



Non-fatal strangulation proforma

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This proforma focuses on the non-fatal strangulation (NFS) elements of an examination and as such should be used as an adjunct to other clinical documentation e.g., SARC proforma/ED/custody proforma etc. where issues such as consent/capacity/alleged assailant details/general medical assessment etc. should be covered. Whilst it is acknowledged that in some circumstances the strangulation may have been consensual, for the purposes of this document the terms 'patient' and 'alleged assailant' have been used.

Date _____ Time _____

Clinician _____ Regulatory number _____

Patient name _____ Patient DOB _____

Patient number _____

History of strangulation

History from _____

Persons present _____

Method Manual one hand Manual two hands

Ligature Head lock

Other
specify below

From 1 to 10 how hard was alleged assailant's grip?
(Low) 1 2 3 4 5 6 7 8 9 10 (High)

From 1 to 10 how painful was it?
(Low) 1 2 3 4 5 6 7 8 9 10 (High)

Time strangulation occurred
(date/time) _____

Time since strangulation
(hours/days) _____

Number of episodes of strangulation in this event
One More than one Unknown

Did alleged assailant say anything during strangulation?

Yes No Unknown Not asked

Actions of the patient during the strangulation

Unknown Not asked

What was the patient thinking at time of strangulation?

Unknown Not asked

Has the alleged assailant strangled the patient before?

Yes No Unknown Not asked



Symptoms at the time of/immediately after strangulation

History from _____ Persons present _____

Vision	Flashing lights	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Not asked <input type="checkbox"/>	Tunnel vision	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Not asked <input type="checkbox"/>	Spots	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Not asked <input type="checkbox"/>
	Blurred vision	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Not asked <input type="checkbox"/>	Loss of vision	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Not asked <input type="checkbox"/>	Seeing 'stars'	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Not asked <input type="checkbox"/>
	Other:					
Hearing	Buzzing, roaring or popping					
	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	Not asked <input type="checkbox"/>		
	Details:					
Loss of consciousness	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	Not asked <input type="checkbox"/>		
	Details:					
Dizzy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	Not asked <input type="checkbox"/>		
	Details:					
Difficulty breathing	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	Not asked <input type="checkbox"/>		
	Details:					
Difficulty speaking	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	Not asked <input type="checkbox"/>		
	Details:					
Pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	Not asked <input type="checkbox"/>		
	Details:					
Incontinence of urine	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	Not asked <input type="checkbox"/>		
	Details:					
Incontinence of bowels	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	Not asked <input type="checkbox"/>		
	Details:					
Loss of strength	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	Not asked <input type="checkbox"/>		
	Details:					



Symptoms and signs since the time of strangulation

History from _____ Persons present _____

Neck pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	Not asked <input type="checkbox"/>
	Site _____ Severity _____			
	Details: _____			
Neck swelling	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	Not asked <input type="checkbox"/>
	Details: _____			
Neck injuries	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	Not asked <input type="checkbox"/>
	Details: _____			
Coughing	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	Not asked <input type="checkbox"/>
	Details: _____			
Dysphagia/drooling	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	Not asked <input type="checkbox"/>
	Details: _____			
Odynophagia (Painful swallowing)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	Not asked <input type="checkbox"/>
	Details: _____			
Dysphonia or voice changes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	Not asked <input type="checkbox"/>
	Details: _____			
Dyspnoea	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	Not asked <input type="checkbox"/>
	Details: _____			
Vomiting	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	Not asked <input type="checkbox"/>
	Details: _____			
Headache	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	Not asked <input type="checkbox"/>
	Details: _____			
Memory disturbance	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	Not asked <input type="checkbox"/>
	Details: _____			
Have any other symptoms or injuries thought to be related to the strangulation been noted?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Unknown <input type="checkbox"/>	Not asked <input type="checkbox"/>
	Details: _____			



Physical examination findings related to strangulation at the time of the examination

Skin pigmentation/Fitzpatrick scale¹ (circle) I II III IV V VI

Respiratory rate _____ Pulse _____ Blood pressure _____

Site	Finding		Body chart/details
	Yes	No	
1. Neck			Carotid bruit Surgical emphysema
2. Face			
3. Eyes (including ophthalmoscope findings)			
4. Scalp			
5. Mouth			
6. Behind ears			
7. Neurological deficits			Glasgow Coma Scale
8. Other			Voice quality

¹dermnetz.org/topics/skin-phototype



Management

See IFAS and FFLM for latest guidance on management of NFS.

- [Guidelines for clinical management of non-fatal strangulation in acute and emergency care services](#)
- [Non-fatal strangulation: in physical and sexual assault](#)

Checklist

1. Forensic samples	Yes <input type="checkbox"/> Not required <input type="checkbox"/> Declined <input type="checkbox"/>
2. Line drawings	Yes <input type="checkbox"/> Not required <input type="checkbox"/>
3. Photography	Done as part of FME <input type="checkbox"/> Requested from police/other <input type="checkbox"/> N/A <input type="checkbox"/> Declined <input type="checkbox"/>
4. Are there red flags suggesting requirement for medical imaging?	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. Referral to ED	Yes <input type="checkbox"/> Not required <input type="checkbox"/> Declined <input type="checkbox"/> Details:
6. Advice sheet re NFS given to patient	Yes <input type="checkbox"/> Declined <input type="checkbox"/> Information Leaflets for Victims (ifas.org.uk)
7. Include NFS details (including if applicable ED referral) in summary to police	Yes <input type="checkbox"/> Not required <input type="checkbox"/> Declined <input type="checkbox"/>
8. Include NFS details (including if applicable ED/ENT referral) in GP letter	Yes <input type="checkbox"/> Declined <input type="checkbox"/>
9. Include NFS in safeguarding assessments	Yes <input type="checkbox"/> Not required <input type="checkbox"/> Declined <input type="checkbox"/>
10. Requires other follow up?	Yes <input type="checkbox"/> Not required <input type="checkbox"/> Declined <input type="checkbox"/> Details: