

MEDICAL EXAMINATION RECORD

**For the examination of Homicide, Assault and Sexual Assault
Victims and Suspects in these offences**

| | |
|--|---|
| HOMICIDE VICTIMS AND SUSPECTS AND SEXUAL ASSAULT VICTIMS AND SUSPECTS | Complete full medical examination kit and Medical Examination Record, and use a DNA kit for obtaining samples from suspects. Note – The provisions of the relevant legislation must be complied with |
| NON SEXUAL PHYSICAL ASSAULT VICTIMS AND SUSPECTS | Complete medical examination kit except envelope 8 (swabs and slides). Complete all sections of the medical examination record except genital examination (pages 13 and 14). Use a DNA kit for obtaining samples from suspects |

MEDICAL PROTOCOL: DO NOT GIVE EXAMINEE FOOD OR DRINK UNTIL THE ORAL EXAMINATION IS COMPLETED. IF THERE IS CLINICAL EVIDENCE OF DRUG IMPAIRMENT; PRIORITISE THE COLLECTION OF THE BLOOD AND URINE SAMPLES FOR DRUG ANALYSIS USING ENVELOPES 1 & 4 SAMPLE BOTTLES AND THE MEK SYRINGE AND SWAB.

**PLEASE FOLLOW INSTRUCTIONS FOR COMPLETING THIS BOOKLET
PRESS FIRMLY AND WRITE LEGIBLY**

- 16 sensitised pages. **Using protecting manilla inner fold between pages.**
- Original kept for examining doctors records (pages 2 – 17)
- Pink copies sealed in kit for ESR (pages 2 – 15, excluding pages 16 and 17)
- Blue copies handed to Police (pages 2 - 16, excluding page 17)
- **Answer all questions** and tick appropriate boxes

| | |
|---|------------|
| Contents: | |
| General details and consent | Pages 2 |
| History of Assault | 3 & 4 |
| Medical History | 5 |
| Toxicology | 6 & 7 |
| Examination, Body and facial diagrams | 8 to 14 |
| Specimens and investigations and summary of physical findings | 15 |
| Consent to release information to Police | 16 |
| Arrangements for continuing care | 17 |

MEDICAL EXAMINATION KITS (MEK)

Notes re use These Kits have been assembled to facilitate the examination of victims and suspects of assault and should be used strictly according to **all** the instructions printed. For more detailed instructions and background reading, examining doctors are referred to the DSAC Manual for the Medical management of Sexual Abuse, www.dsac.org.nz.

Apart from ensuring that the examinee is fully examined and laboratory specimens correctly collected, the requirements of the law will be fulfilled if **all** details are completed, obviating unnecessary legal argument at Court.

Police Must complete a Police 143 form and be responsible for rapid transit of the MEK to the forensic laboratory. If a Toxicology Kit has been used, the Police will also be responsible for ensuring that it is delivered to the nearest Service Centre of ESR.

Enquiries To: Institute of Environmental Science and Research (ESR) Ltd

at Mt Albert Science Centre Phone (09) 815 3670
Hampstead Road
Private Bag 92-021, Auckland Fax (09) 849 6046

Kenepuru Science Centre Phone (04) 914 0700
34 Kenepuru Drive
PO Box 50-348, Porirua Fax (04) 914 0640

Christchurch Science Centre Phone (03) 351 0033
27 Creyke Road
PO Box 29-181, Christchurch Fax (03) 351 0046

For urgent ESR after hours advice
Phone 0800 367 367 (0800 FORENSIC)

ARRANGEMENT REGARDING RELEASE OF INFORMATION TO POLICE

The examinee should be given an opportunity to discuss and consider the decision regarding police action before the Consent to Release of Information to Police (page 16) is signed.


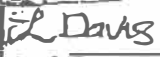


If the consent is signed, hand the POLICE COPY of the Protocol (blue pages) and the sealed kit, containing the ESR copy of the protocol (pink pages) to the POLICE.

If the consent is not signed at the time of the examination, the duplicate pages and specimens may be held by the examining doctor for up to a week and should be refrigerated. Chain of custody must be maintained.

Ethnic Origin Details of the examinees ethnic origin are required for statistical purposes only. **Be specific** if you can, e.g. 25% Maori, 75% European New Zealander; or 50% Tongan and 50% Cook Islander; or 50% Malaysian and 50% Singaporean.

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GENERAL DETAILS AND CONSENT

| | | | |
|--|-------------------|---|-----------------------|
| SURNAME SMITH | | OTHER NAMES ERICA | |
| ADDRESS 9 BRUCE MASON RD., MT ROSKILL, AUCKLAND | | | |
| AGE 15 | DOB 19/11/03 | GENDER F | OCCUPATION STUDENT |
| ETHNIC ORIGIN NZ EUROPEAN / MAORI | | GP NAME DR PATEL GP ADDRESS MT ROSKILL MED CENTRE GP TO BE NOTIFIED YES <input checked="" type="radio"/> NO | |
| TIME AND DATE OF ALLEGED ASSAULT 9-10 AM/PM 11/6/2018 | | TIME ELAPSED BETWEEN ASSAULT & EXAMINATION ± 12 HOURS | |
| TIME AND DATE OF EXAMINATION Start time 9 AM/PM Finish time 1 AM/PM 12/6/2018 12/6/2018 | | PLACE OF EXAMINATION | |
| TYPE OF ALLEGED ASSAULT: (Circle) | | | |
| <input checked="" type="radio"/> Sexual Assault | | Child Under 14 yrs | |
| <input type="radio"/> Non-sexual Physical Assault | | <input checked="" type="radio"/> Youth 14 yrs to 16 yrs | |
| <input type="radio"/> Homicide | | Adult Over 17 yrs | |
| Other (specify | | | |
| CONSENT TO MEDICAL EXAMINATION (VICTIMS AND SUSPECTS) | | | |
| I consent to medical examination, including a pelvic (internal) examination, and to the collection of specimens for forensic and medical examination including DNA testing, and photography. | | | |
| EXAMINEE'S SIGNATURE  | DATE 12/6/2018 | SURNAME (Print) SMITH | OTHER NAMES ERICA |
| SIGNATURE OF WITNESS (if present)  | DATE 12/6/2018 | SURNAME (Print) DAVIS | OTHER NAMES Lisa. |
| WITNESS RELATIONSHIP TO EXAMINEE | | | |
| <input type="checkbox"/> Parent | | <input type="checkbox"/> Guardian | |
| <input type="checkbox"/> Police | | <input checked="" type="checkbox"/> Other (specify) NURSE | |
| NAME OF EXAMINING DOCTOR (Print) S. CAMPANELLA | | SIGNATURE  | |
| WORK ADDRESS PUAWAITAHI | | | |
| NAME OF WITNESS TO EXAMINATION (If present) (Print) Lisa Davis | | SIGNATURE  | |

