



Examining the Characteristics, Processes, and Outcomes of Sexual Assaults in Alaska

NIJ Grant No. 2004-WB-GX-0003

André Rosay and Tara Henry
Co-Principal Investigators

SECTION 1. BASIC INFORMATION

- SART Program: _____
- Examiner's Initials: _____ • Form completed by: _____
- Law enforcement agency: _____ • Case #: _____
- Post-mortem? Yes No
- Victim date of birth: _____ / _____ / _____
- Victim sex: Female Male
- Victim race (Check all that apply):
 - Caucasian Black
 - Alaska Native / American Indian Asian Hispanic
 - Pacific Islander Other (specify): _____
- Was victim homeless at time of assault? Yes No Unknown
- Date of assault: _____ / _____ / _____
- Time of assault: _____ (if an exact time is unknown, enter time frame)
- Date of report: _____ / _____ / _____ • Time of report: _____
- Date of exam: _____ / _____ / _____ • Time of exam: _____
- Reasons for time elapsed between report and exam: _____

- Was exam completed: Yes No
- If exam was not completed, why not?

SECTION 2. PATIENT MEDICAL HISTORY

- Is the patient pregnant? Yes No
 Trimester: First (1-11 wks) Second (12-27 wks) Third (28-42 wks)
 Gravida: _____
 Para: _____
 Abortion: _____

- Was patient menstruating at time of attack? Yes No

- Within 96 hours prior to assault:
 Consensual vaginal sex? Yes No If yes, when? _____
 Consensual anal sex? Yes No If yes, when? _____
 Consensual oral sex? Yes No If yes, when? _____

- Post assault actions of patient (check all that apply):
 Urinated Defecated Genital wipe / wash
 Bath / shower Douched Ate / drank
 Brushed teeth Oral gargle / wash Changed clothing
 None of the above / not applicable

- Post assault removal / insertion of (check all that apply):
 Sponge Diaphragm Tampon
 Pad None of the above / not applicable

- Consensual vaginal sex since assault? Yes No
- Consensual anal sex since assault? Yes No
- Consensual oral sex since assault? Yes No

- Appearance of patient's clothing on arrival (check all that apply):
 Intact Clean Dirty
 Wet Bloody Torn
 All missing Partially missing Buttons missing
 Other (please explain):

- Is patient's clothing on arrival same clothing worn at time of assault? Yes No

SECTION 3. INCIDENT DESCRIPTION (PART 1)

- Location of initial contact with suspect (just prior to assault):
 - Outdoors
 - Patient's house
 - Other's house
 - Other indoor location (please describe):
 - Other (please describe):
 - Work
 - Suspect's house
 - Hotel (please name):
 - Vehicle
 - Patient and suspect's house
 - Bar (please name):
 - Unknown
-

- Location of assault:
 - Outdoors
 - Patient's house
 - Other's house
 - Other indoor location (please describe):
 - Other (please describe):
 - Work
 - Suspect's house
 - Hotel (please name):
 - Vehicle
 - Patient and suspect's house
 - Bar (please name):
 - Unknown
-

• Name of the city / town / village where assault took place: _____

- Methods employed by assailant (check all that apply and describe):

- Weapon used: _____
- Physical blows by hands / feet: _____
- Grabbing / grasping / holding: _____
- Physical restraints used: _____
- Strangulation: _____
- Burns (toxic / chemical): _____
- Verbal threats: _____
- Other methods: _____

IF STRANGULATION OCCURRED, PLEASE FILL OUT STRANGULATION FORM.

- Patient's position during assault:
 - Supine
 - Prone
 - Sitting
 - Standing
 - Knee chest
 - Unknown
 - Straddling suspect
 - Lying on side
 - Other (please explain):
-
-

SECTION 4. INCIDENT DESCRIPTION (PART 2)

SEX ACTS REPORTED:

- **Kissing, licking, biting, scratching:** Yes No Unsure Attempted
Please describe: _____

- **Touching / fondling with hands of the:**
 - Breast Yes No Unsure Attempted
 - Vagina Yes No Unsure Attempted
 - Penis Yes No Unsure Attempted
 - Anus Yes No Unsure Attempted

- **Oral copulation of genitals:**
 - Of victim by suspect Yes No Unsure Attempted
 - Of suspect by victim Yes No Unsure Attempted

- **Oral copulation of anus:**
 - Of victim by suspect Yes No Unsure Attempted
 - Of suspect by victim Yes No Unsure Attempted

- **Masturbation:**
 - Of victim by suspect Yes No Unsure Attempted
 - Of suspect by victim Yes No Unsure Attempted

- **Penetration of vagina by:**
 - Finger Yes No Unsure Attempted
 - Penis Yes No Unsure Attempted
 - Foreign Object Yes No Unsure AttemptedIf foreign object, please describe: _____

- **Penetration of anus by:**
 - Finger Yes No Unsure Attempted
 - Penis Yes No Unsure Attempted
 - Foreign Object Yes No Unsure AttemptedIf foreign object, please describe: _____

- **Lubricants, condoms, contraceptives:**
 - Was condom used? Yes No Unsure Attempted
 - Was contraceptive foam used? Yes No Unsure Attempted
 - Was contraceptive jelly used? Yes No Unsure Attempted
 - Was lubricant used? Yes No Unsure AttemptedIf lubricant was used, please describe: _____

- **Did ejaculation occur?** Yes No Unsure Attempted
If yes, specify ejaculation location (check all that apply):
 - Vagina Rectum Mouth Stomach
 - Back Napkin / cloth Bed Clothing
 - Condom Unknown Other (please explain):_____

SECTION 5. EXAMINATION (PART 1)

