



Pro Forma

Paediatric Forensic Medical Examination

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Note: This form has been designed for use by Doctors. It is provided to assist the examining Doctor 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 the property of the examining Doctor. 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 Doctor 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 Doctor should consider if she/he has all the necessary skills^{1, 2} to examine the child/young person, or if there is a need to involve a second Doctor. Children should be examined in a child friendly environment.

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

The Doctor 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 Doctor 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,³ any injuries however minor, and the medical needs of the child/young person (e.g. HIV Post Exposure Prophylaxis, emergency contraception).

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 samples³. 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? _____

In all cases, presenting within 5 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? _____

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. Doctor Details

Name of Doctor _____

GMC _____

Other Doctors (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 _____

Social care involvement in the past and reasons _____

6. General Practitioner

Name of GP _____

Surgery address _____

Surgery telephone number _____

7. Present

Family / Friends _____

Police _____

Social Care _____

Crisis worker _____

Others _____

8. 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
- b) Collection of forensic samples
- c) Collection of medical samples
- d) Recording in writing
- e) 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
- f) I understand that the Doctor will provide a Child Protection report for the police, social services, paediatric services and the patient’s GP
- g) I understand that the Doctor will provide a court statement if requested
- h) I understand that the Doctor will give evidence in court if ordered
- i) 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
- j) I agree to the use of photo documentation and anonymised medical notes for teaching
- k) I agree to the use of my anonymised-medical notes for audit and research
- 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 (Doctor) Date and time.....

Name printed

9. Patient Details

Name _____

Address _____

Date of Birth _____ Age _____

Gender Female / Male / Trans / Prefer not to say Ethnicity _____

Case number _____

10. Family composition

Adults

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

Children

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

Lives with _____ Shares bedroom with _____

School/nursery _____ Safeguarding lead at school/nursery _____

Address _____

Do siblings / close family members / friends need assessment? Yes No

Has an appointment been made? Yes No

11. 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 _____

12. 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

13. 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 _____

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 4 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) _____

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	(details, including sites)	
Mouth to genitalia/anus?	YES / NO / NOT KNOWN	(details)	
Digit to vulva/vagina/anus?	YES / NO / NOT KNOWN	(details)	
Penis into vulva/vagina?	YES / NO / NOT KNOWN	(details)	
Penis into mouth?	YES / NO / NOT KNOWN	(details)	
Penis into anus?	YES / NO / NOT KNOWN	(details)	
Ejaculation?	YES / NO / NOT KNOWN	(details, including sites)	
Object to vulva/vagina/anus?	YES / NO / NOT KNOWN	(details)	
Other sexual/physical act(s)	YES / NO / NOT KNOWN	(details)	
Injuries?	YES / NO	(details)	
Ano-genital bleeding?	YES / NO	(details)	
Weapon used?	YES / NO / NOT KNOWN	(details)	
Damage to clothing?	YES / NO	(details)	

14. Forensic samples taken before examination started (details)

Mouth _____

Urine _____

Tissues used to wipe _____

Condom(s) _____

Sanitary protection _____

Clothing _____

By whom taken _____

15. 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>
<i>Circle:</i>	Brushed: teeth / gums / dentures
	Mouth wash / spray used
	Washed / bathed / showered / douched
	Changed tampon / pad / sponge / diaphragm

16. Direct Questions *ask if relevant*

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

17. 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 _____

Additional needs _____

C. General Health

Vision _____

Hearing _____

Medications _____

Allergies _____

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"/>	
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, night time	<input type="checkbox"/>	<input type="checkbox"/>	Age
Wetting day time	<input type="checkbox"/>	<input type="checkbox"/>	
Wetting night time	<input type="checkbox"/>	<input type="checkbox"/>	
Dysuria	<input type="checkbox"/>	<input type="checkbox"/>	
Haematuria	<input type="checkbox"/>	<input type="checkbox"/>	
Urinary tract infection	<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"/>	
Date of last period			
Routine sanitary protection	Tampons, regular use <input type="checkbox"/> Tampons tried <input type="checkbox"/> Pads <input type="checkbox"/>		
Contraception			
Pregnancies			
Birth history			
Sexual history			
Other			