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HISTORY OF ASSAULT

| | |
|--|---|
| 1 NAME OF PERSON/S PROVIDING HISTORY DET. PETER DAVIS | 2 RELATIONSHIP TO EXAMINEE AUCKLAND CENTRAL C.I.B |
| 3 LOCATION AND PHYSICAL SURROUNDINGS OF ASSAULT (Bed, Field, Car, Rug, Floor, etc) BED | 4 NAME(S), NUMBER OF ASSAILANTS KEVIN - 19 YRS OLD |
| 5 DESCRIPTION OF ASSAULT AND ASSOCIATED PAIN OR SYMPTOM IN ORDER TO DIRECT PHYSICAL EXAMINATION ONLY (CAN PARAPHRASE, CLEARLY DOCUMENT SOURCE OF INFORMATION) ALLEGEDLY RAPED ON EVENING OF 11/6/2018 WHILE AT A PARTY <p>The above history was taken in order to direct the examination and does not necessarily constitute a full or detailed history or record of the event.</p> | |

HISTORY OF ASSAULT (CONTINUED)

DESCRIPTION OF ASSAULT (Tick relevant boxes) Attempted (A) or Unsure (U), Multiple assailants (M). This is a check-list only and may be used to clarify description above

Penetration of vagina/genitalia by

| | Y | N | A | U | M |
|---------------------|-------------------------------------|-------------------------------------|--------------------------|--------------------------|--------------------------|
| Penis | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Finger | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Foreign object | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Describe the object | _____ | | | | |

Penetration of anus/rectum by

| | Y | N | A | U | M |
|---------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|--------------------------|
| Penis | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Finger | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Foreign object | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Describe the object | _____ | | | | |

Oral → genital contact

| | Y | N | A | U | M |
|--------------------|-------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| assailant → victim | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| victim → assailant | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Oral → anal contact

| | Y | N | A | U | M |
|--------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|--------------------------|
| assailant → victim | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| victim → assailant | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Digital - genital contact

| | Y | N | A | U | M |
|--------------------|-------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| assailant → victim | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| victim → assailant | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Did ejaculation occur inside

| | Y | N | A | U | M |
|---------------------|--------------------------|--------------------------|--------------------------|-------------------------------------|--------------------------|
| A body orifice | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Where? (describe) | _____ | | | | |
| On the body surface | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Where? (describe) | _____ | | | | |

Foam, jelly, lubricant used (circle)

| | Y | N | A | U | M |
|--------------------------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|--------------------------|
| Foam, jelly, lubricant used (circle) | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Condom used | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Biting, licking, kissing or sucking (circle)

| | Y | N | A | U | M |
|--|-------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Biting, licking, kissing or sucking (circle) | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Where? (describe) | NECK } BILATE BREASTS } | | | | |

Lapse of Consciousness

| | Y | N | A | U | M |
|------------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|--------------------------|
| Lapse of Consciousness | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Vomited during/since assault

| | Y | N | A | U | M |
|------------------------------|--------------------------|-------------------------------------|--------------------------|--------------------------|--------------------------|
| Vomited during/since assault | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Pre-existing physical injuries (detail)

| | Y | N | A | U | M |
|---|--------------------------|-------------------------------------|--------------------------|--------------------------|--------------------------|
| Pre-existing physical injuries (detail) | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | _____ | | | | |
| | _____ | | | | |

6 METHODS EMPLOYED BY ASSAILANT

| | Yes | No | Area of body |
|--|--------------------------|-------------------------------------|--------------|
| Weapon inflicted Injuries | <input type="checkbox"/> | <input checked="" type="checkbox"/> | _____ |
| Type of weapon(s) | _____ | | |
| Physical blows by hands or feet (circle) | <input type="checkbox"/> | <input checked="" type="checkbox"/> | _____ |
| Grabbing/grasping/holding (circle) | <input type="checkbox"/> | <input checked="" type="checkbox"/> | _____ |
| Physical restraints type(s) used | <input type="checkbox"/> | <input checked="" type="checkbox"/> | _____ |
| Bites | <input type="checkbox"/> | <input checked="" type="checkbox"/> | _____ |
| Strangulation (see note opposite) | <input type="checkbox"/> | <input checked="" type="checkbox"/> | _____ |
| Burns (including chemical/toxic) | <input type="checkbox"/> | <input checked="" type="checkbox"/> | _____ |
| Threats of harm | <input type="checkbox"/> | <input checked="" type="checkbox"/> | _____ |
| Type of threat(s) | _____ | | |
| Other method(s) used | _____ | | |
| (describe) | _____ | | |

7 POST-ASSAULT HYGIENE/ACTIVITY

(not applicable if over 96 hours)

| | Yes | No | N°x |
|---|-------------------------------------|-------------------------------------|--------------------------|
| Urinated | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Defecated | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Genital wipe/wash | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Bath/shower | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Douche | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Removed / inserted tampon, sponge, diaphragm (circle) | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Brushed teeth | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Oral gargle / swish | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Changed clothing | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Food / drink <i>MILK</i> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Vomited | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| Vaginal pain / bleeding | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Anal pain / bleeding | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

8 ADDITIONAL NOTES

VAGINAL Pain + BLEEDING AT THE TIME - NOT NOW

MEDICAL HISTORY

1. RELEVANT MEDICAL HISTORY

NIL

2. ALLERGIES

NIL

3. CURRENT MEDICATIONS

NIL

4. RELEVANT GYNAECOLOGICAL HISTORY

LNMP start: UNSURE +/- 2/52 AGO

MENARCHE 11 YEARS
Usual Cycle: REGULAR

Was patient menstruating at the time of the assault?

