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 Others present during history: ________________________________
Advocate present: □ Yes □ No Others present during exam: ________________________________
Interpreter used: □ Yes □ No 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: ______________________
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.

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(printed name and title of person completing form) (signature) (Date)
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: ____________________________________________
VI. ACTS DESCRIBED BY THE PATIENT

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

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):

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

How was breathing impaired? (check all that apply)

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

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How was breathing impaired? (check all that apply)

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- Pressure applied to face (describe)
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: __________

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

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. 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
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- TE = Tenderness
- OI = Other injury
- PTA = Per patient- injury present prior to assault

Shade tender areas.
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

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**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

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

<table>
<thead>
<tr>
<th>Injury Number</th>
<th>Diagram Letter</th>
<th>Key Code</th>
<th>Photo Y/N</th>
<th>Pain 0-10</th>
<th>Description</th>
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(Printed name and title of person completing form) ____________________________ (Signature) ____________________________ (Date) ____________________________
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
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) ___________

______________________________
(printed name and title examiner) ________________________________ (signature of examiner) ___________

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