Skin Diseases/Warts	Yes	No	Comment
	<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"/>	
Other			

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			
Parental drug abuse	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Parental alcohol abuse	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Domestic violence			
Siblings			

F. Sexual History

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

Has the child been sexually active? _____

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

Items used in previous intercourse

Condom Not known Yes No Spermicide Not known Yes No

Lubricant Not known Yes No Other (specify) _____

If relevant, clarify types of intercourse _____

18. General Examination

Name(s) of person(s) present _____

Height and centile _____ Weight and centile _____

Head circumference and centile _____

General appearance _____

Hair (last washed, last dyed) _____

Nails _____

Teeth _____

Cleanliness _____

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) _____

Additional needs/developmental disorders _____

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	
Back	Y / N	Y / N	
Buttocks	Y / N	Y / N	
Arms: R	Y / N	Y / N	
L	Y / N	Y / N	
Hands/wrists: R	Y / N	Y / N	Note if R or L handed
L	Y / N	Y / N	
Fingers/nails: R	Y / N	Y / N	Note if cut / broken / false
L	Y / N	Y / N	
Front of chest	Y / N	Y / N	
Breasts	Y / N	Y / N	Tanner stage 1 / 2 / 3 / 4 / 5
Back of chest	Y / N	Y / N	
Abdomen	Y / N	Y / N	
Legs: R	Y / N	Y / N	
L	Y / N	Y / N	
Feet/ankles/soles: R	Y / N	Y / N	
L	Y / N	Y / N	
Additional details <i>Injection sites</i>			

Systems Examination

CVS	Pulse rate/character _____ BP _____ Cyanosis _____ Heart size _____ Heart sounds _____ Ankle oedema _____ Other _____ _____
ENT	Ears, external auditory meatus, tympanic membrane _____ Hearing; Renee and Weber if needed _____ Lymphadenopathy _____ Mouth including frenulum _____
RS	Trachea / Air entry / Percussion / Breath Sounds _____ PEFr (if indicated) _____ Oxygen Sats _____
Abdomen	Inspection-distended _____ Prominent Veins _____ Scars _____ Palpating-tenderness _____ Guarding _____ Rebound _____ Liver _____ Kidneys _____ Spleen _____ Uterus _____ Auscultation-bowel sounds _____ Other _____

Neurology	Pupil Size _____
	Reaction to light _____
	Accommodation _____
	Nystagmus _____
	Cranials _____
	Balance / ataxia _____
	Tone _____
	Power _____
	Reflexes _____
Sensation _____	
Musculoskeletal	Joints _____
	Swollen _____
	Red _____
	Tender _____
	Hot _____
	Motility _____
	Back _____
	Kyphosis _____
	Scoliosis _____
	Range of movement _____
	Erythema _____
	Warmth _____
	Disability _____

Other _____	

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

<p>Thighs</p> <p>Mons pubis</p> <p>Pubic hair (<i>Tanner stage 1 / 2 / 3 / 4 / 5</i> <i>and description, e.g. shaved, cut</i>)</p> <p>Clitoral hood</p> <p>Clitoris</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>Internal findings</p> <p>Vaginal wall</p> <p>Cervix</p>	
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Details of Anal findings

Natal Cleft

Perianal / Anal margin

Internal findings

Was a digital rectal examination done?
 Yes No

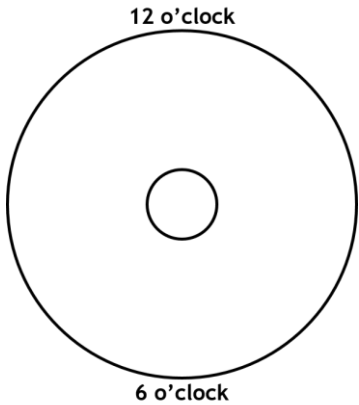
Why?

