INSTRUCTIONS
DoD SEXUAL ASSAULT EVIDENCE COLLECTION KIT AND DD FORM 2911

FOR MEDICAL PERSONNEL
BEFORE YOU BEGIN

Purpose of this Kit

- This kit is designed to assist the healthcare provider in the collection of evidentiary specimens for analysis by a crime laboratory. The military treatment facility (MTF) is not requested or encouraged to analyze any of the specimens/evidence collected in this kit. Any specimens required by the MTF are to be collected with MTF supplies.

Sexual Assault is not a Medical Diagnosis

- You are not requested or encouraged to analyze any of the specimens/evidence collected in this kit. While sexual assault is a medico-legal concern, whether or not such a crime occurred is a matter for the court to decide. The healthcare provider should not express conclusions, opinions of diagnosis to the patient or others, nor should any such opinions be written in the record.

Separate Instructions for SUSPECT and Label Markings

- If this kit is being used for evidentiary specimen collection from a SUSPECT, follow the SUSPECT instructions provided in the kit.
- When using this kit for a VICTIM, cross out “SUSPECT” on all labels.
- Many kit items have labels to fill out. Ensure that each item is labeled completely. If no sample was collected using a kit item, check “no” on the label and indicate the reason. Return all items to the kit, whether used or not.

Sexual Assault Is an Emergency:

- Sexual assault patients shall be given **priority as emergency cases.** Individuals disclosing a recent sexual assault shall be quickly transported to the exam site, promptly evaluated, treated for serious injuries, and undergo a sexual assault forensic examination, should they so elect.
- Sexual assault patients shall be given priority, regardless of whether physical injuries are evident. Patients’ needs shall be assessed for immediate medical or mental health intervention. When severely traumatized, sexual assault patients may display any of a variety of emotions. They may be calm, indifferent, submissive, jocular, angry, emotionally distraught, or even uncooperative or hostile towards those who are trying to help.

When to Conduct a Sexual Assault Forensic Examination:

- Perform a SAFE up to one full week following the reported sexual assault. When indicated, SAFEs may be performed at even longer post-assault intervals.

Required Use of DD Form 2911:

- The Department of Defense requires that every healthcare provider who conducts a sexual assault medical forensic examination in a MTF must use a standard form to record findings. Although this form is completed as part of a medical forensic examination, the form is primarily intended to document forensic findings, and as such, is not a complete medical treatment record.
- Complete this report in its entirety. Use N/A (not applicable) when appropriate to indicate that an item was read but not inadvertently skipped.
- Numbered paragraphs in these instructions correspond to the numbered blocks within the lettered sections on DD Form 2911.

Other Documentation:

- When electronic medical charting is being used, a patient encounter should be created in the Armed Forces Health Longitudinal Technology Application (AHLTA), documenting the additional medical examinations (if any), treatments, labs and prescriptions provided.
- When no electronic medical charting is being used, create a patient encounter using a Standard Form 600, *Chronological Record of Medical Care*, or other such form used by your MTF to document patient care. Document the additional medical examinations (if any), treatments, labs and prescriptions provided.
- **The original, completed DD Form 2911 should be kept with the Sexual Assault Forensic Examination kit, in the storage compartment on the exterior of the box**. Should the kit be sent to the laboratory for analysis, a copy of the DD Form 2911 must accompany the kit. DD Form 2911 is retained for a period of 50 years.

Planning for Obtaining Toxicology Specimens

- Toxicology: At the outset of the examination, determine the requirement for toxicology specimens (blood and urine) and plan a time for them to be taken, ***Wcbg]XYf]b['UdUh]YbhD'g'bYYX'hc'i f]bUhY"*** See Part II of the DD Form 2911, Sexual Assault Medical Forensic Examination Report, for toxicology instructions.
  - o If the patient cannot wait until after the examination to urinate, then instruct the patient to capture a urine specimen, but keep and turn over any tissue used for wiping their genital area. Provide the patient with a paper bag for these tissues.
  - o Instruct the patient that they should not wash or clean himself/herself until after the SAFE can be completed.

FORM INSTRUCTIONS FOR VICTIM:

<u>STEP 1: OBTAINING GENERAL INFORMATION AND PATIENT CONSENT</u> (DD Form 2911, Part 1, Sections A-D)
Fill Out Patient identification Block at the Top of Each Page of DD Form 2911:

- **For Unrestricted Reports**: Enter the patient's full name in the block.
- **For Restricted Reports**: Enter only the Restricted Report Control Number (RRCN) provided by the Sexual Assault Response Coordinator or the Victim Advocate.

DD FORM 2911, SECTION A. GENERAL INFORMATION: Print or type the name of the facility where the examination was conducted.

1. Name of Patient and Patient ID Number.
   - **For Unrestricted Reports**: Enter the patient's full name and Patient ID Number (if available) in the appropriate blocks.
   - **For Restricted Reports**: Enter only the Restricted Report Control Number (RRCN) in the Patient ID Number block. Write "N/A" in the Name of Patient block.
2. Address.
   - **For Unrestricted Reports**: Enter the patient's address and telephone number **only if required by requesting agency.** This information is confidential and every effort must be made to protect the privacy of the patient.
   - **For Restricted Reports:** Leave Blank.
3. Demographics. Enter the patient's age, date of birth, gender, race and ethnicity.
4. Arrival Date. Enter the date / time of arrival to facility.
5. Discharge Date. Enter the date / time of discharge from facility.

