

ANNEXURE-B
MEDICO-LEGAL FORM: SEXUAL ASSAULT
ALL INDIA INSTITUTE OF MEDICAL SCIENCES, NEW DELHI

.....MLC No.....

Date and time of arrival to hospital.....

Name Age..... Sex.....

Address.....

Identification Marks 1.

2.

Brought by : Self / Police / Relative (Details).....

Name of Police Person.....PIS No.

Police Station

Marital Status : Married/Single/Divorced.....

Accompanied by:

Examined in Presence of / Nursing Staff (Female) (name and signature).....

CONSENT FORM

I..... (Name of person Giving Consent)
hereby give voluntary consent to

1. Examine and Treat.....(Name of Victim)/Myself/
My...../Relationship..... For the effects of sexual assault.
2. Be examined by a male gynaecologist
5. Conduct a medico legal investigation for the purpose of assisting the police in apprehending and/or prosecuting the persons who committed the assault. This investigation will include physical examination which may involve an examination of the mouth, breasts, vagina, anus, rectum, in addition it may include the removal and isolation of articles of clothing, scalp hairs, foreign substances from the body surface, saliva, pubic hair, samples taken from the vagina, anus, rectum and the collection of blood and urine specimen.
4. Inform the police the history as recorded and the findings of the examination and provide them with any substances collected during the course of medical investigation and/or any information and observations that might assist them in apprehending and/or prosecuting the person(s) who committed the assault.

I give my consent to the above fully and freely. I also understand that I was given the right to refuse either a medico-legal investigation or information to be given to the police or both, and was told that my refusal will in no way result in denial of treatment for the effects of the assault.

I also understand that I am free to revoke all or any part of this consent at any time during the examination. The consent of above is explained to me in the language which I understand and hence I sign./ affix my thumb:

Name and Signature of Witness

(Relation, Police, Hospital Staff):

.....

Name and Signature of Victim:

.....

Name and Signature of Guardian

.....

or

Relative of Victim (*Less than 12 years Age/Mentally Unsound*).....

Date, Place and Time

सहमति प्रपत्र

मैं (सहमति देने वाले व्यक्ति का नाम) एतद्वारा निम्नलिखित हेतु
स्वैच्छिक सहमति देता/देती हूँ -

1. सुश्री..... (पीड़ित का नाम)
स्वयं/मेरी.....(संबंध के यौन दुष्कर्म के प्रभावों की जांच तथा उपचार करने संबंधी।
2. एक पुरुष स्त्रीरोग चिकित्सक द्वारा जांच कराए जाने हेतु
3. दुष्कर्म करने वाले के उद्देश्य से चिकित्सा विधिक जांच-पड़ताल करने संबंधी। इस जांच में शारीरिक परीक्षण सम्मिलित है जिसमें मुंह, योनि, गुदा, मल द्वार का परीक्षण हो सकता है, इसके साथ-साथ इसमें वस्त्रों का हटाना व अलग करना, बाल उतारना, शरीर की त्वचा के ऊपर से बाहरी तत्व हटाना, लार, योनि के बाल हटाना, योनि, गुदा, मल द्वार से नमूने लेना तथा रक्त एवं मूत्र के नमूने संग्रहित करना भी सम्मिलित हैं
4. रिकॉर्ड किए गए घटनाक्रम एवं जांच के परिणामों के बारे में पुलिस को सूचित करना उनको चिकित्साक्रम एवं जांच के परिणामों के बारे में पुलिस को उपलब्ध करना जोकि दुष्कर्म करने वाले व्यक्ति/यों को पकड़ने और/ अथवा उन पर मुकदमा चलाने में पुलिस की सहायता कर सके।

मैं उपर्युक्त कार्यों हेतु स्वेच्छा से एवं पूर्ण रूप से अपनी सहमति देता/देती हूँ। मैं यह भी समझता/समझती हूँ कि मुझे चिकित्सा विधिक जांच में मना करने अथवा पुलिस को सूचना देने से मना करने अथवा दोनों के लिये मना करने का अधिकार दिया गया था और मुझे यह भी बताया गया था कि मेरे इन्कार करने के कारण दुष्कर्म के प्रभावों हेतु उपचार से बिल्कुल भी इन्कार नहीं किया जाएगा।

मैं यह भी समझता/समझती हूँ कि परीक्षण के दौरान किसी भी समय मैं इस सहमति को पूरा अथवा इसके किसी भाग को रद्द करने हेतु स्वतंत्र हूँ। उपर्युक्त की सहमति के बारे में मुझे मेरी समझ में आने वाली भाषा में समझा दिया गया है और इसलिये मैं हस्ताक्षर करता/करती हूँ/ अपना अंगूठा लगाता/लगाती हूँ।

पीड़िता का नाम व हस्ताक्षर :.....

