Patient Label

Strangulation Kit

Note: This kit is intended to be used to collect strangulation evidence when no sexual assault has occurred. If strangulation occurred during a sexual assault, samples should be collected using a sexual assault forensic evidence (SAFE) kit.

Exam Date/Time: _____
Examiner: _____
Facility/Location: _____

Patient's Preferred Name: _____
Patient's Pronouns: _____

Date of Assault: _____ Time: _____ Hours Post Assault: _____
OSP Kit Collected: ☐ Yes: Kit # _____ ☐ No
Agency: _____ Case # _____

Mandatory Reporting:

Serious physical injury: ☐ No ☐ Yes *(Injury must be reported. Report of assault not mandated.)*
Injury from a deadly weapon: ☐ No ☐ Yes *(Injury must be reported. Report of assault not mandated.)*
Younger than 18 years of age: ☐ No ☐ Yes
65 years of age or older: ☐ No ☐ Yes
Disabled or mentally ill: ☐ No ☐ Yes

If any mandatory reporting box checked yes:
Agency reported to: _____
Report made by: _____
Date/time of report: _____

Advocate called: ☐ Yes ☐ No
Advocate present: ☐ Yes ☐ No
Interpreter used: ☐ Yes ☐ No

Others present during history: _____
Others present during exam: _____
Name: _____
Language: _____

I. SINCE THE TIME OF THE ASSAULT

Has the patient done any of the following since the assault?

Changed clothes: ☐ Yes ☐ No

If changed clothes, location and description of clothing:
_____
_____
_____

Bathed/showered: ☐ Yes ☐ No

When was the last bath/shower: _____
baths/showers since assault: _____

Patient Label

II. REPORT OF INCIDENT

This form is to be completed by ONE examiner.

Report is not an exhaustive account of every detail of the assault.
It is a brief description for the purposes of diagnosis and treatment.
Please recount the patient's own words in quotes when possible.
Do not include personal opinion or conjecture.
Include only information that directly relates to this assault
Ensure that the patient understands your questions and vocabulary.
Record patient's own terminology. Do NOT sanitize language.

(printed name and title of person completing form) (signature) (Date)

Patient Label

III. PERTINENT/RECENT HEALTH HISTORY

Does the patient have a prior health history that may affect physical findings or evidence collection? ☐ Yes ☐ No
(describe- e.g. vascular surgeries, clotting disorders etc.)

Has the patient ever been strangled before? ☐ Yes ☐ No
By Whom? _____
When? _____

Patient currently pregnant: ☐ Yes, # of weeks: _____ ☐ No ☐ Unknown

IV. INFORMATION PERTAINING TO ASSAULT

Location of assault: _____
House/apartment, automobile, outdoors, other, unknown: _____
Did patient consume drugs/alcohol prior to assault: ☐ Yes, type/when: _____ ☐ No
Did patient consume drugs/alcohol after the assault: ☐ Yes, type/when: _____ ☐ No

During assault, were there individuals under the 18 years of age present? ☐ Yes ☐ No ☐ Unknown
Name(s)/ages: _____
Relationship to the patient (if any): _____
Relationship to the assailant (if any): _____
Were the individual(s) physically injured during the assault? ☐ Yes ☐ No ☐ Unknown
Describe: _____
Mandatory report to DHS regarding safety of minor(s) involved/witness to assault: ☐ Yes ☐ No
Agency reported to: _____
Report made by: _____
Date/time of report: _____

V. ASSAILANT INFORMATION

Name: _____ ☐ Unknown
Description: _____
Relationship to patient: _____ Age: _____

Patient Label

VI. ACTS DESCRIBED BY THE PATIENT

During the assault did assailant(s):

Kiss, lick, spit, or make other oral contact: ☐ Yes ☐ No ☐ Unknown _____

Touch the patient in any other way: ☐ Yes ☐ No ☐ Unknown _____

Did the patient do anything during the assault that could have caused injury to the assailant(s)? e.g. scratches, punches, torn clothing, etc.

☐ Yes ☐ No ☐ Unknown _____

Describe:_____

_____

Weapons/force used?

Check all that apply per patient report/physical findings; describe the incident/body part involved.

☐ Strangulation/suffocation: See detailed strangulation report on next page	
☐ Verbal threats	
☐ Bites	
☐ Hitting	
☐ Gun	
☐ Knife	
☐ Blunt object	
☐ Other weapon	
☐ Restraints	
☐ Chemical(s)	
☐ Lifted off the ground	
☐ Other physical force	

Any injury to patient needs to be documented on bodygram and injury log.