Yes No

Contraception

Yes No

If yes, please specify:

Any recent (last 60 days) genital procedure or treatment which may affect physical finding?

Yes No

If yes, please specify:

Assailant vasectomised? [If known]

Yes No Unknown

Male examinees - vasectomy?

Yes No

5. RELEVANT PRIOR BOWEL HABIT/ANO-RECTAL HISTORY, (IF ANAL ASSAULT ALLEGED)

6. IMMUNISATION

Hepatitis B

Yes No

No

Unsure

Tetanus

Yes

No

Unsure

Age 11 YRS

CURRENT SYMPTOMS

NIL

Medical treatment already received since alleged incident Yes No

By whom:

Where:

When:

Specify:

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RECENT INTERCOURSE

The following should be explained to the patient.
Evidence of intercourse may be found up to ten days after intercourse. This may give misleading information to investigators. To avoid this it is important to know if you have had intercourse in the past 10 days, so that evidence may be interpreted correctly.

Intercourse within last 10 days YES NO

| | |
|--|---|
| Partner 1-Dates and times EVENING OF 10/06/2018 <hr/> Condom used Yes / <input checked="" type="radio"/> No | Partner 2- Dates and times MORNING OF 11/06/2018 <hr/> Condom used Yes / <input checked="" type="radio"/> No |
| Partner 3- Dates and times <hr/> Condom used Yes / No | Partner 4- Dates and times <hr/> Condom used Yes / No |

Toxicology (record if <96 hours since event)

SUSPICION OF INVOLUNTARY ALCOHOL/DRUG INGESTION : YES / NO

If YES, record here.

.....

.....

.....

Symptoms related to possible drug ingestion (as reported by patient):

.....

.....

.....

History of liver or kidney impairment:

.....

.....

KNOWN ALCOHOL & DRUG USE:

Please note - documentation is required for:

any alcohol in the 48 hours prior to this examination; any drugs in the 96 hours prior to this examination; any drugs or alcohol since the assault until time of examination.
See next page to record these details.

If need extra space, record here please.

| | | TYPE & QUANTITY | DATE | TIME |
|---|--------------|-----------------|---------|--------|
| ALCOHOL * | PRE ASSAULT | 4 x WOODSTOCKS | 11/6/18 | 7-9 PM |
| | PRE ASSAULT | 2 x ICE BEERS | 11/6/18 | 7-9 PM |
| ALCOHOL * | POST ASSAULT | 2 x SHOTS | 11/6/18 | 7-9 PM |
| | POST ASSAULT | | | |
| DRUGS * RECREATIONAL | PRE ASSAULT | | | |
| | PRE ASSAULT | | | |
| DRUGS * RECREATIONAL | POST ASSAULT | | | |
| | POST ASSAULT | | | |
| DRUGS - PRESCRIPTION | PRE ASSAULT | | | |
| | PRE ASSAULT | | | |
| DRUGS - PRESCRIPTION | POST ASSAULT | | | |
| | POST ASSAULT | | | |
| DRUGS - OVER THE COUNTER - HERBAL REMEDY | PRE ASSAULT | | | |
| | PRE ASSAULT | | | |
| DRUGS - OVER THE COUNTER - HERBAL REMEDY | POST ASSAULT | | | |
| | POST ASSAULT | | | |

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EXAMINATION

| 1 | BP | PULSE | TEMP | RESPIRATION | 2 | HEIGHT | WEIGHT | HAIR COLOUR |
|---|--------|-------|------|-------------|---|--------|----------------------------|-------------|
| | 120/70 | 70 | — | 16/min | | 175 | (Estimated) Measured 65 | BROWN |
| 3 APPEARANCE AND MOOD OF PATIENT (emotional state, state of dress, hair, signs of drug/alcohol consumption) | | | | | | | | |
| CALM . NOT OBVIOUSLY INTOXICATED. UNDISTRESSED | | | | | | | | |
| Proceed with examination following instructions on numbered envelopes. Document injuries, trace evidence collection sites etc. on body diagram pages 9 to 14. Document specimens collected on page 15. | | | | | | | | |
| 4 On completion of the examination return all forensic samples and duplicate copies of medical examination record (pages 2 – 15 pink) to MEK, fill out the kit seal and place it over the kit opening thereby sealing the kit. Sign on box over seal. | | | | | | | | |
| 5 SUMMARY OF PHYSICAL FINDINGS. (To be completed at end of examination) | | | | | | | | |
| MULTIPLE SUCTION INJURIES TO THE NECK AND BREASTS ARE CONSISTENT WITH "SUCTION KISSING" | | | | | | | | |
| THE COMPLETE TEAR TO THE HYMEN IS DIAGNOSTIC OF PENETRATION THROUGH THE HYMEN | | | | | | | | |

Facial Views



①

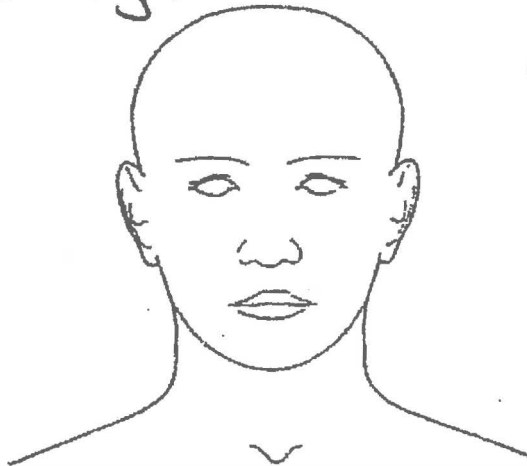
5x3 cm
"Suction bite"
Cluster of petechiae
with larger central area
of bruising. Area of
bruising tender to touch



