



## Pro Forma

# Paediatric Forensic Medical Examination

Jul 2024 Review date Jul 2027 - check [www.fflm.ac.uk](http://www.fflm.ac.uk) for latest update

Note: This form has been designed for use by Clinicians. It is provided to assist the examining Clinician in the assessment of a child or young person who may have been sexually abused. It is to be regarded as an aide-memoire and it is therefore not necessary for all parts of the pro forma to be completed. On completion this form is in the control of the examining Clinician. It is for both acute and historic (delayed reporting) cases; please be flexible in the way it is used.

Throughout the notes use 24 hour clock to avoid confusion

### 1. Initial Call

The initial call to attend a child/young person frequently comes from an individual with little information regarding the nature and timing of the allegation. Because such information will inform the decision regarding the venue and timing of the examination the Clinician should endeavour to speak directly with the sexual offence trained police officer who is with the child/young person.

Date and time of initial call \_\_\_\_\_

Name of referrer \_\_\_\_\_

Contact telephone number of referrer \_\_\_\_\_

Name of professional (e.g. Police Officer) who will be attending with the child/young person \_\_\_\_\_

Contact telephone number of attending professional \_\_\_\_\_

Name of child/young person \_\_\_\_\_

Age of child/young person and date of birth \_\_\_\_\_

The Clinician should consider if she/he has all the necessary skills<sup>1,2</sup> to examine the child/young person, or if there is a need to involve a second Clinician. Children should be examined in a child friendly environment.

Does the child/young person have any serious injuries or other acute medical problems? \_\_\_\_\_

The Clinician should ensure that the venue proposed for the examination is appropriate. It may be necessary to arrange for the child/young person to be transferred, via an ambulance, to the nearest ED department if she/he appears to have serious injuries or an altered level of consciousness. The Clinician should be willing to attend a hospital if required to.

When did the incident(s) take place, if known? \_\_\_\_\_

A decision with regard to the timing of the examination should be made after consideration of the persistence data regarding forensic evidence,<sup>3</sup> any injuries however minor, and the medical needs of the child/young person (e.g., HIV Post Exposure Prophylaxis, emergency contraception, Mental Health etc).

What is the nature of the sexual assault, if known? \_\_\_\_\_

If there is any suggestion that penis-mouth penetration (fellatio) may have taken place, or the nature of the sexual assault is not known, the referrer should be reminded to obtain urgently the oral samples<sup>3</sup>. Police officers have access to an 'Early Evidence Kit' so these should be used.

Is there any suggestion that drugs or alcohol have been used to facilitate the sexual assault of the complainant (DFSA)? \_\_\_\_\_

In all cases, presenting within 14 days of the allegation, the referrer should be reminded to access urgently a Urine Module/ 'Early Evidence Kit' and request a urine sample from the child/young person. The time of the last urination (prior to the one yielding the sample) and the time that the sample was produced should be noted. If within 24 hours, 2 samples less than an hour apart are ideal.

Does the child have capacity to consent? Who holds parental responsibility for the child/young person? Will they accompany the child? \_\_\_\_\_

Is that person, and the child if they have capacity, aware of the referral and willing to give consent to the paediatric forensic examination? \_\_\_\_\_

Does the child/young person/carer have any additional needs e.g., difficulty understanding English? \_\_\_\_\_

If yes, consideration should be given to arranging an interpreter. Consider all other additional needs e.g. A signer for the deaf; a laptop for the child with autism who only communicates that way etc.

Agreed venue and time for examination \_\_\_\_\_

## 2. Examination Details

Location \_\_\_\_\_

Date of examination \_\_\_\_\_

Time of arrival \_\_\_\_\_

Time introduced to child/young person \_\_\_\_\_

Referred by self/police/social services/paediatrician/general practitioner/sexual health/other (*delete/annotate as applicable*) \_\_\_\_\_

## 3. Clinician Details

Name of Clinician \_\_\_\_\_

GMC/NMC \_\_\_\_\_

Other Clinicians (*if present*) \_\_\_\_\_

## 4. Police Details

Force Incident Number \_\_\_\_\_

Name and contact details of attending police officer \_\_\_\_\_

Name and contact details of investigating officer \_\_\_\_\_

## 5. Social Services

Name and contact details of attending social worker \_\_\_\_\_

Name and contact details of allocated social worker \_\_\_\_\_

## 6. General Practitioner

Name of GP \_\_\_\_\_

Surgery address \_\_\_\_\_

Secure email address \_\_\_\_\_

Surgery telephone number \_\_\_\_\_

## 7. School/Nursery

Name of school/nursery \_\_\_\_\_

Safeguarding lead \_\_\_\_\_

Secure email address \_\_\_\_\_

## 8. Present

Family/Friends \_\_\_\_\_

Crisis worker \_\_\_\_\_

Others \_\_\_\_\_

## 9. Consent

### Name and address of person with Parental Responsibility (PR)

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone number \_\_\_\_\_

Name of child \_\_\_\_\_

Date of birth of child \_\_\_\_\_

Address \_\_\_\_\_

Telephone number \_\_\_\_\_

NHS number \_\_\_\_\_

I consent to the following and understand that the paediatric forensic examination will include (delete if not applicable):

- a) A full medical history and complete examination recorded in writing
- b) Collection of forensic samples
- c) Collection of medical samples
- d) Photo documentation for recording and evidential purposes (including second opinions from medical experts and peer review). I have been told that any sensitive images will be stored securely and only be made available to other non-medical persons on the order of a judge
- e) I understand that the Clinician will provide a Child Protection report for the police, social services, paediatric services and the patient's GP
- f) I understand that the Clinician will provide a court statement if requested
- g) I understand that the Clinician will give evidence in court if ordered
- h) I understand and agree that a copy of the forensic medical notes may be given to professionals involved in the case (e.g., police or lawyers) and may be used in a court
- i) I agree to the use of photo documentation and anonymised medical notes for teaching
- j) I agree to the use of my anonymised-medical notes for audit and research
- k) I understand staff at the SARC have a duty of care and have to inform the Multi Agency Safeguarding Hub
- l) I have been advised that I may halt the examination at any time

Signed (Child) ..... Date and time .....