Patient Label

VII. STRANGULATION/SUFFOCATION ASSESSMENT

Strangulation can cause permanent damage or death if not assessed properly and immediately.

Screen for the following and when reported symptoms began (check all that apply):

- ☐ Loss of consciousness: _____
- ☐ Involuntary urination/defecation: _____
- ☐ Difficulty/pain swallowing: _____
- ☐ Memory loss: _____
- ☐ Voice loss/changes: _____
- ☐ Coughing: _____
- ☐ Drooling: _____
- ☐ Persistent throat pain: _____
- ☐ Neck pain: _____
- ☐ Breathing difficulties: _____
- ☐ Nausea/vomiting: _____
- ☐ Headache: _____
- ☐ Vision Changes: _____
- ☐ Pain/tenderness: _____
- ☐ Swelling/edema of neck/throat: _____
- ☐ Combativeness/irritability/restlessness: _____
- ☐ Uncontrolled shaking: _____
- ☐ Hyperventilation: _____
- ☐ Dyspnea/apnea: _____
- ☐ Petechiae (scalp, eyelids, ears, oral cavity): _____
- ☐ Bruising: _____
- ☐ Crepitus: _____
- ☐ Abnormal carotid pulse: _____
- ☐ Lightheaded: _____
- ☐ Red eyes: ☐ Right ☐ Left _____
- ☐ Numbness/weakness: _____

Patient's description:

Estimated length of time strangulation occurred: _____

Number of times patient was strangled during assault: _____

Number of different methods used for strangulation during incident: _____

Method(s) of strangulation: _____

Description of strangulation event(s): _____

_____

What did the assailant say to the patient during strangulation? _____

_____

What did the patient think was going to happen? _____

_____

Why or how did the strangulation stop? _____

_____

From 1 to 10, how hard was the assailant's grip (circle number)? 1 2 3 4 5 6 7 8 9 10

How was the patient strangled? (check all that apply)

- ☐ One hand
- ☐ Right hand
- ☐ Left hand
- ☐ Two hands
- ☐ Right forearm
- ☐ Left forearm
- ☐ Knee
- ☐ Foot
- ☐ Ligature (describe): _____
- ☐ Uncertain

Was the patient shaken during strangulation? ☐ Yes, description: _____ ☐ No

Did the patient's head strike any surface? ☐ Yes, description: _____ ☐ No

Was the patient's breathing impaired at any time? ☐ Yes ☐ No

(describe)_____

How was breathing impaired? (check all that apply)

- ☐ Face (nose/mouth) covered (describe)_____
- ☐ Pressure applied to chest (describe)_____
- ☐ Pressure applied to face (describe)_____
- ☐ Uncertain

Patient Label

VIII. DRUG-FACILITATED ASSAULT ASSESSMENT

Consider collecting blood and urine for alcohol and drug testing as soon as possible if any boxes checked "Yes."

Patient appears impaired, intoxicated, or has altered mental status: ☐ Yes ☐ No

Patient reports blackout, memory lapse, or partial or total amnesia for event: ☐ Yes ☐ No

Patient or other is concerned that he or she may have been drugged: ☐ Yes ☐ No

Suspected substances: _____

XI. HEAD-TO-TOE EXAM

Affect assessment:

Describe objective behaviors you observe during exam (i.e. crying, laughing, wringing hands, pacing). Avoid subjective interpretations of patient's mood and behavior (i.e. angry, sad, flat, anxious).

_____

_____

_____

_____

_____

_____

_____

_____

Physical assessment:

Neck circumference obtained: Yes ☐ No ☐ Date/Time:_____Measurement:_____

	WNL	Describe (use diagrams for injuries) – if not assessed, note not assessed.
Head	☐	
Mouth	☐	
Neck/Shoulders	☐	
Chest/Breasts	☐	
Abdomen	☐	
Left arm	☐	
Right arm	☐	
Back	☐	
Left leg	☐	
Right leg	☐	