गवाह का नाम व हस्ताक्षर :.....
(संबंधी, पुलिस, अस्पताल स्टाफ)

पीड़िता के अभिभावक अथवा संबंधी का नाम :.....
(12 वर्ष से नीचे/मानसिक रूप से अस्वस्थ)

तारीख, स्थान तथा समय :.....

MEDICAL HISTORY

Relevant medical/surgical history.....

Past history of abuse/allergy/medication.....

Menstrual History:

Menarche.....Menstrual Cycle.....LMP.....

Obstetric History:- G P A L

Contraception:- Yes/No.....Method used.....

Any sexual Intercourse within one week prior to assault? (Yes/No/Don't Know)

Any Vagina/Anal/Oral bleeding or discharge prior to assault?

SEXUAL ASSAULT HISTORY

(Narration of incident in survivors own words. In case narrator is some other person-details of the same)

Location of Assault.....

Date and Time of Assault.....

Number of Persons Involved and Names.....

.....(signature/thumb impression)

Whether Assailant Known or Unknown.....

If Known, relationship with survivor.....

Verbal Threats (Yes/ No).....

Body Areas Touched.....

Physical Violence (Yes/ No).....

Weapons or Objects Used (or threatened with).....

1. Injuries inflicted on the Body of Assailant (Yes/No).....If Yes

Details.....

Details regarding penetration (by penis, fingers or other objects)- Yes or No

Orifice	Attempted Penetration				Completed Penetration			Emission of semen		
	By Penis	By finger	By Object	Do not know	By Penis	By finger	By Object	Yes	No	Do Not know
Vagina										
Anus										
Mouth										

Other details:

	Yes	No	Don't Know
Oral Sex Performed			
Masturbation of Victim by assailant			
Masturbation of Assailant by Victim			
Did Ejaculation occur outside body orifice			
Location of Ejaculation			
Kissing, Licking or sucking of breasts or Other body parts ?			

Use of condom (Yes / No / Don't Know).....

if Yes (Status of condom).....

Use of Lubricant (Yes/No/ Don't Know).....

Penetration by object (Describe Object).....

Menstruation at the time of assault (Yes/No).....

Menstruation at the time of examination (Yes/No).....

Activity of Victim between assault and Examination

	Yes	No	Don't Know
Bathe			
Douche			
Void Urine			
Defecate			
Use Spermicide			
Any Vagina/Anal/Oral bleeding or discharge after assault?			