Name printed .....

Signed (Person with PR) ..... Date and time.....

Name printed .....

Signed (Witness to signatures)..... Date and time.....

Name printed .....

Signed (Clinician)..... Date and time.....

Name printed .....

**GIVE A COPY OF THIS CONSENT FORM TO THE CHILD AND / OR THE PERSON WITH PARENTAL RESPONSIBILITY**

### 10. Patient Details

Name \_\_\_\_\_

Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Gender Female / Male / Trans / Prefer not to say Ethnicity \_\_\_\_\_

Case number \_\_\_\_\_

### 11. Household

#### Adults

	Surname	First names	DOB	Relation to child (ren) e.g. father of examinee and child
1				
2				
3				
4				

#### Children

	Surname	First names	DOB	Relation to child (ren) e.g. brother, half-brother, stepbrother of examinee
1				
2				
3				
4				
5				
6				

Own bedroom Yes  No

### 12. Vulnerabilities

Missing episodes \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Exploitation - criminal e.g., county lines/sexual \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Looked after child, young carer \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Unaccompanied asylum seeker \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Risk of Female Genital Mutilation \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Domestic abuse/coercive control \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**13. Social care involvement**

Child Protection Plan/Child in Need Plan, details of when \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reason(s) Neglect  Physical Injury  Sexual abuse  Emotional abuse

Court Orders? (PPO/EPO/ICO/CO) Yes  No

**14. Reason for Referral**

Briefing taken from \_\_\_\_\_

Contact details \_\_\_\_\_

Names of persons present during briefing \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have the police conducted an ABE interview with the child/young person? Not known  Yes  No

Location of assault(s) if known/given \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Brief history of assault(s) if known/given \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



Brief history of assault(s) if known/given continued \_\_\_\_\_

---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---

Did the alleged assailant consume alcohol?      Yes       No       Not known

If yes, please specify      Prior       During       After offence

Start time of drinking \_\_\_\_\_ End time of drinking \_\_\_\_\_

Quantity and type of beverage consumed \_\_\_\_\_

Time last ate \_\_\_\_\_

Did the complainant consume alcohol?      Yes       No       Not known

If yes, please specify      Prior       During       After offence

Start time of drinking \_\_\_\_\_ End time of drinking \_\_\_\_\_

Quantity and type of beverage consumed \_\_\_\_\_

Time last ate \_\_\_\_\_

Alcohol use history \_\_\_\_\_

---



---

Any other substances been used by/administered to the complainant within 14 days of the examination (Including prescribed and over the counter medication)?      Yes       No       Not known

If yes, please specify      Prior       During       After offence

Give details \_\_\_\_\_

---



---



---

**Substance misuse history** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Number of assailants if known/given** \_\_\_\_\_

**Prior knowledge of assailant(s)** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Details of assailant(s)** *Asked to determine risk of STIs (see 22. Medical Aftercare)*

**Confirmation/additions from child/young person (verbatim)**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Last contact with alleged assailant(s)** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Possible sexual abuse/assault/exploitation in connection with this allegation(s) (if known)** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## Asked to direct forensic sampling and determine risk of STIs and pregnancy

			Confirmation/additions from child/young person and/or parent/carer, if relevant (verbatim & recorded contemporaneously)
Kissing/licking/biting/sucking/spitting?	YES / NO / NOT KNOWN	<i>(details, including sites)</i>	
Mouth to genitalia/anus?	YES / NO / NOT KNOWN	<i>(details)</i>	
Digit to vulva/vagina/anus?	YES / NO / NOT KNOWN	<i>(details)</i>	
Penis into vulva/vagina?	YES / NO / NOT KNOWN	<i>(details)</i>	
Penis into mouth?	YES / NO / NOT KNOWN	<i>(details)</i>	
Penis into anus?	YES / NO / NOT KNOWN	<i>(details)</i>	
Ejaculation?	YES / NO / NOT KNOWN	<i>(details, including sites)</i>	
Object to vulva/vagina/anus?	YES / NO / NOT KNOWN	<i>(details)</i>	
Other sexual/physical act(s)	YES / NO / NOT KNOWN	<i>(details)</i>	
Injuries?	YES / NO	<i>(details)</i>	
Ano-genital bleeding?	YES / NO	<i>(details)</i>	
Strangulation?	YES / NO	<i>(details)</i>	
Weapon used?	YES / NO / NOT KNOWN	<i>(details)</i>	
Damage to clothing?	YES / NO	<i>(details)</i>	
Condom used?	YES / NO	<i>(details)</i>	

**15. Forensic samples taken before examination started (details)**

**Mouth** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Urine** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Tissues used to wipe** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Condom(s)** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Sanitary protection** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Clothing** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**By whom taken** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**16. Post Assault**