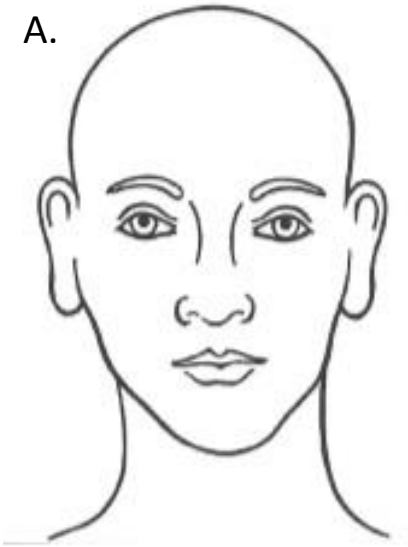
Patient Label

XI. HEAD-TO-TOE EXAM, cont. - BODYGRAM - HEAD AND NECK

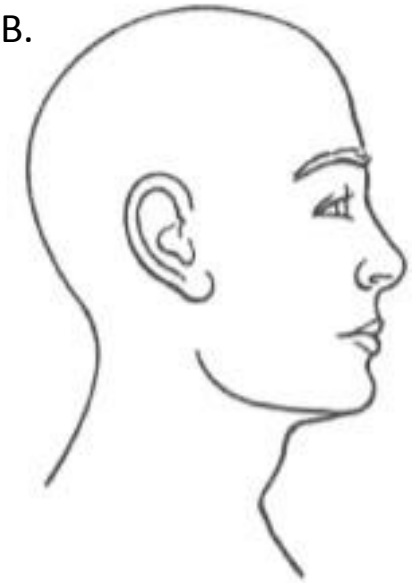
Note: Physical findings should be noted on the bodygram that allows for the best visual representation. Duplication across bodygrams is not recommended.

☐ No physical findings noted at this time

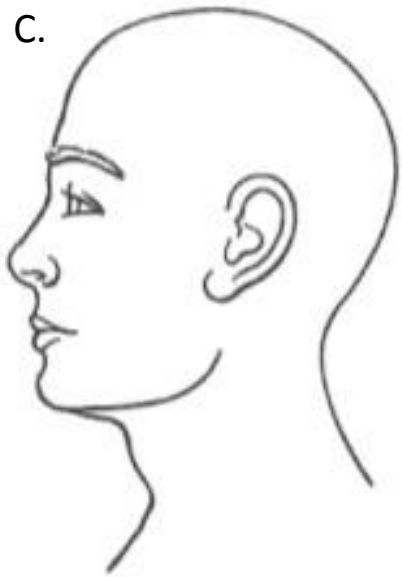
A.



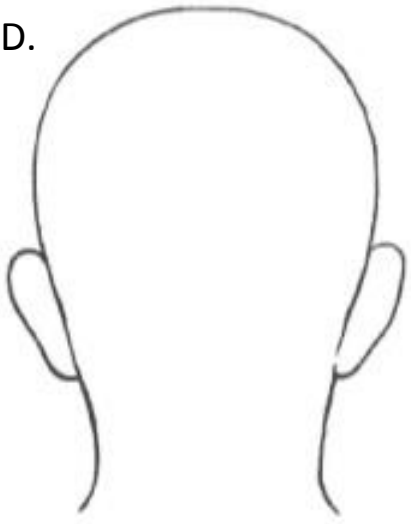
B.



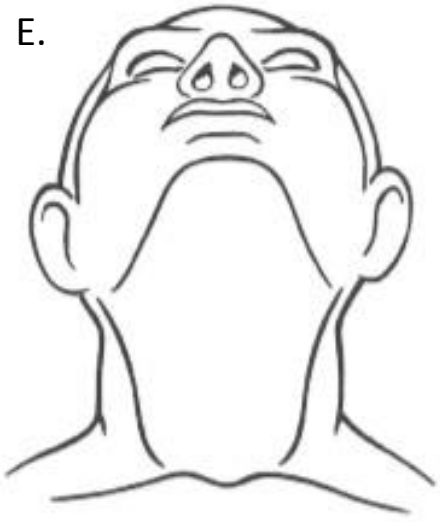
C.



D.



E.



F.

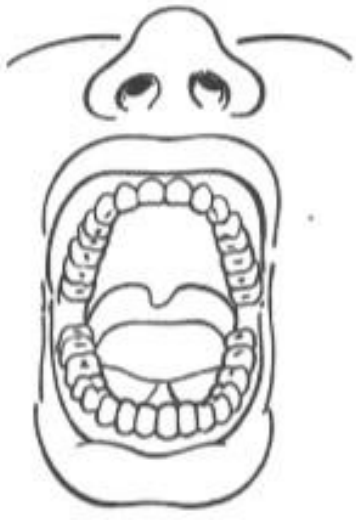


Diagram Key: A = Abrasion AL = Alternate light source fluorescence B = Bruising BI = Bite BU = Burn C = Cut CN = Contusion E = Ecchymosis FB = Foreign body/debris LA = Laceration PE = Petechiae R = Redness S = Swelling SHX = Sample per history SI = Suction injury T = Tear TE = Tenderness OI = Other injury PTA=Per patient- injury present prior to assault

Shade tender areas.

Patient Label

XI. HEAD-TO-TOE EXAM, cont. - BODYGRAM - FULL BODY

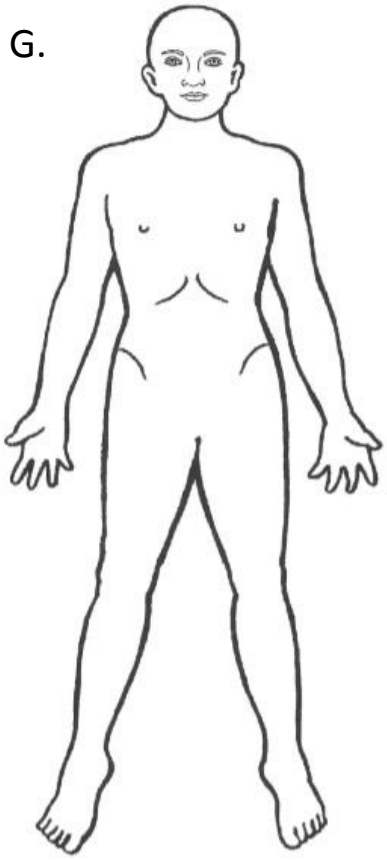
Note: Physical findings should be noted on the bodygram that allows for the best visual representation. Duplication across bodygrams is not recommended.

☐ No physical findings noted at this time

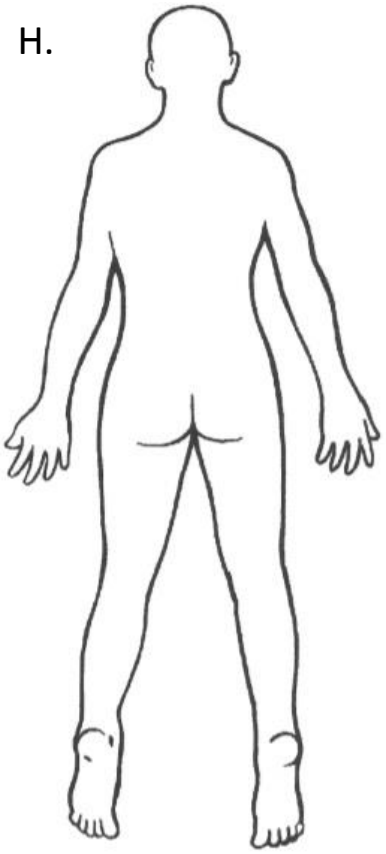
Diagram Key: A = Abrasion AL = Alternate light source fluorescence
B = Bruising BI = Bite BU = Burn
C = Cut CN = Contusion
E = Ecchymosis FB = Foreign body/debris LA = Laceration
PE = Petechiae R = Redness
S = Swelling SHX = Sample per history SI = Suction injury T = Tear
TE = Tenderness OI = Other injury
PTA= Per patient- injury present prior to assault

Shade tender areas.

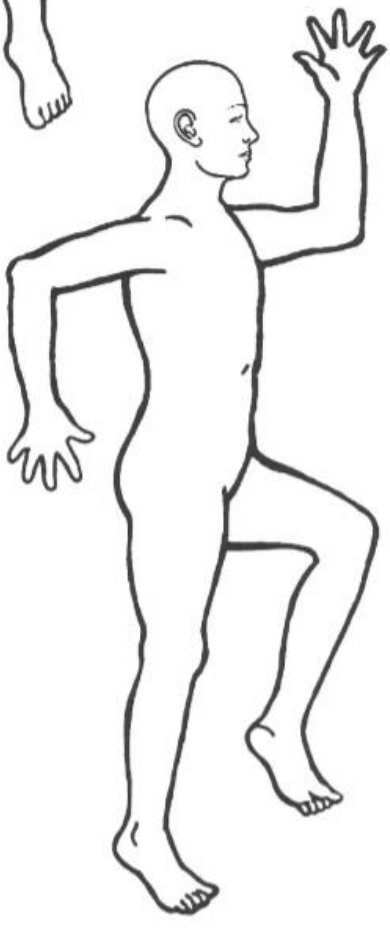
G.