②

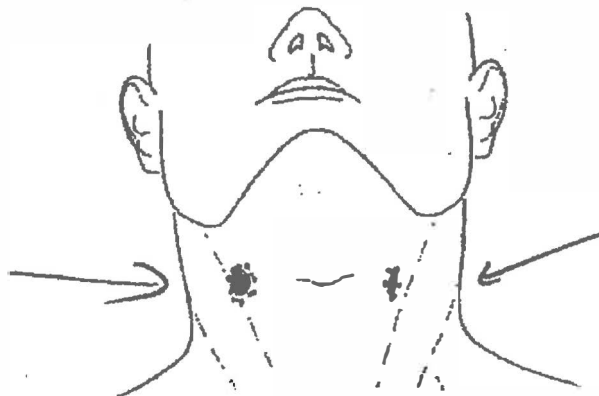
4x1 cm vertical
cluster of petechiae.
Appearance of
LEFT "suction
bite"

RIGHT



- Normal (tick)
- Face
 - Eyes
 - Nose
 - Mouth
 - Ears
 - Neck

① AS
DESCRIBED
ABOVE



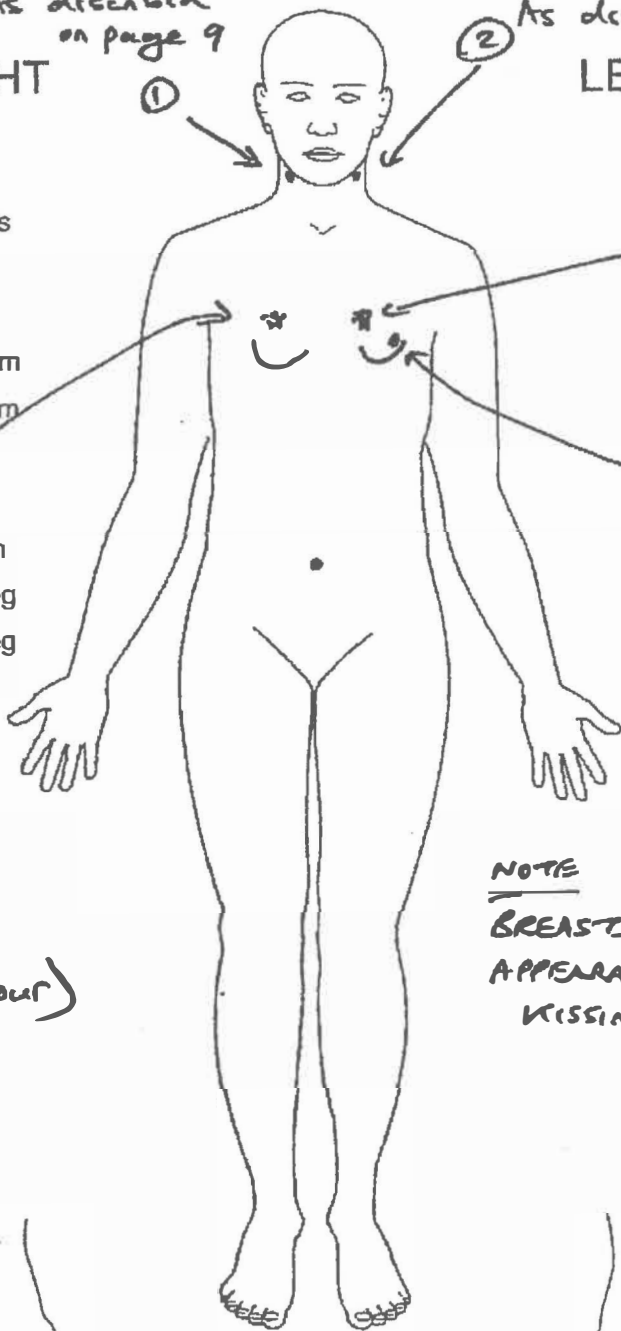
② AS
DESCRIBED
ABOVE

Frontal View

As described on page 9
RIGHT

As described on page 9
LEFT

- Normal (tick)
- Shoulders
 - Breasts
 - Thorax
 - Upper Arm
 - Lower Arm
 - Hands
 - Fingers
 - Abdomen
 - Upper Leg
 - Lower Leg
 - Feet

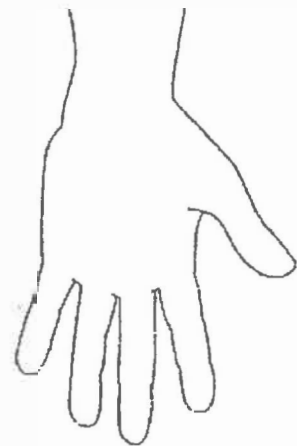
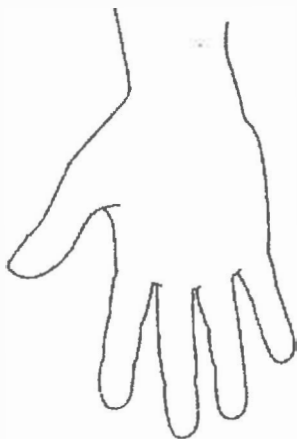


2.5 x 2 cm
petechial cluster
upper contour
L breast

1 x 2 cm cluster
of faint petechiae

2 x 1.5 cm petechial
cluster on upper
contour of breast
(centre of upper contour)

NOTE BRUISING TO
BREASTS (L + R)
APPEARANCE OF "SUCTION
KISSING"