Eaten	YES / NO / NOT KNOWN
Drank	YES / NO / NOT KNOWN
Passed urine	YES / NO / NOT KNOWN <i>(note time)</i>
Bowels open	YES / NO / NOT KNOWN
Wiped	YES / NO / NOT KNOWN <i>(specify site and disposal of e.g. cloth/tissue)</i>
Changed clothes	<i>(specify)</i>
Self harm	<i>(sites)(method)</i>
Circle:	Brushed: teeth / gums / dentures
	Mouth wash / spray used
	Washed / bathed / showered / douched
	Changed tampon / pad / sponge / diaphragm

**17. Direct Questions** *ask if relevant*

	Since assault	Details	If yes, note if previously experienced the problem described
<b>Pain</b>			
<b>Urinary symptoms</b>  <i>e.g., dysuria, frequency, haematuria, incontinence, UTI</i>			
<b>Genital symptoms</b>  <i>e.g., soreness, discharge, bleeding, dyspareunia, pruritis, injuries</i>			
<b>Perianal/rectal symptoms</b>  <i>e.g., soreness, pain on defaecation, discharge, bleeding, change in bowel habit, incontinence, pruritis, injuries</i>			
<b>Other symptoms</b>			

### 18. Medical History

#### A. Birth History

Pregnancy \_\_\_\_\_

Gestation \_\_\_\_\_

Birth \_\_\_\_\_

Place of birth \_\_\_\_\_

Birth weight \_\_\_\_\_

Neonatal history \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

#### B. Development

Motor milestones                      Normal     Delayed

Speech                                      Normal     Delayed

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

School progress \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Learning Difficulties/Neurodiversity \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Additional needs \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**C. Health**

**Vision** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Hearing** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medications** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**General Health** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Bathing - shower or bath; hygiene products** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Immunisations up to date** Yes  No  Unknown   
\_\_\_\_\_  
\_\_\_\_\_

**Past Medical and Surgical History** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Emergency Department attendance** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**D. Review of Systems** (Please specify as much detail as possible, including whether prior to the alleged offence(s) or just post. | This is part of the holistic assessment of the child.)

Gastrointestinal	Yes	No	Comment
Appetite			
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	
Rectal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	
Perianal Pruritus	<input type="checkbox"/>	<input type="checkbox"/>	
Rectal Discharge	<input type="checkbox"/>	<input type="checkbox"/>	
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	
Diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	
Soiling	<input type="checkbox"/>	<input type="checkbox"/>	
Regular bowel action	<input type="checkbox"/>	<input type="checkbox"/>	
Worms	<input type="checkbox"/>	<input type="checkbox"/>	
Other			

Urinary	Yes	No	Comment
Frequency	<input type="checkbox"/>	<input type="checkbox"/>	
Urgency	<input type="checkbox"/>	<input type="checkbox"/>	
Clean & dry, daytime	<input type="checkbox"/>	<input type="checkbox"/>	Age
Clean & dry, nighttime	<input type="checkbox"/>	<input type="checkbox"/>	Age
Wetting daytime	<input type="checkbox"/>	<input type="checkbox"/>	
Wetting nighttime	<input type="checkbox"/>	<input type="checkbox"/>	
Dysuria	<input type="checkbox"/>	<input type="checkbox"/>	
Haematuria	<input type="checkbox"/>	<input type="checkbox"/>	
Urinary tract infection(s)	<input type="checkbox"/>	<input type="checkbox"/>	
Other			

Genital	Yes	No	Comment
Blood in underwear	<input type="checkbox"/>	<input type="checkbox"/>	
Discomfort/pain	<input type="checkbox"/>	<input type="checkbox"/>	
Pruritus	<input type="checkbox"/>	<input type="checkbox"/>	
Rash	<input type="checkbox"/>	<input type="checkbox"/>	

Discharge	<input type="checkbox"/>	<input type="checkbox"/>	
Penile discomfort/rash	<input type="checkbox"/>	<input type="checkbox"/>	
Penile discharge	<input type="checkbox"/>	<input type="checkbox"/>	
Menarche	<input type="checkbox"/>	<input type="checkbox"/>	
Menstrual cycle	<input type="checkbox"/>	<input type="checkbox"/>	
Any spotting/bleeding out with cycle?	<input type="checkbox"/>	<input type="checkbox"/>	
Date of last period			
Routine sanitary protection	Tampons, regular use <input type="checkbox"/> Tampons tried <input type="checkbox"/> Pads <input type="checkbox"/>		
Sexual history			
Contraception			
Pregnancies			
Birth history			
Other			

	Yes	No	Comment
Skin Diseases/Warts	<input type="checkbox"/>	<input type="checkbox"/>	

Neurology	Yes	No	Comment
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	
Faints	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Dizzy spells	<input type="checkbox"/>	<input type="checkbox"/>	
Other			

Cardiovascular	Yes	No	Comment
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	
Ankle swelling	<input type="checkbox"/>	<input type="checkbox"/>	
Short of Breath	<input type="checkbox"/>	<input type="checkbox"/>	



Respiratory	Yes	No	Comment
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Short of Breath	<input type="checkbox"/>	<input type="checkbox"/>	
Cough	<input type="checkbox"/>	<input type="checkbox"/>	
Other			

Musculoskeletal	Yes	No	Comment
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	
Back pain	<input type="checkbox"/>	<input type="checkbox"/>	
Joint swelling	<input type="checkbox"/>	<input type="checkbox"/>	
Disabilities	<input type="checkbox"/>	<input type="checkbox"/>	
Other			

Behaviour/emotional problems	Comment
Sleep pattern	
Appetite	
Anger	
School work	
School friendships	
Substance misuse	
Alcohol misuse	
Behaviour at home	
Other	

Mental Health	Comment
Self-harm	
Suicidal thoughts/threats/attempts	

Eating disorders	
Depression	
Anxiety	
Psychosis	
Hallucinations	
Hospital admissions Ever sectioned, details	
Other	

**E. Family History**

Family Health (including psychiatric)	Comment		
Mother			
Father			
Substance misuse within the household	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Alcohol misuse within the household	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Domestic violence within the household			
Siblings			

### F. Sexual History

(note who was present when taken) Asked to assist with interpretation of (forensic) findings and medical aftercare - for the latter the time frame may need to be extended to 'since last normal menstrual period'.