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

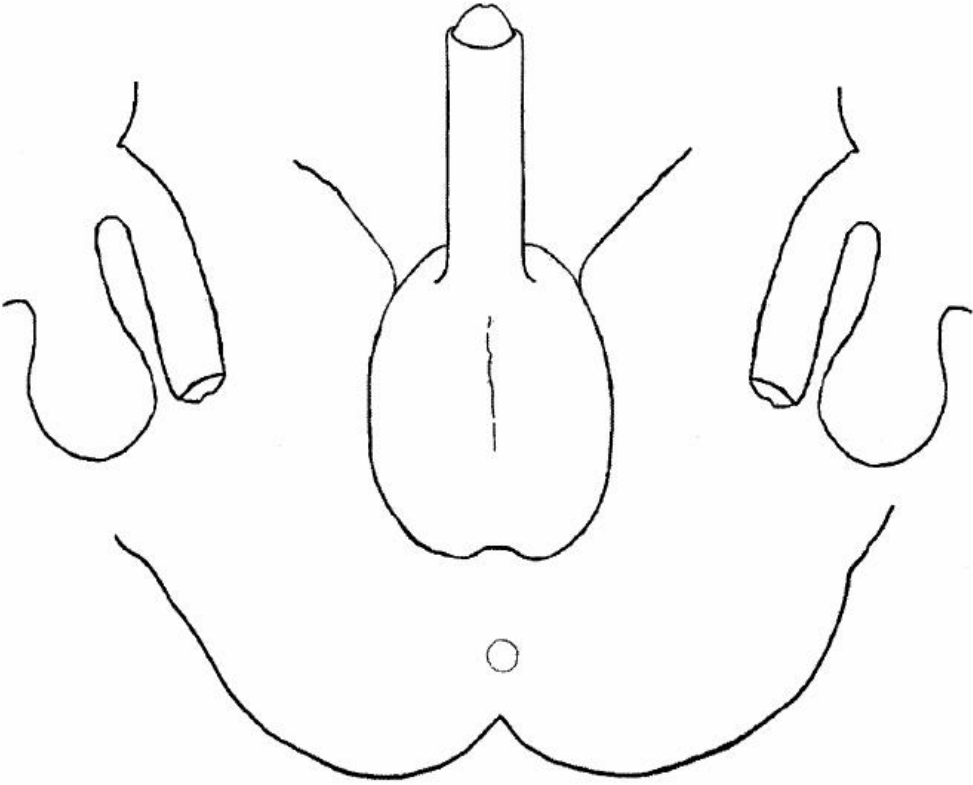
Tanner 1 / 2 / 3 / 4 / 5

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 _____

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

Viral swabs

18. Site(s) _____
-

Urine

- | | | |
|----------|------------------------------|-----------------------------|
| 19. MS/C | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 20. PCR | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Blood

If too early for these, who will do them at the appropriate interval? _____

- | | | |
|-----------------|------------------------------|-----------------------------|
| 21. Hepatitis B | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 22. Hepatitis C | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 23. Syphilis | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 24. HIV | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

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? _____

20. Photo documentation

Photo documentation obtained Yes No

List photo documentation obtained _____

Where stored _____

Photo documentation encryption code _____

If not done, why _____

21. Conclusions / Advice Given to Police

22. 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 effective⁴. There is no evidence for prophylaxis in children. However, if in doubt take advice for paediatric infectious diseases.

B. Emergency ContraceptionPost pubertal 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 Doctor 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 _____