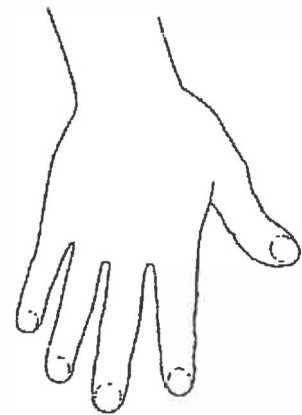
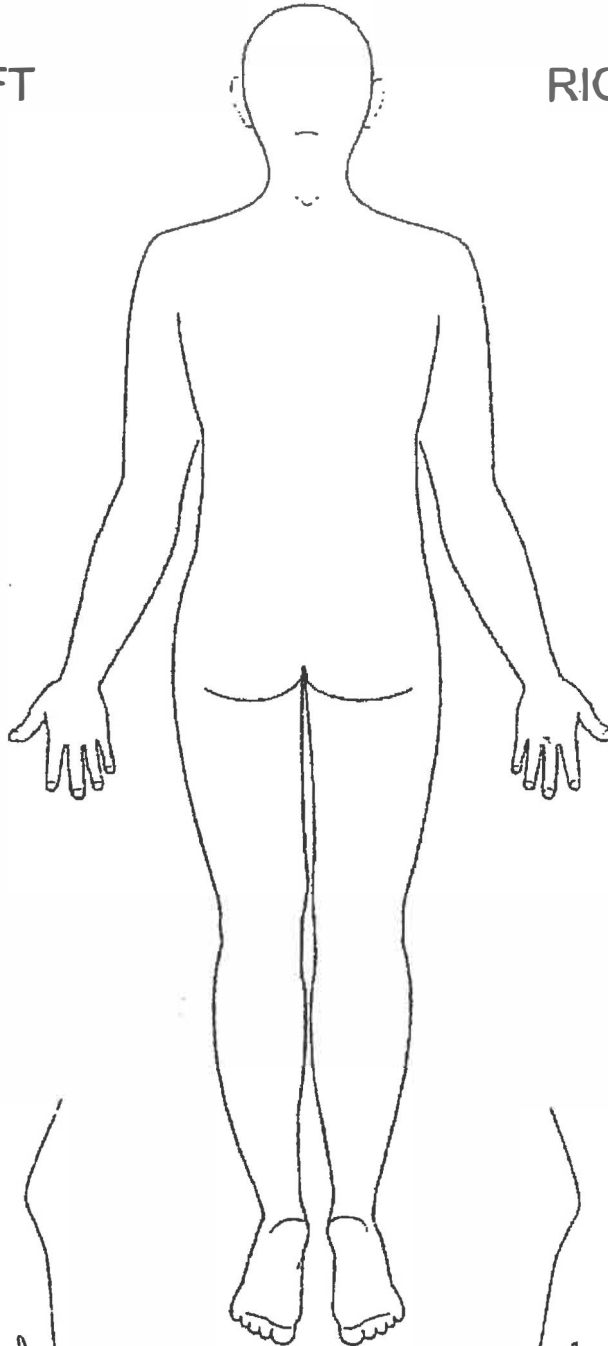
Rear View

LEFT

RIGHT

Normal (tick)

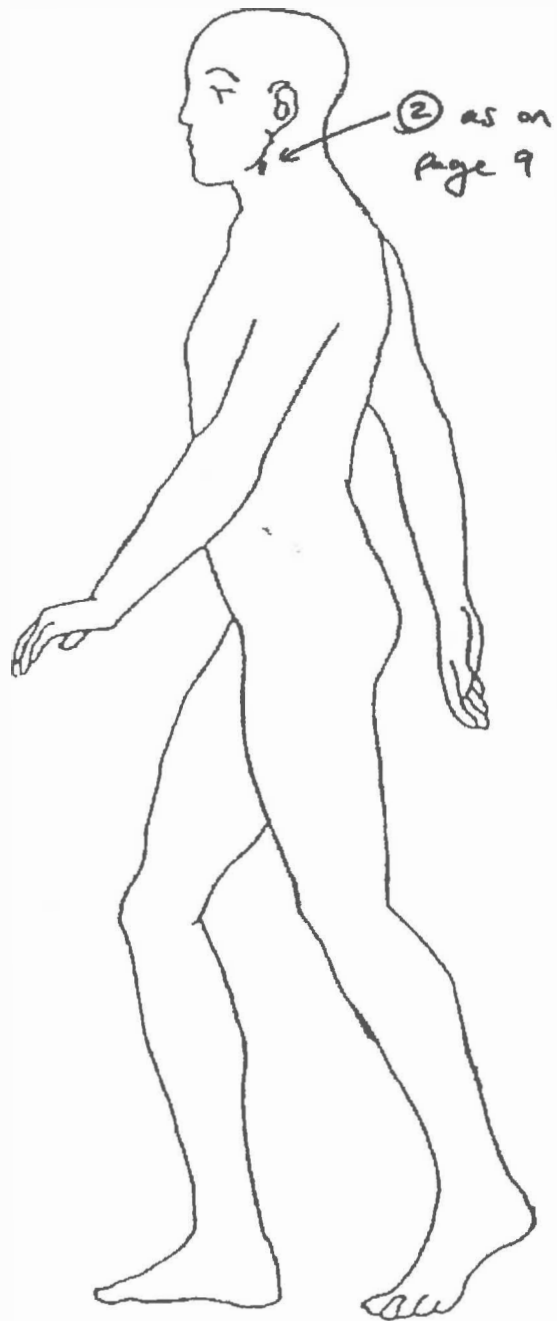
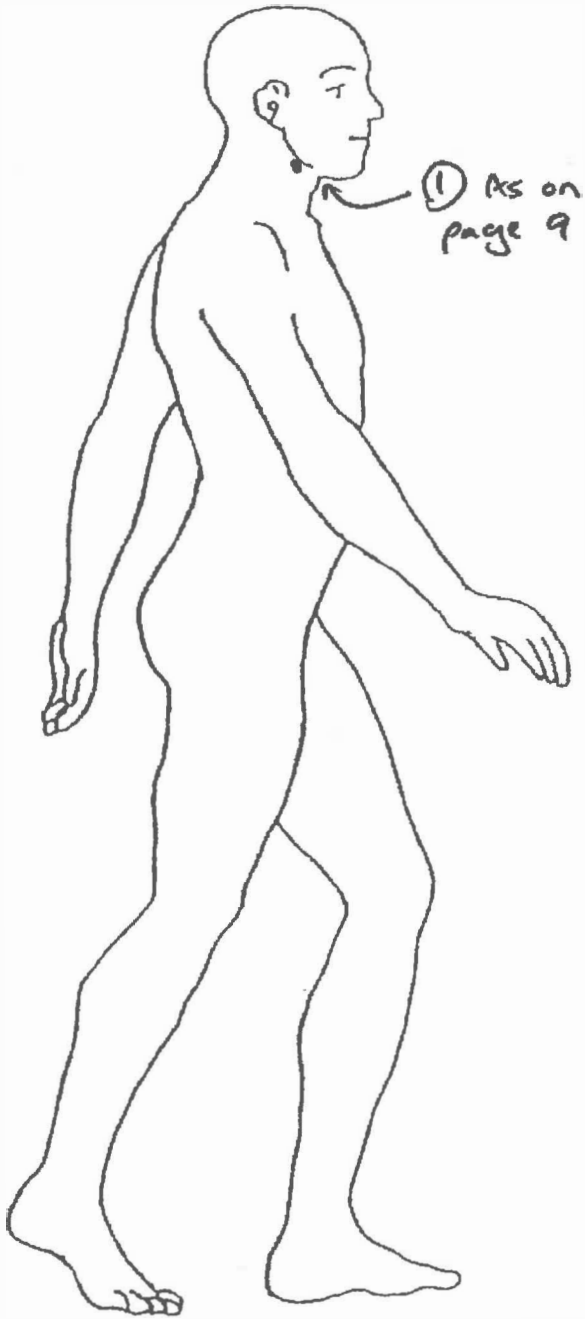
- Scalp
- Ears
- Neck
- Shoulders
- Back
- Upper Arm
- Lower Arm
- Hands
- Fingers
- Upper Leg
- Lower Leg
- Feet