Dates and times of other relevant sexual activity within the previous 10 days \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### Items used in previous intercourse

<b>Condom</b>	Not known <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<b>Spermicide</b>	Not known <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>Lubricant</b>	Not known <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<b>Other (specify)</b>	_____		

If relevant, clarify types of intercourse \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### 19. General Examination

Name(s) of person(s) present \_\_\_\_\_

\_\_\_\_\_  
PPE worn \_\_\_\_\_  
\_\_\_\_\_

Height and centile \_\_\_\_\_ Weight and centile \_\_\_\_\_

Head circumference and centile \_\_\_\_\_

Ethnicity \_\_\_\_\_

<b>Fitzpatrick Skin Tone</b>	I: Ivory <input type="checkbox"/>	II: Beige <input type="checkbox"/>	III: Light Brown <input type="checkbox"/>
	IV: Medium Brown <input type="checkbox"/>	V: Dark Brown <input type="checkbox"/>	VI: Very Dark Brown <input type="checkbox"/>

General appearance \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Nails \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Teeth \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Cleanliness** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Hair (last washed, last dyed)** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Clothing, appropriate or not and detail if needed** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Given age and appearance correspond** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Demeanour/behaviour/interaction with carer and examiner, eye contact** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Speech (e.g., content, form, any slurring)** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Additional needs** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Developmental disorders (a brief developmental assessment should be done in a younger child)** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Right or left handed or ambidextrous** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Injuries/scars/rash/gooseflesh (indicate if self-harm)	Examined	Injuries	See Body Chart
Scalp/hair	Y / N	Y / N	
Face	Y / N	Y / N	
Eyes	Y / N	Y / N	
Ears	Y / N	Y / N	
Lips	Y / N	Y / N	
Inside mouth/palate (Note any foetor)	Y / N	Y / N	
Teeth	Y / N	Y / N	
Neck	Y / N	Y / N	
Buttocks	Y / N	Y / N	
Arms: R L	Y / N Y / N	Y / N Y / N	
Hands/wrists: R L	Y / N Y / N	Y / N Y / N	Note if R or L handed
Fingers/nails: R L	Y / N Y / N	Y / N Y / N	Note if cut / broken / false
Front of chest	Y / N	Y / N	
Breasts	Y / N	Y / N	Tanner stage 1 / 2 / 3 / 4 / 5
Back	Y / N	Y / N	
Abdomen	Y / N	Y / N	
Legs: R L	Y / N Y / N	Y / N Y / N	
Feet/ankles/soles: R L	Y / N Y / N	Y / N Y / N	
Additional details <i>e.g., Injection sites, signs of Non-Fatal Strangulation</i>			

**Systems Examination**

<b>CVS</b>	Pulse rate/character _____ BP _____ Cyanosis _____ Heart size _____ Heart sounds _____ Ankle oedema _____ Other _____ _____ _____ _____ _____
<b>ENT</b>	Drooling _____ Ears, external auditory meatus, tympanic membrane _____ Hearing: Renee and Weber if needed _____ Voice (hoarse) _____ Lymphadenopathy _____ Mouth including frenulum _____
<b>RS</b>	Trachea / Air entry / Percussion / Breath Sounds _____ Cough _____ _____ PEFR (if indicated) _____ Oxygen Saturation ( <i>ONLY if indicated</i> ) _____

<b>Abdomen</b>	Inspection _____
	Distended Prominent Veins _____
	Scars _____
	Palpation _____
	Tenderness _____
	Guarding _____
	Rebound _____
	Liver _____
	Kidneys _____
	Spleen _____
	Uterus _____
	Auscultation-bowel sounds _____
Other _____ _____	
<b>Neurology</b>	Pupil Size _____
	Reaction to light _____
	Accommodation _____
	Nystagmus _____
	Cranials _____
	Speech (slurred, content) _____
	Balance / ataxia _____
	Tone _____
	Power _____
	Reflexes _____
	Sensation _____

<b>Musculoskeletal</b>	Joints (swollen red, tender, hot, range of movement) _____ _____ _____ _____ _____
	Motility _____
	Back _____
	Kyphosis _____
	Scoliosis _____ _____ _____ _____
	Disability _____ _____
	Other _____ _____ _____

**Additional Notes** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**Genital and Anal Examination**

Colposcope  Additional magnification

Encryption code \_\_\_\_\_

**Position used**

Knee-chest Yes  No  Supine Yes  No   
 Left lateral Yes  No

**Mode of examination**

Vulval separation Yes  No  Vulval traction Yes  No   
 Delineation of hymenal edges Yes  No  With what? \_\_\_\_\_  
 Speculum Yes  No  Size Large  Medium  Medium Long  Small  Virgin   
 Foley catheter used Yes  No  Inflated with Air  Water

