearly.
- Examiner signs, dates and includes license number.

P. RECORD EVIDENCE DISTRIBUTION AND LIST TO WHOM THE EVIDENCE WAS RELEASED

Q. RECORD DISPOSITION AND FOLLOW UP

Ensure all of the items are addressed by a member of team (examiner, social worker, advocate or law enforcement officer).

R. OBTAIN SIGNATURE OF OFFICER RECEIVING EVIDENCE