Lateral Views

RIGHT

LEFT



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EXAMINATION (CONTINUED)

EXTERNAL GENITALIA EXAMINATION (FEMALE)

DEVELOPMENTAL STAGING: Mature Pubertal Pre-pubertal Tanner Stage V

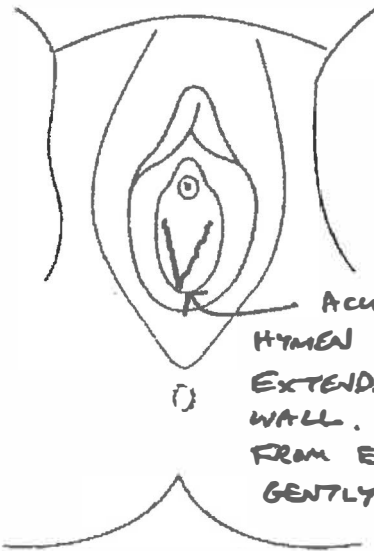
MAGNIFICATION DEVICE: Direct Vision Colposcope Other (describe) _____

Injuries discernable without magnification Yes No

Record all signs of trauma and sites of Trace Evidence.
Inspection and Palpation: (Record any pain or tenderness)

Normal (tick) **Abnormal (specify)** Note possibility of lubrication, semen, blood, mucous)

- Inner thighs
- Mons
- Labia Majora
- Labia Minora
- Clitoris
- Urethra
- Fossa Navicularis
- Post Fourchette
- Hymen
- Perineum
- Anus
- Perianal Skin



ACUTE TEAR TO HYMEN AT 7 O'CLOCK EXTENDS TO VAGINAL WALL. FRESH BLEEDING FROM EDGE WHEN TOUCHED GENTLY WITH A SWAB

(Draw in the Hymen)

SPERMATOZOA Not tested Seen Not Seen Motile Non-motile

SPECULUM EXAMINATION

| | |
|---------------------------------------|--------------------------------|
| Normal | Abnormal (specify) |
| <input type="checkbox"/> Lower vagina | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Upper vagina | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Cervix | <input type="checkbox"/> _____ |

BIMANUAL EXAMINATION :

RECTAL EXAMINATION / PROCTOSCOPY

NOT PERFORMED

N. B. See Page 8 for Summary of Physical Findings

MALE EXAMINATION (CONTINUED)

EXTERNAL GENITALIA EXAMINATION

DEVELOPMENTAL Mature Pubertal Pre-pubertal Tanner Stage _____
STAGING:

Record all signs of trauma and sites of Trace Evidence.

Inspection and Palpation: (Record any pain or tenderness)

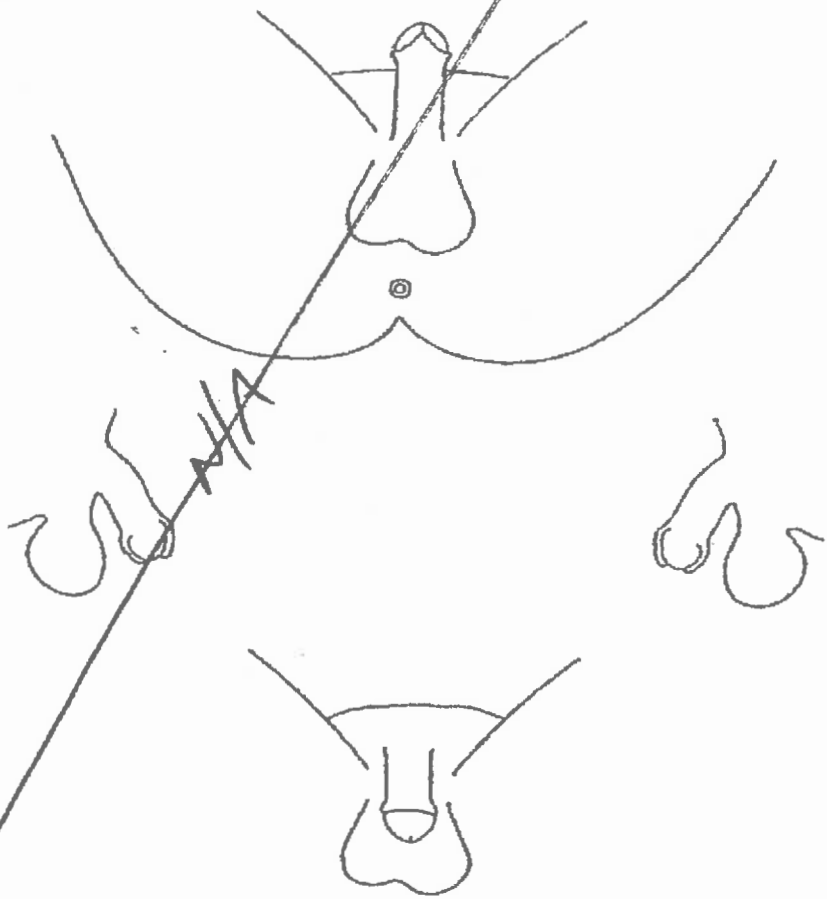
Normal (tick)