Amount of air/water \_\_\_\_\_

Batch number and expiry date of water \_\_\_\_\_

Lubricant used Yes  No  Make \_\_\_\_\_

**Details of Female Genital findings (include injuries, fresh, healing and healed and any evidence of infection)**

<p>Thighs</p> <p>Mons pubis</p> <p>Pubic hair (<i>Tanner stage 1 / 2 / 3 / 4 / 5</i> and description, e.g. shaved, cut)</p> <p>Clitoral hood</p> <p>Clitoris</p> <p>Urethra</p> <p>Labia majora</p> <p>Labia minora</p> <p>Fossa Navicularis</p> <p>Posterior fourchette</p> <p>Hymen (diagram when indicated)</p> <p>Fimbriated / annular / crescentic / other</p> <p><b>Internal findings</b></p> <p>Vaginal wall</p> <p>Cervix</p>	
---	--

**Details of Anal findings**

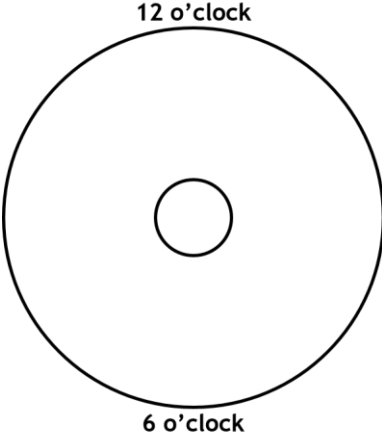
Natal Cleft

Perianal / Anal margin

Internal findings

Was a digital rectal examination done?  
 Yes  No

Why?



Proctoscope used Yes  No

Size:

Sterile water used Yes  No  Batch Number \_\_\_\_\_ Expiry Date \_\_\_\_\_

Lubricant used Yes  No  Type:

**Details of Male Genital Findings**

Thighs

Pubic hair

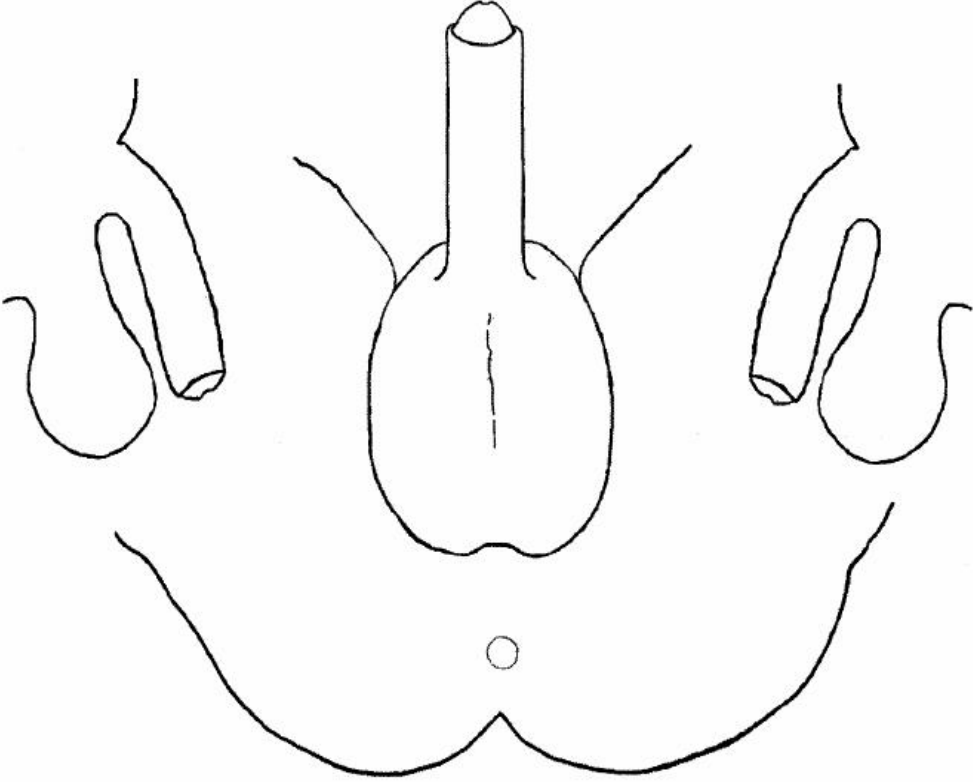
Tanner 1 / 2 / 3 / 4 / 5

Scrotum

Testicles

Shaft

Circumcised Yes  No



### Forensic Samples

Start time \_\_\_\_\_ End time \_\_\_\_\_

	Identification number	Location	Number Taken	Moistened Yes / No
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				

To whom handed \_\_\_\_\_

Date and Time samples handed over \_\_\_\_\_

## 20. Medical Samples

List any samples obtained and record where samples are sent; these are not forensic samples, they are sexually transmitted disease screening, which may be done at base line; should be done at the appropriate interval post alleged/suspected assault; should be taken, given consent, at all historic/delayed reporting medicals. Triple site testing is recommended for all regardless of allegation.