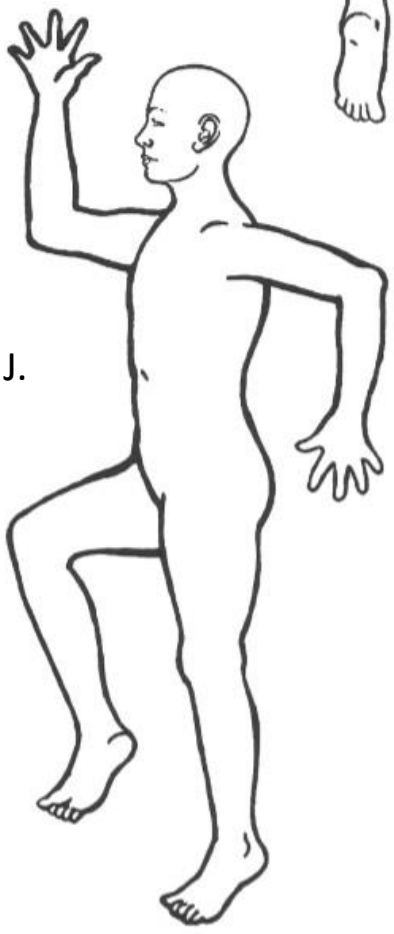
H.



I.



J.



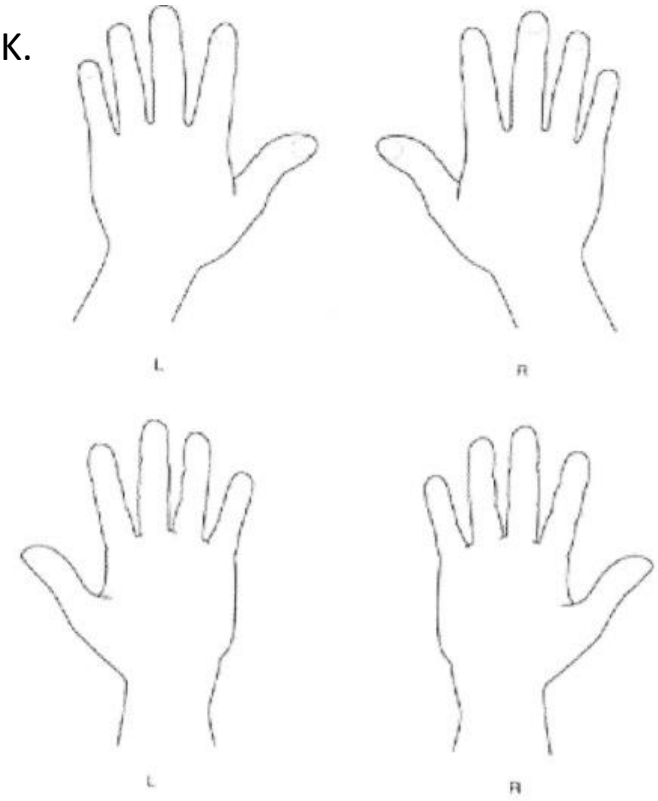
Patient Label

XI. HEAD-TO-TOE EXAM, cont. - BODYGRAM - HANDS AND FEET

Note: Physical findings should be noted on the bodygram that allows for the best visual representation. Duplication across bodygrams is not recommended.

☐ No physical findings noted at this time

K.



L.