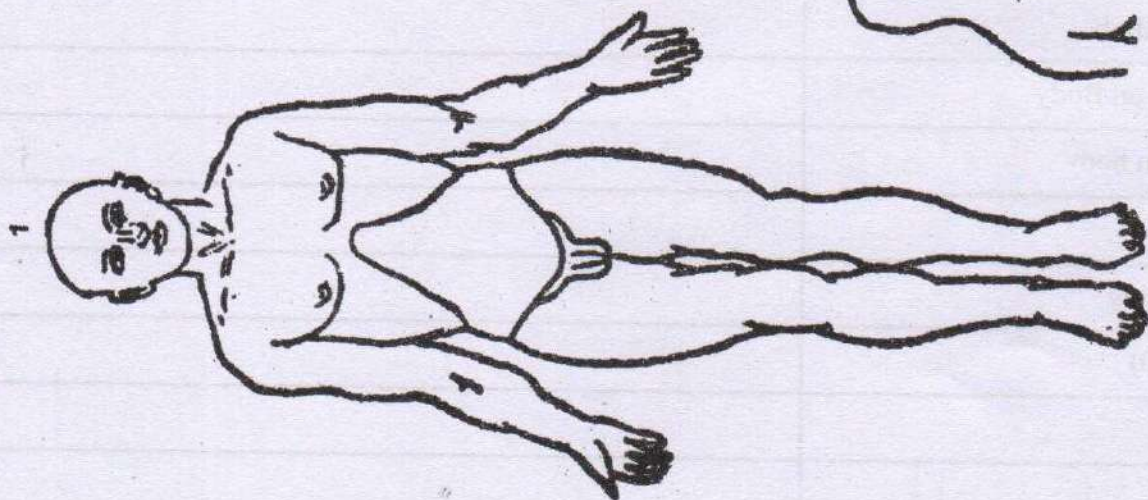
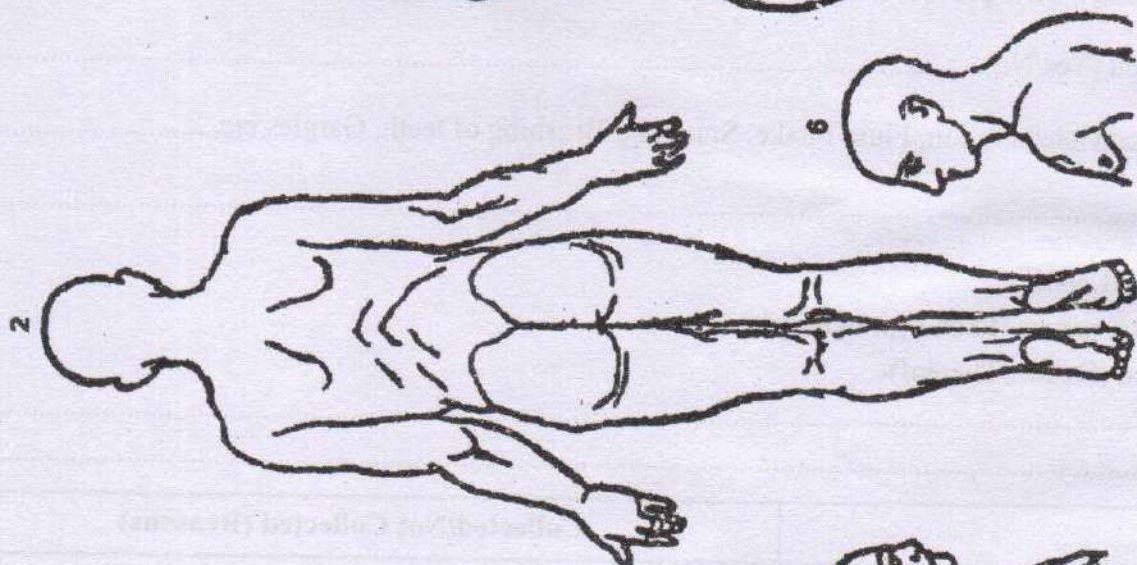
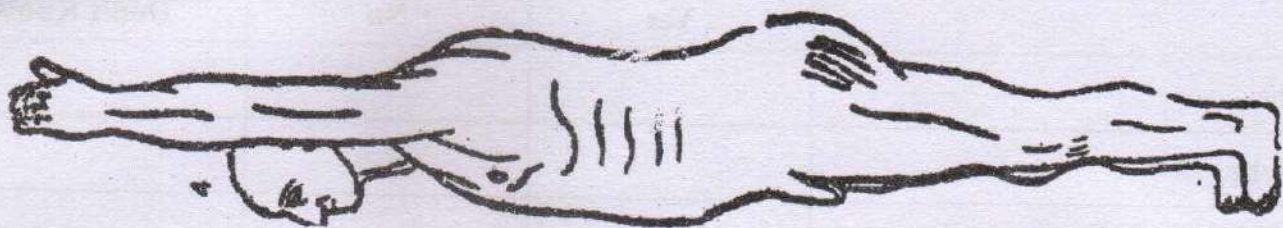
1. Whether clothing's Changed (Yes/No)
2. Clothes Washed (Yes/No).....
3. History of Food Consumption, Fluid Intake, Smoking, Brushing of teeth, Gargles etc.....

FORENSIC EVIDENCE

Debris Collected on papers (to be kept in envelope)

Clothing Preserved (Details Thereof)-

Body Evidence	Collected/Not Collected (Reasons)
Oral Swab	
Blood Stains on Body	
Foreign Material on Body	
Seminal Stains on body	
Other Stains	
Head Hair Combing	
Scalp Hairs (5-10)	
Nail Scrapings	
Nail Clipping	



Blood for Grouping/Drug Estimation (Plain Vacutainer)	
Blood for Drug Estimation (Plain Vacutainer)	
Blood for Alcohol (NaF Vacutainer)	
Blood for DNA-FP (EDTA Vacutainer)	
1. Blood sample for VDRL & HIV-3ml. (HIV lab) 2. Blood samples for HBV & HCV: 2ml. (virology lab) (NOT TO BE SENT TO FSL)	