### Charcoal swabs

- |                    |                              |                             |
|--------------------|------------------------------|-----------------------------|
| 1. Throat          | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. Vulva/introitus | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3. LVS             | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 4. HVS             | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 5. Endocervical    | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 6. Perianal/anal   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 7. Rectal          | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 8. Glans/meatus    | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 9. Other           | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

### PCR swabs

- |                     |                              |                             |
|---------------------|------------------------------|-----------------------------|
| 10. Throat          | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 11. Urethral        | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 12. Vulva/introitus | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 13. HVS             | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 14. Endocervical    | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 15. Perianal/anal   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 16. Rectal          | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 17. Glans/meatus    | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 18. Other           | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

### Viral swabs

19. Site(s)

\_\_\_\_\_

### Urine

20. MS/C Yes  No

21. PCR (specify what for i.e. chlamydia and gonorrhoea/trichomonas)

\_\_\_\_\_

### Blood

If too early for these, who will do them at the appropriate interval i.e. baseline (case dependent), 45 days, 3 months and, if high risk, Hepatitis B and C again 6 months post exposure? \_\_\_\_\_

22. Hepatitis B Yes  No

24. Syphilis Yes  No

23. Hepatitis C Yes  No

25. HIV Yes  No

Where the samples are to be taken \_\_\_\_\_

By whom \_\_\_\_\_

Chain of evidence Yes  No

Who is collecting the results? \_\_\_\_\_

How? \_\_\_\_\_

Who will give the results to the complainant/carer? \_\_\_\_\_

How? \_\_\_\_\_

Who will arrange follow-up / treatment if needed? \_\_\_\_\_

Additional Notes \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### 21. Photo documentation

Photo documentation obtained Yes  No

List photo documentation obtained \_\_\_\_\_

---



---



---



---



---



---



---



---



---



---



---

Where stored \_\_\_\_\_

---

Photo documentation encryption code \_\_\_\_\_

If not done, why \_\_\_\_\_

---



---



---



---



---



---



---

### 22. Conclusions / Advice Given to Police

---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---



---

## 23. Confidential Medical Aftercare

### A. Risk of Sexually Transmitted Infections

The child/young person's risk of contracting a sexually transmitted infection should be considered in every case. Local policy will determine what medication is available on site and what will be provided by other agencies. The following sections should be completed to demonstrate discussion and referral/treatment.

#### Detail of exposure:

Date / time of assault \_\_\_\_\_ Time interval to examination \_\_\_\_\_

Type of exposure: Anal receptive / vaginal receptive / oral receptive / splash semen to eye\*

Other \_\_\_\_\_

Ejaculation occurred? Not known  Yes  No

Condom used throughout? Not known  Yes  No

Injuries resulting in mucosal breach Yes  No

Anal intercourse Yes  No

In contact with assailant's blood or semen Yes  No

Menstruating Yes  No

Multiple assailants Yes  No

#### Assailant details:

Sexuality Not known  Heterosexual  Bisexual MSM WSW

IVDU Not known  Yes  No

UK-born Not known  Yes  No

Foreign born Not known  Yes  No

Lived abroad Not known  Yes  No

Country High risk  Low risk

HIV status Not known  Negative  Positive

\* semen in a healthy eye is no longer considered a risk. In an eye with disease such as conjunctivitis it is a risk.

#### Ai. HIV PEP

According to BASHH guidelines HIV PEP is: Not appropriate  To be considered  Recommended

Is child/young person:

<16 years old / low BMI / pregnant / breast feeding / suffering serious medical condition? Yes  No

(If yes to any of these, discuss with the paediatric Infectious Diseases consultant for under 16 or Infectious Diseases consultant for 16 and over and document outcome. This must be done at the time of the medical; there is no place for delay) \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Where PEP to be considered or recommended, use a starter pack dispensed in the SARC or refer if under 16 / low BMI / pregnant / breast feeding / comorbidities that complicate.

If treatment to be given on site discuss with child/young person:

Rationale / Potential side effects / Regime / Importance of compliance & follow up Yes  No

Starter pack given Yes  Declined

Batch no \_\_\_\_\_ Expiry Date \_\_\_\_\_

Time of first dose PEP (if given on site) or referral to STI / GUM / ED for PEP \_\_\_\_\_

Patient info sheet given and contact if help needed Yes  No

Advised the patient regarding safe sex until completion of screening Yes  Not appropriate

**Aii. Hep B PEP** if <13 years old, check dose in BNF or with appropriate expertAccording to BASHH guidelines Hep B PEP is: **Not appropriate**  **Recommended** Given \_\_\_\_\_ Yes  No 

Batch number \_\_\_\_\_ Expiry date \_\_\_\_\_

Where and when are the next doses to be given? \_\_\_\_\_

**Aiii. Chlamydia / Neisseria Gonorrhoea / Others** if <13 years old, check dose in BNF or with appropriate expertAccording to BASHH guidelines antibiotics are: **Not appropriate**  **To be considered** *Where antibiotics are to be considered, refer to appropriate agency or use a starter pack dispensed in the SARC.*Antibiotics given Yes  Declined  Not available 

Name of antibiotics \_\_\_\_\_

Batch number \_\_\_\_\_ Expiry date \_\_\_\_\_

Dose \_\_\_\_\_

Patient info sheet given Yes  No GP / GUM letter Given to child/young person  Faxed  To be posted 

Details \_\_\_\_\_

**Aiv. Hepatitis C**

In adults there is some evidence that after a high risk exposure from a known hepatitis C positive source if infection is detected, early treatment with direct antivirals may be effective<sup>4</sup>. There is no evidence for prophylaxis in children. However, if in doubt take advice for paediatric infectious diseases.