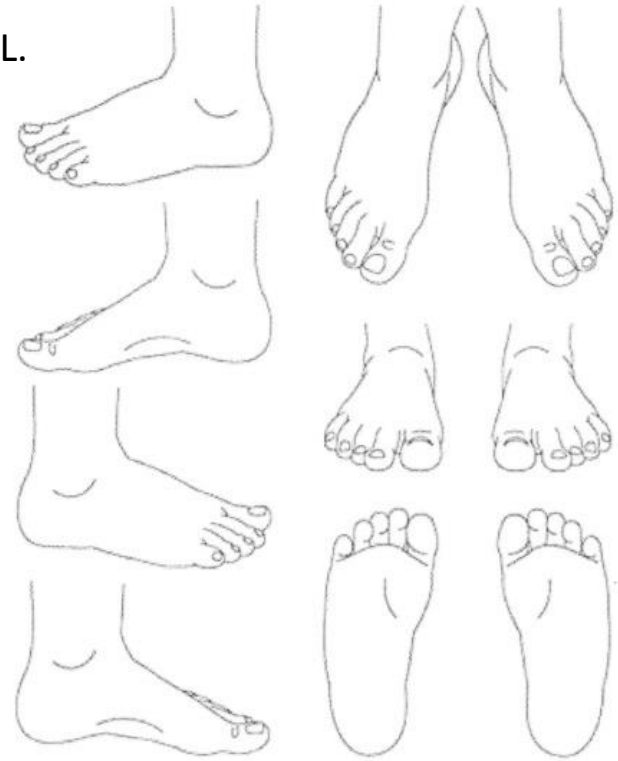


Diagram Key: A = Abrasion AL = Alternate light source fluorescence B = Bruising BI = Bite BU = Burn C = Cut CN = Contusion E = Ecchymosis FB = Foreign body/debris LA = Laceration PE = Petechiae R = Redness S = Swelling SHX = Sample per history SI = Suction injury T = Tear TE = Tenderness OI = Other injury PTA= Per patient- injury present prior to assault

Shade tender areas.

XI. INJURY LOG

Patient Label

Use injury log in conjunction with bodygrams to document type, size, shape, and color of injuries.

Injury Number	Diagram Letter	Key Code	Photo Y/N	Pain 0-10	Description

(Printed name and title of person completing form) (Signature) (Date)

Patient Label

II. EVIDENCE COLLECTION

A. Clothing (each item packaged in separate paper bag)
- ☐ Obtained: descriptions below

_____ _____
_____ _____
_____ _____
_____ _____

- ☐ Obtained by law enforcement: (agency)_____
- ☐ Not Obtained, reason: _____

B. Oral Swabs (4 swabs; always collect as these swabs may be used as a DNA standard)
- ☐ Obtained
- ☐ Not Obtained, reason: _____

C. Alternate Light Source, Blue Maxx if available (2 swabs per site, 1 damp followed by 1 dry)
- ☐ Exam Performed with Positive Fluorescence, swabs obtained from: _____
- ☐ Exam Performed with Negative Fluorescence, no swabs obtained
- ☐ Not Performed, reason: _____
- ☐ Not Applicable

D. Aggressive Handling: Strangulation, Physical Force, etc. (2 swabs per site, 1 damp followed by 1 dry)
- ☐ Obtained
  - Where: _____
  - Where: _____
  - Where: _____
  - Where: _____
- ☐ Not Obtained, reason: _____
- ☐ Not Applicable

E. Possible Saliva: Biting, Kissing, Licking, etc. (2 swabs per site, 1 damp followed by 1 dry)
- ☐ Obtained
  - Where: _____
  - Where: _____
  - Where: _____
  - Where: _____
- ☐ Not Obtained, reason: _____
- ☐ Not Applicable

F. Additional Evidence: Fingernail swabs (2 swabs per site, 1 damp followed by 1 dry)
- ☐ Obtained
  - Where/why: _____
  - Where/why: _____
  - Where/why: _____
  - Where/why: _____
- ☐ Not Obtained, reason: _____
- ☐ Not Applicable

Patient Label

EVIDENCE COLLECTION, cont.

G. Photographs
☐ Obtained by/with: (photographer/equipment) _____
☐ Not Obtained, reason: _____
Notes about photographs: _____

XIII. FOLLOW-UP AND REFERRALS

Follow-up checklist:
☐ Advanced practitioner/LIP notified
Patient directed to nearest emergency department for additional evaluation ☐ Yes ☐ No ☐ Declined ☐ N/A
Facility patient directed to:_____
Patient transported via: ☐ Ambulance ☐ Private vehicle ☐ Law enforcement ☐ Other:_____
☐ Patient provided discharge info with signs and symptoms upon which to seek emergency treatment

Referral packet given: ☐ Yes ☐ No
Advocacy/crisis intervention agency: ☐ Yes, agency: _____ ☐ No
Counseling/social worker: ☐ Yes ☐ No
Safety plan by: _____
Practitioner follow-up with: _____

XVI. POLICE DEPARTMENT RECEIPT OF EVIDENCE

This certifies that on _____ (date) at _____ (time), evidence was:
☐ hand delivered to law enforcement
☐ locked in evidence locker per facility protocol

_____	_____	_____
(printed name and title of receiving agency)	(signature of receiving agency)	Date
_____	_____	_____
(printed name and title examiner)	(signature of examiner)	Date

Please include a copy of pages 1 – 12 in strangulation kit envelope.