Abnormal (specify) Note possibility of lubrication, semen, blood, mucous)

- Inner thighs
 - Perineum
 - Foreskin
 - Glans Penis
 - Penis
 - Scrotum
 - Testicles
 - Anus
 - Perianal Skin
 - Proctoscopy
(if performed)
- Circumcised Y / N

RIGHT

LEFT



COLLECT SWABS AND FORENSIC SAMPLES (Envelope 8, document specimens collected, page 15)

RECTAL EXAMINATION / PROCTOSCOPY

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SPECIMENS AND INVESTIGATION

FORENSIC SPECIMENS COLLECTED
(Place a tick in each box to show each sample collected)

| <p>ENVELOPE 1 - TOXICOLOGY</p> <p><input type="checkbox"/> Urine Time taken: am/pm Date: / / 20 <input type="checkbox"/> Other, please specify:</p> | <p>ENVELOPE 7 - SPARE / WET & DRY SWABS</p> <table border="0"><thead><tr><th>SITE</th><th>WET</th><th>DRY</th></tr></thead><tbody><tr><td><u>RIGHT SIDE NECK</u></td><td><input checked="" type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr><tr><td><u>LEFT SIDE NECK</u></td><td><input checked="" type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr><tr><td><u>RIGHT BREAST BRUISE</u></td><td><input checked="" type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr><tr><td><u>LEFT BREAST BRUISES</u></td><td><input checked="" type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr><tr><td><u>LOWER ABDOMEN</u> <u>(above the belly, the</u> <u>was shaved)</u></td><td><input checked="" type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr><tr><td>.....</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr><tr><td>.....</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr><tr><td colspan="3"><input type="checkbox"/> Other, please specify:</td></tr></tbody></table> | SITE | WET | DRY | <u>RIGHT SIDE NECK</u> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <u>LEFT SIDE NECK</u> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <u>RIGHT BREAST BRUISE</u> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <u>LEFT BREAST BRUISES</u> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <u>LOWER ABDOMEN</u> <u>(above the belly, the</u> <u>was shaved)</u> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Other, please specify: | | |
|--|---|-------------------------------------|--------------------------|--------------------------|------------------------|-------------------------------------|-------------------------------------|--------------------------|-------------------------------------|-------------------------------------|----------------------------|-------------------------------------|-------------------------------------|----------------------------|-------------------------------------|-------------------------------------|--|-------------------------------------|-------------------------------------|-------|--------------------------|--------------------------|-------|--------------------------|--------------------------|---|--|--|
| SITE | WET | DRY | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <u>RIGHT SIDE NECK</u> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <u>LEFT SIDE NECK</u> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <u>RIGHT BREAST BRUISE</u> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <u>LEFT BREAST BRUISES</u> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <u>LOWER ABDOMEN</u> <u>(above the belly, the</u> <u>was shaved)</u> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Other, please specify: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>ENVELOPE 2 - ORAL SWABS</p> <p><input checked="" type="checkbox"/> Oral swab. <input checked="" type="checkbox"/> Oral slide. <input checked="" type="checkbox"/> Saliva sample on chewing gum. <input checked="" type="checkbox"/> Buccal DNA reference sample. <input type="checkbox"/> Other, please specify.</p> | <p>ENVELOPE 8 - GENITAL SWABS & SLIDES</p> <table border="0"><thead><tr><th>VAGINAL SWABS</th><th>Swab</th><th>Slide</th></tr></thead><tbody><tr><td>Introital</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr><tr><td>Blind Vaginal</td><td><input type="checkbox"/></td><td>N/A</td></tr><tr><td>Vaginal 1 } BOTH BLIND</td><td><input checked="" type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr><tr><td>Vaginal 2 } BOTH BLIND</td><td><input checked="" type="checkbox"/></td><td><input checked="" type="checkbox"/></td></tr><tr><td>Cervical</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr></tbody></table> | VAGINAL SWABS | Swab | Slide | Introital | <input type="checkbox"/> | <input type="checkbox"/> | Blind Vaginal | <input type="checkbox"/> | N/A | Vaginal 1 } BOTH BLIND | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Vaginal 2 } BOTH BLIND | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | Cervical | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | |
| VAGINAL SWABS | Swab | Slide | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Introital | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Blind Vaginal | <input type="checkbox"/> | N/A | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Vaginal 1 } BOTH BLIND | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Vaginal 2 } BOTH BLIND | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cervical | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>ENVELOPE 3 - HANDS & FINGERNAILS</p> <p><input type="checkbox"/> Fingernail clippings <input type="checkbox"/> Fingernail scrapings <input type="checkbox"/> Other, please specify</p> | <p>ENVELOPE 5 - HEAD & PUBIC HAIRS</p> <p><input checked="" type="checkbox"/> Combed and plucked head hair <input type="checkbox"/> Combed pubic hair <input type="checkbox"/> Cut pubic hair } <u>SHAVED</u></p> | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>ENVELOPE 4 - BLOOD</p> <p><input checked="" type="checkbox"/> Blood alcohol / toxicology sample Time taken <u>AMPM</u> DATE <u>12/6/2018</u> <u>12 MIDDAY</u> <input checked="" type="checkbox"/> Blood DNA Reference sample Time taken <u>12 MIDDAY</u> DATE <u>12/6/2018</u></p> | <p>ANAL / RECTAL SWABS</p> <table border="0"><tbody><tr><td>Perianal</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr><tr><td>Anal</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr><tr><td>Rectal (via proctoscope)</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr><tr><td>Rectal (Blind)</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr></tbody></table> | Perianal | <input type="checkbox"/> | <input type="checkbox"/> | Anal | <input type="checkbox"/> | <input type="checkbox"/> | Rectal (via proctoscope) | <input type="checkbox"/> | <input type="checkbox"/> | Rectal (Blind) | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | |
| Perianal | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Anal | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Rectal (via proctoscope) | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Rectal (Blind) | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>ENVELOPE 6 - TRACE EVIDENCE</p> <p><input checked="" type="checkbox"/> Large paper sheet (undressed on) <input checked="" type="checkbox"/> Paper sheet from genital examination <input type="checkbox"/> Other items eg trace evidence, Tampon, speculum- Itemise:</p> | <p>PENILE</p> <table border="0"><thead><tr><th></th><th>Swab</th><th>Slide</th></tr></thead><tbody><tr><td>Glans penis (wet)</td><td><input type="checkbox"/></td><td>N/A</td></tr><tr><td>Glans penis (dry)</td><td><input type="checkbox"/></td><td>N/A</td></tr><tr><td>Wet penile shaft</td><td><input type="checkbox"/></td><td>N/A</td></tr></tbody></table> | | Swab | Slide | Glans penis (wet) | <input type="checkbox"/> | N/A | Glans penis (dry) | <input type="checkbox"/> | N/A | Wet penile shaft | <input type="checkbox"/> | N/A | | | | | | | | | | | | | | | |
| | Swab | Slide | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Glans penis (wet) | <input type="checkbox"/> | N/A | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Glans penis (dry) | <input type="checkbox"/> | N/A | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Wet penile shaft | <input type="checkbox"/> | N/A | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p><input checked="" type="checkbox"/> Clothing no. of bags (...8.....) Description: <u>1 PAIR PINK KNICKERS</u> <u>1 PAIR BLUE BOXER SHORTS</u> <u>1 WHITE BRA</u> <u>1 PINK CROP TOP</u> <u>1 BLACK SWEATER</u> <u>1 DENIM JEANS</u> <u>1 PAIR PURPLE SOCKS</u> <u>1 PAIR BLACK SNEAKERS</u></p> | <p><input type="checkbox"/> OTHER SWAB (list)</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Summary of physical findings, page 8, completed