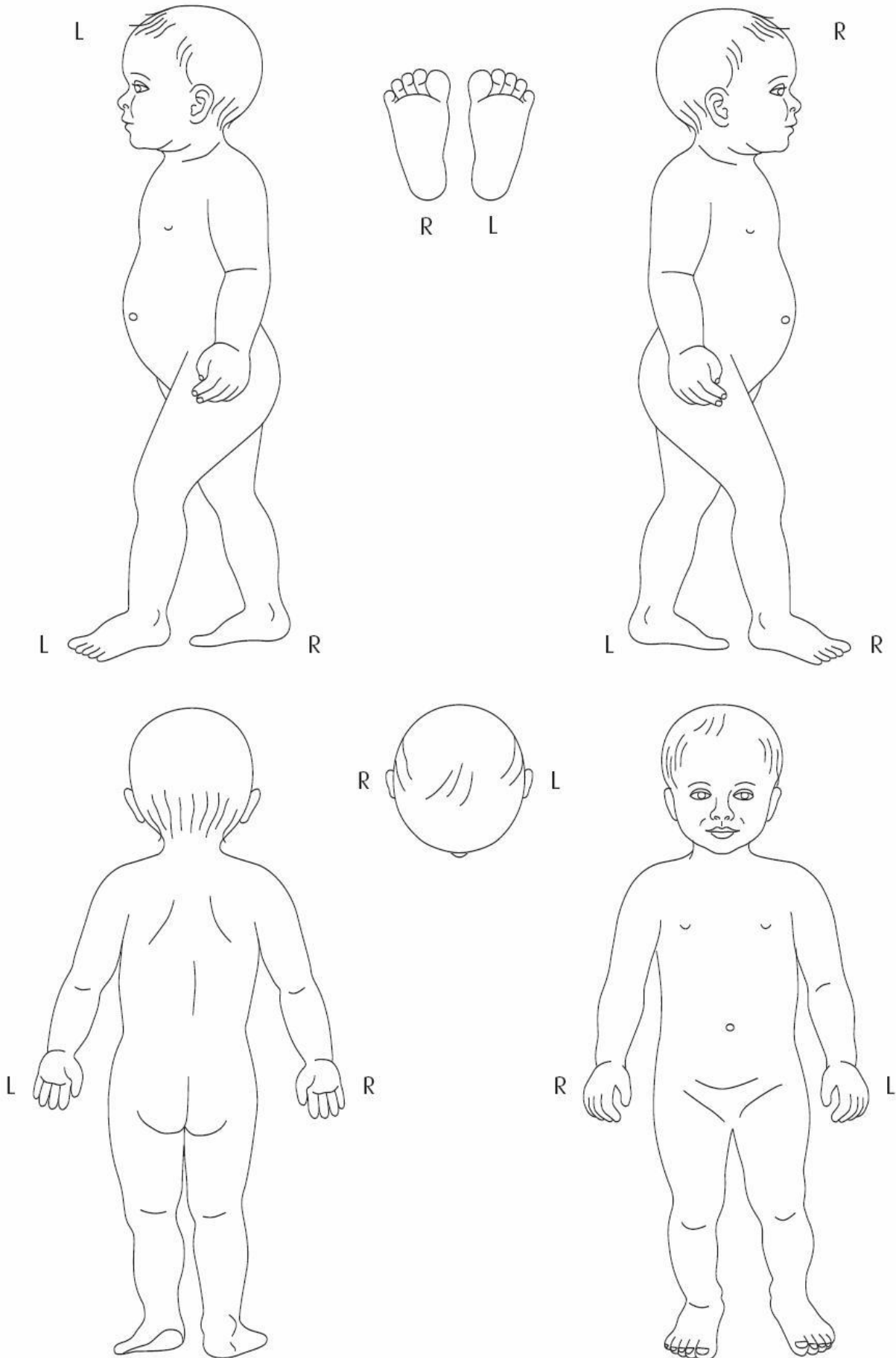
Multi Agency Safeguarding Hub (MASH) _____