Genital and Anal Evidence (Use distil water if necessary)

Genital and Anal Evidence	Collected/Not Collected (Reasons)
Matted Pubic Hair	
Combing of Pubic hair (Shaved/Unshaved)	
Cutting of Pubic hairs (5-10)	
Vulval Swabs (1) & vulval smear	
Vaginal Swabs (1) & vaginal smear	
Anal Swab (2)	
Outer(1)	
Inner(1)	
Vaginal Smear (Sperm Detection)	
Urine sample for drug/specimen	

GENERAL EXAMINATION

General Mental status.....

Physical Examination.....

Gait.....

Scalp Examination.....

Facial/Orbital injuries/Tenderness.....

Petechial Haemorrhages in eyes.....

Lips/Gums/Buccal Mucosa.....

Ears.....

Neck, Shoulder, Breasts.....

Arms, Forearms and Wrists.....

Thighs and Buttocks.....

Any other Finding.....

GENITAL EXAMINATION (please mark the diagram on the obverse side)

1. State of sphincters.....
2. Labia Majora.....
3. Labia Minora.....
4. Fourchette and Introitus.....
5. External Urethral Meatus.....
6. Hymen (only if relevant).....
7. Anus and Rectum.....
8. Findings of speculum Examination.....
9. Any other Finding.....

SPECIMENS PRESEVED FOR

1. Sexually Transmitted Diseases (STD's) (Gonorrhoea, chlamydia, syphilis, HIV, Hepatitis B)
2. Pregnancy (In case UPT can be conducted, Write results here; in that case no need to preserve sample)

PROPHYLACTIC TREATMENT GIVEN FOR

1. STD'S :
2. POST COITAL CONTRACEPTION:
3. TETANUS OR ANY OTHER:

REFERRAL SOUGHT FROM

- 1.
- 2.

Signature of examining doctor/doctors:

- 1.
- 2.
- 3.

AGE ESTIMATION FORMAT

(To Be Done by Forensic Resident on call)

General Physical Examination

(Breasts, Axillary and Pubic hairs)

Dental Examination

Right

Left

S	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8	S
S	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8	S

Total Teeth-

Temporary

Permanent

Radiological Examination

1. X rays advised

2. Observations

OPINION REGARDING AGE

After considering the findings of physical, dental and radiological examination, I am of the opinion that bone age of Is.....
Years,

Who will sign this age form

Date

Time

Place

Signature of Doctor

Name of Doctor with Designation

ALL INDIA INSTITUTE OF MEDICAL SCIENCES, NEW DELHI
REQUEST FORM FOR FORENSIC SCIENCE LABORATORY

Dated:

To,
The Director
Forensic Science Laboratory

.....
.....
Sub: Request for laboratory examination of material evidence collected

Sr/Madam,

Submitted herewith material evidence collected from.....

Age.....Sex.....MLC No.....

Dated.....

Police Station.....

Please examine the following sealed contents and opine on

- 1.....for evidence orY/N
- 2.....for evidence of
- 3.....for evidence of
- 4.....for evidence of
- 5.....for evidence of
- 6.....for evidence of
- 7.....for evidence of
- 8.....for evidence of
- 9.....for evidence of
- 10.....for evidence of

Yours Sincerely

Name and Signature of Doctor with Seal

Intact, Sealed and labelled samples along with sample of seal received by
Signature, Name and Designation of Police Officer with Belt No.

Police Station

Date

ALL INDIA INSTITUTE OF MEDICAL SCIENCES, NEW DELHI
REQUEST FORM FOR MICROBIOLOGY/ LABORATORY MEDICINE

Dated :

To,
The Professor & Head
Department of

.....
.....
Sub: Request for laboratory examination of material evidence collected
Sir/Madam,

Submitted herewith material evidence collected from.....

Age.....Sex.....MLC No.....

Dated.....Case FIR No.....U/S.....

Police Station.....

Please examine the following sealed contents and opine on

1.....for evidence of

2.....for evidence of

3.....for evidence of

4.....for evidence of

5.....for evidence of

Yours Sincerely

Name and Signature of Doctor with Seal

(In case Samples are to be submitted to Lab outside AIIMS, hand it over to Police)

Intact, Sealed and labelled samples along with sample of seal received by

Signature, Name and Designation of Police Officer with Belt No.

Police Station

Date