**B. Emergency Contraception**Post menarchal Yes  No Pregnancy test at centre? Yes  No 

Batch Number \_\_\_\_\_

Expiry Date \_\_\_\_\_

Result \_\_\_\_\_

LMP \_\_\_\_\_ Hours post unprotected sexual intercourse (UPSI) \_\_\_\_\_

Cycle length \_\_\_\_\_

Other unprotected sexual intercourse since LMP? \_\_\_\_\_

Contraception used? \_\_\_\_\_

Emergency contraceptive given: Yes  No  Declined Follow up advice Yes  No 

Name \_\_\_\_\_ Batch Number \_\_\_\_\_ Expiry Date \_\_\_\_\_

Details \_\_\_\_\_

IUCD Considered  Discussed  Recommended 

Appointment date time and venue for IUCD \_\_\_\_\_

Oral EC given in case IUCD cannot be inserted \_\_\_\_\_

**C. Self-Harm Risk**

Any specific concerns arisen regarding imminent risk of self-harm? Yes  No

Further information / action \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**D. Suicide Risk**

Any specific concerns arisen regarding imminent risk of suicide? Yes  No

Thoughts / Plans / Actions \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Management \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**E. Referred for Follow-up/Aftercare to** *(delete as applicable)*

Paediatrician \_\_\_\_\_  
GP \_\_\_\_\_  
Therapy, specify \_\_\_\_\_  
Other support, specify \_\_\_\_\_  
GUM \_\_\_\_\_  
Advocate \_\_\_\_\_



**F. Sharing of information**

Child Protection report to be written by the examining Clinician and sent by secure email to:

GP \_\_\_\_\_  
\_\_\_\_\_

Social Care \_\_\_\_\_  
\_\_\_\_\_

Officer in the Case \_\_\_\_\_  
\_\_\_\_\_

Designated/named paediatrician in area the child resides (for information only) \_\_\_\_\_  
\_\_\_\_\_

Child and Adolescent Mental Health Services \_\_\_\_\_  
\_\_\_\_\_

Other \_\_\_\_\_  
\_\_\_\_\_

Notification by secure email to \_\_\_\_\_

School/nursery/college Safeguarding lead \_\_\_\_\_

Multi Agency Safeguarding Hub (MASH) \_\_\_\_\_

**The MASH notification should be done in all cases whether they come with a social worker or not.**

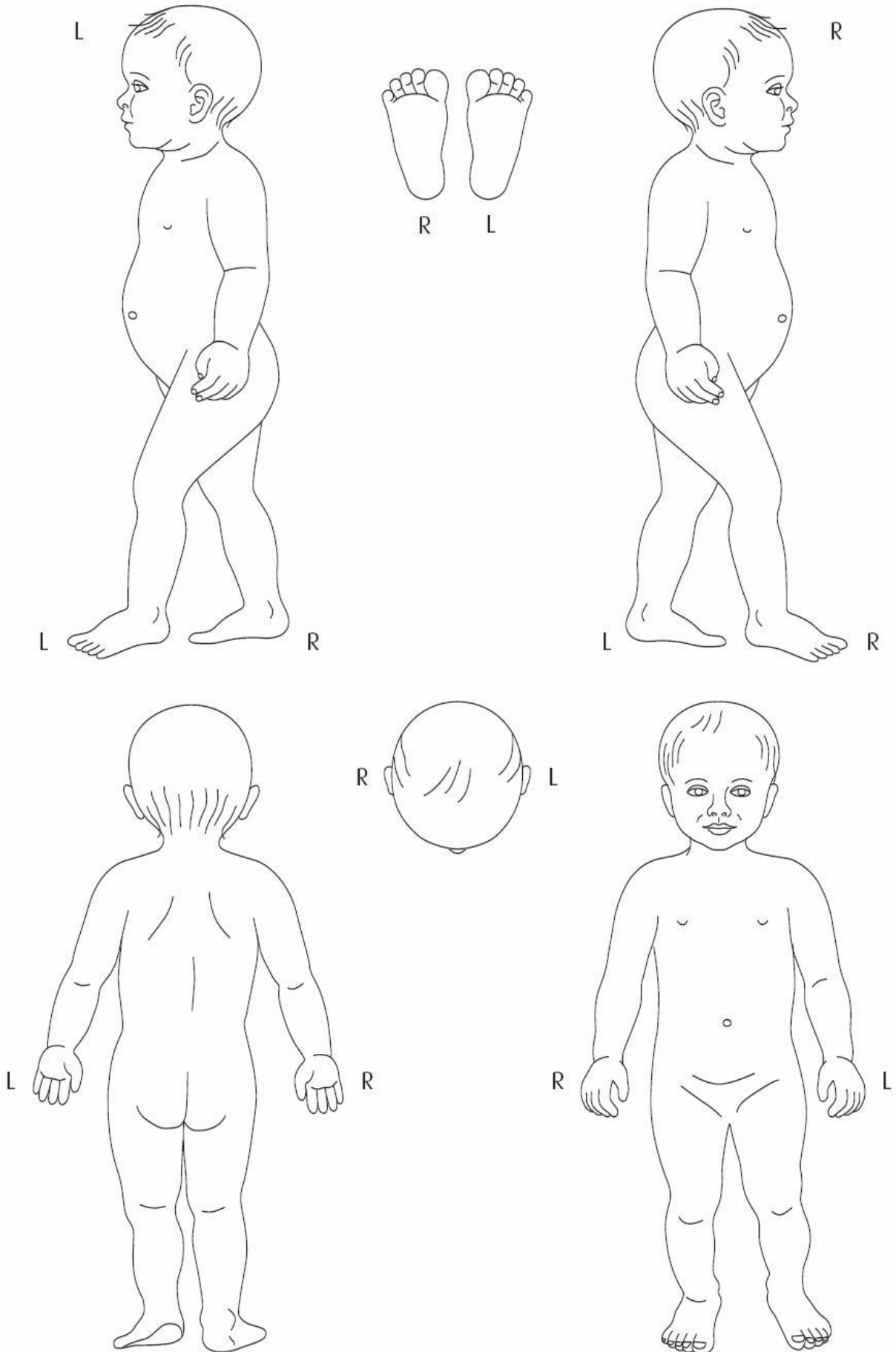
Health care action plan \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**This should be in the GP Child Protection report and also given to the patient / carer.**