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

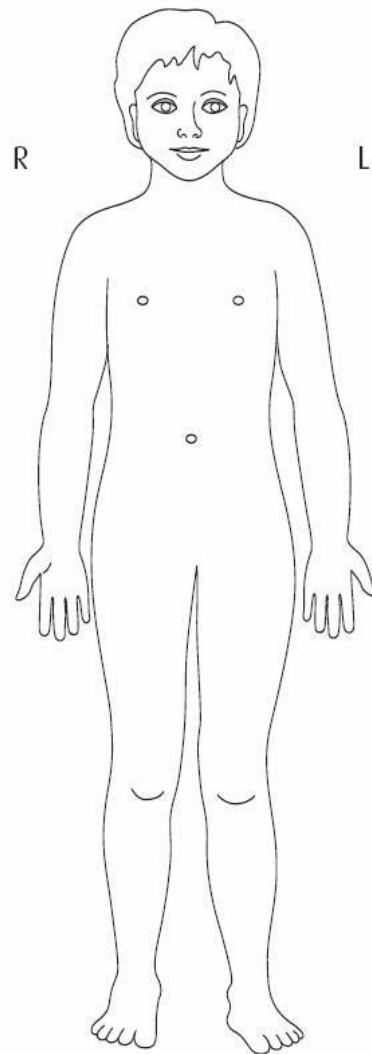
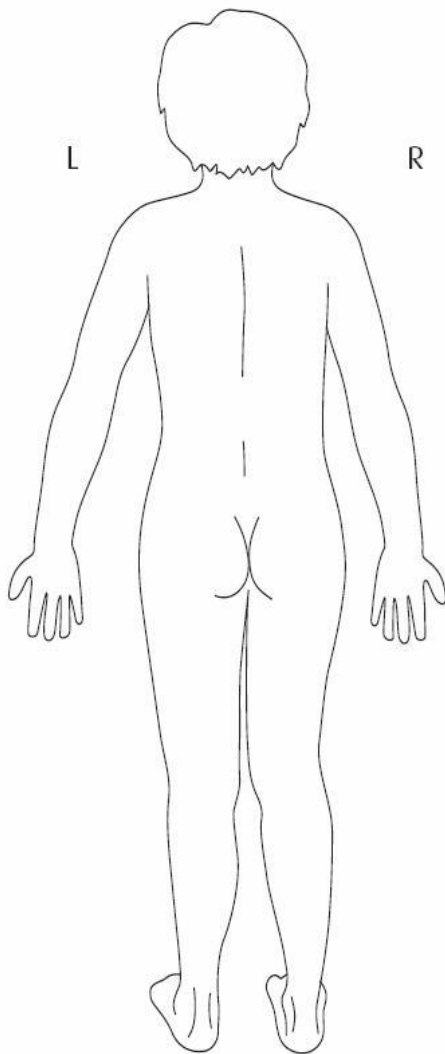
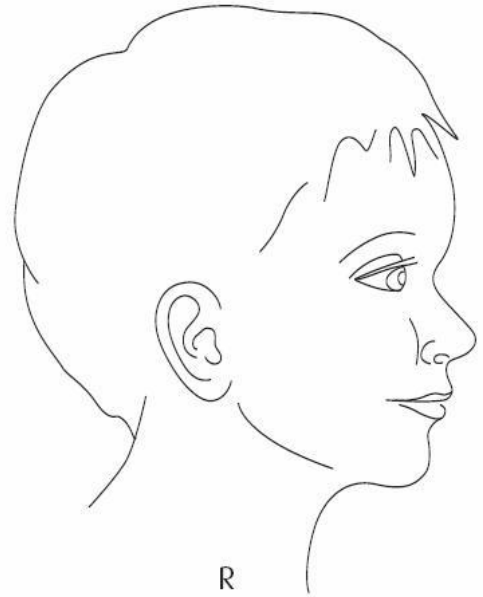
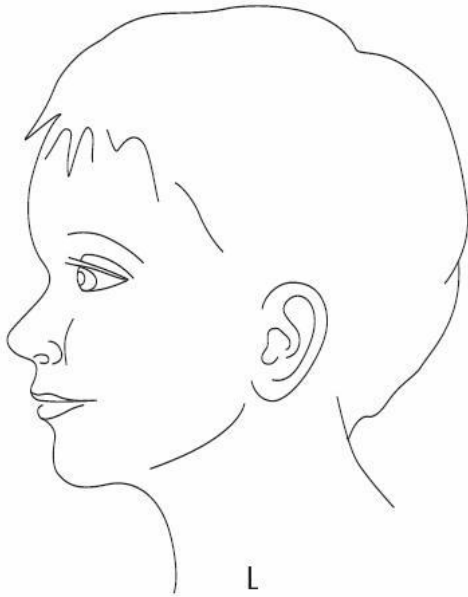
Health care action plan _____

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
3. [Recommendations for the Collection of Forensic Specimens from Complainants and Suspects](#)
FFLM
January 2020 (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. [Child Sexual Abuse Forensic Examinations: Interim Guidance regarding number of examinations and maintenance of competence](#)
FFLM
February 2020
6. [Quality Standards for Doctors Undertaking Paediatric Sexual Offence Medicine \(PSOM\)](#)
FFLM
April 2017 (see www.fflm.ac.uk for latest update)

Dr Sheila Paul and Dr Marie-Elle Vooijs

On behalf of the Faculty of Forensic & Legal Medicine

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Send any feedback and comments to forensic.medicine@fflm.ac.uk