- Patient's behavior observed during exam (check all that apply):
 - Controlled
 - Expressive
 - Cooperative
 - Fearful
 - Tense
 - Yelling
 - Trembling
 - Other (please explain): _____
- Quiet
- Staring
- Stoic
- Tearful
- Hysterical
- Listless
- Angry

- Wood's lamp used? Yes No
- Fluorescence found? Yes No
- If yes, please describe: _____

- Speculum exam: Yes No
- Colposcope exam: Yes No
- Anoscope exam: Yes No
- Evidence kit collected: Yes No

- Received ER treatment for nongenital injuries: Yes No
- Received ER treatment for genital injuries: Yes No
- Received ER treatment for alcohol level: Yes No
- Received ER treatment for other reason: Yes No
- If other, please describe: _____

- Admitted to hospital? Yes No
- Victim's height (in inches): _____ Victim's weight: _____

- Victim's use of alcohol: Yes No Unsure
- Victim's use of drugs: Yes No Unsure

- Blood alcohol done: Yes No Alcohol level: _____
- Collection date: _____ Collection time: _____

- Breathalyzer done: Yes No Alcohol level: _____
- Collection date: _____ Collection time: _____

SECTION 6. EXAMINATION (PART 2)

- Urine tox screen done: Yes No
Results: Positive Negative

If positive, check all that apply:

<input type="checkbox"/> EtOH	<input type="checkbox"/> Barbiturates
<input type="checkbox"/> MDMA	<input type="checkbox"/> THC
<input type="checkbox"/> Benzodiazepines	<input type="checkbox"/> Ketamine
<input type="checkbox"/> Cocaine	<input type="checkbox"/> Opiates
<input type="checkbox"/> GHB	<input type="checkbox"/> Amphetamines
<input type="checkbox"/> Other: _____	

- Prior sexual assault? Yes No Unsure

If yes, number of prior sexual assaults: _____

seen at SART prior to this report? Yes (# of times: _____) No

- Disabilities (check all that apply): Mental Physical Psychiatric

- Condition at time of assault (check all that apply):
 Alcohol intoxicated Drug intoxicated Sober
 Sleeping Passed out Unconscious from trauma
 Other (describe): _____

- Infections at exam? Yes No Not tested

Infections tested positive for (check all that apply):

<input type="checkbox"/> Bacterial vaginosis	<input type="checkbox"/> Chlamydia
<input type="checkbox"/> Genital warts	<input type="checkbox"/> Gonorrhea
<input type="checkbox"/> HIV	<input type="checkbox"/> Herpes
<input type="checkbox"/> Trichomoniasis	<input type="checkbox"/> Hepatitis B
<input type="checkbox"/> Syphilis	<input type="checkbox"/> Yeast
<input type="checkbox"/> Hepatitis C	

- Sperm seen on wet prep? Yes No No data Not done

- Sperm motile? Yes No Not seen

- Follow-up done? Yes No

If yes, date: _____ time: _____

- Consensual sex within 24 hours before follow-up? Yes No

Notes: _____

SECTION 7. NONGENITAL AND ANOGENITAL INJURIES

- **Nongenital trauma?** Yes No If yes, check all that apply:

<i>Injury site:</i>	<i>For each injury site, check as many injury types as apply:</i>									
	Bruising	Redness	Abrasions	Lacerations	Swelling	Fracture	Bite Mark	Pain	Other	Notes:
Head / face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Buttocks/hips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- **Anogenital trauma?** Yes No If yes, check all that apply:

<i>Injury site:</i>	<i>For each injury site, check as many injury types as apply:</i>						
	Bruising	Redness	Abrasion	Laceration	Swelling	Tender	Notes:
Mons pubis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Labia majora	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Labia minora	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Labia majora/minora junction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clitoral hood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clitoris	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Periurethra	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hymen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fossa navicularis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Posterior fourchette	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perineum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal walls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cervix	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rectum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- **Clockface distribution of anogenital trauma:**

SECTION 10. STRANGULATION INFORMATION

- How was patient strangled? (check all that apply)
 - One - handed Two - handed Forearm Leg Ligature: _____
- What was patient's position during strangulation? (check all that apply)
 - Standing Sitting Prone Supine Side-Lying Hands-Knees
- What was suspect's position to patient during strangulation? (check all that apply)
 - Front Back Side Straddling patient
- How many times did suspect strangle patient? _____
- How long did strangulation last? _____ seconds _____ minutes _____ unsure
- Was patient also smothered during strangulation? Yes No
- Was patient also shaken during strangulation? Yes No
- Was patient's hair pulled during strangulation? Yes No
- Was patient's head pounded against wall/floor/ground during strangulation? Yes No
- What was suspect's grip strength during strangulation?: (low) 1 2 3 4 5 6 7 8 9 10 (high)
- How was patient feeling during strangulation? (check all that apply)
 - Saw stars Saw blackness Dizzy Difficulty breathing
 - Difficulty talking Difficulty hearing Pressure in head Neck Pain
 - Lost consciousness Urine incontinence Bowel incontinence
 - Other: _____
- What did patient think was going to happen?
 - Going to die Other: _____
- What did suspect say to patient during strangulation? _____
- What made the suspect stop the strangulation?
 - Patient lost consciousness Person interrupted: _____ Police arrived
 - Doesn't remember Doesn't know Other: _____
- Was radiological testing completed? X- ray CT scan MRI Not done
- Other testing completed related to strangulation evaluation? No Yes: _____
- Symptoms described by patient or noted by examiner after strangulation: (check all that apply)
 - Difficulty breathing Hyperventilation Coughing Stridor
 - Hoarse voice Loss of voice Difficulty swallowing Painful swallowing
 - Neck pain Nauseated Vomited Dizzy
 - Headache Agitated Amnesia Hallucinations
 - Combativeness Other: _____