I.D. Number
23431

CONSENT TO RELEASE OF INFORMATION TO POLICE

I hereby authorise the examining doctor, S.G. CAMPANELLA to release a copy of the Medical Examination Record and any relevant laboratory reports to the New Zealand Police or to the office of the Crown Prosecutor, as requested, for medico-legal purposes, to ESR Forensic and examining Doctor.

Signed [Signature] Date 12-6-18

Name (print) SMITH ERICA
Surname Other names

Signature of Witness [Signature] Date 12-6-18
(If Present)

Name(print) Davis Lisa
Surname Other names

Relationship to examinee Parent Police
 Guardian Other (specify) NURSE

| | | |
|--|------------------------|-----------------|
| POLICE OFFICER IN CHARGE OF CASE (print) | | |
| Rank: <u>Det</u> | Name: <u>John Love</u> | No. <u>1234</u> |
| Contact Police Station: <u>Auckland Central C.I.B.</u> | | |
| Phone No: <u>321 444</u> Police File / Event No: | | |
| I HAVE RECEIVED <u>8</u> (Give number) ITEMS OF CLOTHING BELONGING TO | | |
| <u>Erica Smith</u> FROM DR <u>Campanella</u> | | |
| Signature of Police Officer <u>[Signature]</u> | | |
| Rank: <u>Detective</u> | Name: <u>John Love</u> | No. <u>1234</u> |
| I HAVE RECEIVED A SEALED MEDICAL EXAMINATION KIT, TOXICOLOGY KIT OR DNA KIT (delete if necessary) containing | | |
| SPECIMENS FROM [EXAMINEE] <u>Erica Smith</u> | | |
| FROM DR <u>Campanella</u> AND A COPY OF THE MEDICAL EXAMINATION RECORD, | | |
| Signature of Police Officer <u>[Signature]</u> | | |
| Rank: <u>Detective</u> | Name: <u>John Love</u> | No. <u>1234</u> |

I.D. Number

23431

TREATMENT AND ARRANGEMENTS FOR CONTINUING CARE

| | |
|---|--|
| EXAMINEE | |
| Name: ERICA SMITH | Phone 028 1113336 |
| DOB: 19/1/03 | OK to text <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| Address: 9 BRUCE MASON RD., MT. ROSKILL, AUCKLAND | |
| ALTERNATE CONTACT ADDRESS | |
| Name: NIL | Phone: |
| Address: | |
| HOSPITAL ADMISSION REQUIRED <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | PHOTO REFERRAL <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| REASON FOR ADMISSION N/A | |
| STI SCREEN | DETAILS |
| <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| BASILINE BLOODS | HEP / SYPH / HIV OTHERS |
| <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| PREGNANCY TEST | METHOD |
| <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | URINE |
| PREGNANCY TEST | <input type="checkbox"/> Positive <input checked="" type="checkbox"/> Negative |
| STI PROPHYLAXIS | DETAILS |
| <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | AZITHROMYCIN 1g STAT CEFTRIAXONE 250mg IV STAT. |
| VACCINATIONS REQUIRED | WHAT ? |
| <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | HEPATITIS B |
| INJURY TREATMENT GIVEN | |
| NIL | |
| ACCIDENT COMPENSATION CORPORATION | |
| ACC FORMS <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | FORM NO/S. CW123456 |
| WHICH ONES | |
| MEDICAL FOLLOW UP | |
| <input type="checkbox"/> GP <input checked="" type="checkbox"/> Here <input type="checkbox"/> Other (specify) | <input type="checkbox"/> Referral Letter |
| COUNSELLOR PRESENT | |
| <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No | |
| Name: JOSEPHINE BLOGGS | Agency: HELP |
| COUNSELLING FOLLOW-UP | |
| Referred to: HELP | |
| CLAIM FOR MEDICAL EXPENSES | DSAC STATISTICS FORM? (if applicable) |
| Police form 175 <input type="checkbox"/> | <input type="checkbox"/> YES <input type="checkbox"/> NO |