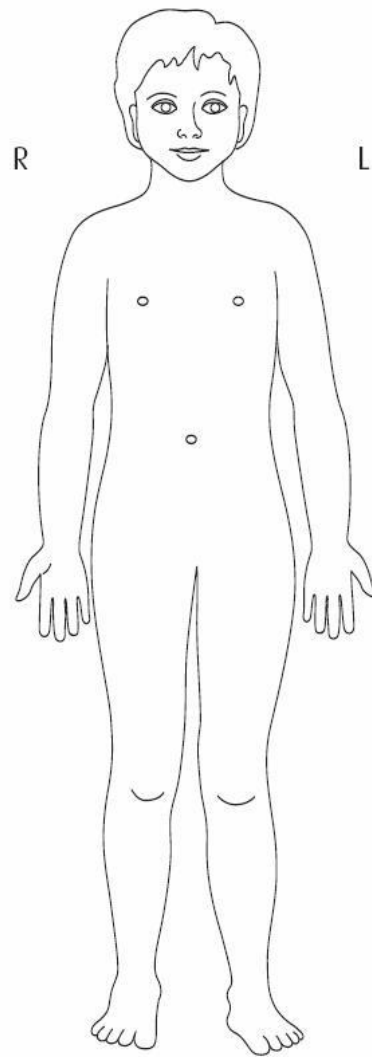
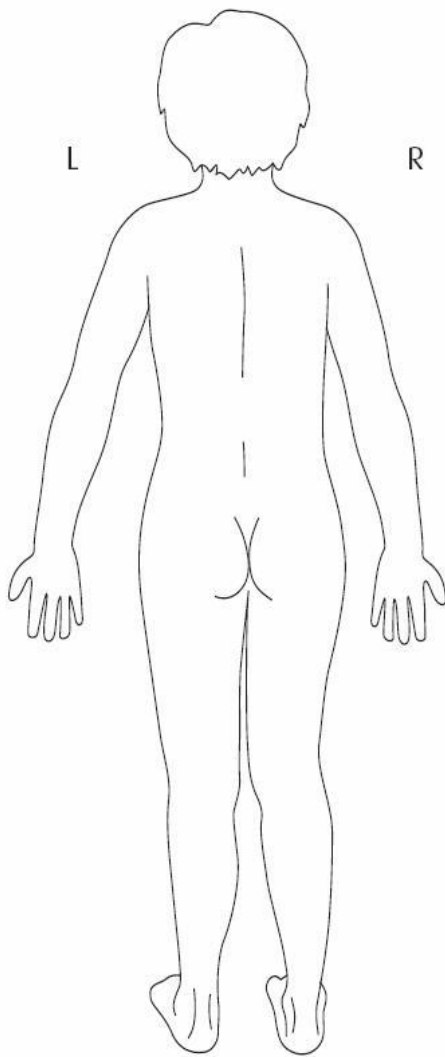
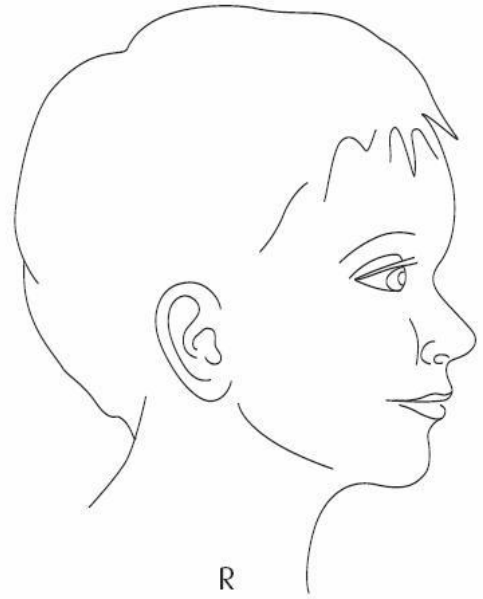
**PLEASE REMEMBER TO KEEP COPY IN THE NOTES OF ANY LETTERS TO OTHER AGENCIES such as GP, GU clinic, ED etc.**



### Baby body diagrams



### Child body diagrams



## References

1. [Service specifications for the clinical evaluation of children and young people who may have been sexually abused](#)  
FFLM and RCPCH  
September 2015
2. [The Physical Signs of Child Sexual Abuse an evidence based review and guidance for best practice](#)  
AAP, FFLM, RCP, RCPCH  
May 2015 (update due to be published 2024)
3. [Recommendations for the Collection of Forensic Specimens from Complainants and Suspects](#)  
FFLM  
January 2024 (Updated biannually, in January and July)
4. [BASHH National Guideline on the Management of Sexually Transmitted Infections and Related Conditions in Children and Young People](#)  
BASHH
5. [Quality Standards for Clinicians Undertaking Paediatric Sexual Offence Medicine \(PSOM\)](#)  
FFLM  
March 2021 (update due to be published 2024)