DD FORM 2911, SECTION B. NOTIFICATION AND AUTHORIZATION. Indicate the location and jurisdiction where the incident(s) occurred. Check "On Installation" if the patient reports that the incident occurred within the boundaries of a military installation, ship or aircraft. Check "Off Installation" if the patient reports the incident occurred outside the boundaries of a military installation. When another agency is participating in the investigation of an Unrestricted Report, check the box indicating who has jurisdiction and whether it is a US civilian agency or foreign agency. Enter the name of the agency in the area provided.

1. Enter the name and telephone number of the servicing Sexual Assault Response Coordinator (SARC).
2. Enter the name, rank, title and telephone number of the sexual assault forensic examiner (the healthcare provider conducting this examination).
3. Enter the name and telephone number of the Victim Advocate (VA) assigned to the patient.
4. **For Unrestricted Reports**: Enter the name, telephone, agency and identification number (e.g. badge or employee number, if available) of the investigator from the Military Criminal Investigative Organization (MCIO) (e.g., Army CID, NCIS, AFOSI). The completed kit and documentation should be turned over to one of these agencies. Indicate if the victim declines sections of the forensic exam. **For Restricted Reports:** Place "N/A" in the blanks.
5. **For Unrestricted Reports:** Place "N/A" in the blanks.
   For Restricted Reports: Enter the name, telephone, agency and identification number of the Service-designated evidence collecting officer. This person will be responsible for taking control of the completed kit and documentation and storing them. This authority varies by Service; check your Service's policy for the procedures to follow. Also enter the Restricted Report Control Number (RRCN, which is obtained from the VA or SARC) for patient identification.

DD FORM 2911, SECTION C. REPORTING INFORMATION

1. Ask the patient (or the patient's parent or guardian, if appropriate) to read and initial the information regarding Restricted and Unrestricted Reporting on the DD Form 2911 and initial the block on the form.
2. In the event that a victim wishes to speak to an SVC/VLC before electing a reporting option, the SARC will facilitate contact with the SVC/VLC. The victim will be asked whether s/he would like to proceed with the SAFE and then speak to the SVC/VLC, or whether they would rather wait to speak to the SVC/VLC before starting the SAFE.
3. Ask the patient to check the box designating their choice of Restricted or Unrestricted Reporting and initial the block on the form. NOTE: Military dependents under age 18 who have been sexually assaulted by either parent and/or caregiver are not covered under the sexual assault restricted reporting policy.

DD FORM 2911, SECTION D. PATIENT CONSENT. Ask the patient (or patient's parent or guardian, if appropriate) to read, select and initial each consent section. Upon completion, the patient (or patient's parent or guardian) will sign. A witness signature is required.

STEP 2: PATIENT'S MEDICAL HISTORY AND ASSAULT INFORMATION (DD Form 2911, Part 1, Sections E - H)

DD FORM 2911, SECTION E. PATIENT HISTORY

1. NAME OF PERSON PROVIDING HISTORY. Record the name of the person providing the patient history and the relationship to the patient, date and time. When patients provide their own history enter "self" in box b.

> **NOTE:** The following sections ask for very personal information that may be embarrassing to discuss. Before asking for the information, talk with the patient about the sensitive nature of the questions about to be asked, the necessity for the information as part of the examination, and that all data gathered will be handled with the greatest of care and professionalism.

2. PERTINENT MEDICAL HISTORY.

a) Record the date of the last menstrual period. This information is used to determine whether the patient was menstruating at the time of the examination and to evaluate the potential for pregnancy and preventive options.

b) Obtain recent (past 60 days) information on any anal-genital injuries, surgeries, diagnostic procedures or medical treatment that may affect the interpretation of current physical findings. This information is requested to avoid confusing pre-existing lesions with injuries or findings related to the assault. Consider photographing items that might be misinterpreted as injuries associated with the sexual assault.

c) Describe any chronic, hereditary or other medical conditions that may affect the interpretation of current physical findings.

d) Ask the patient to describe all pre-existing physical injuries, scratches or marks that may have occurred more than 60 days ago. Ensure that you account for each item the patient describes in your forthcoming physical examination. Photograph items that might be misinterpreted as injuries associated with the sexual assault.

3. PERTINENT NON-ASSAULT HISTORY. Block (a)**:** Ask if patient had any non-assault sexual activity within the past five days. If patient says yes or is unsure, complete the questions in blocks (b) through (f). If patient says no, then check "no" in block (a) and move to Section 4, Post-assault Hygiene/Activity.

- Ask whether the patient has had (b) anal or (c) vaginal intercourse within the last five days that was not related to the assault.
- Ask whether the patient has had (d) oral-genital contact within the past five days not related to the assault.
- If yes to any of the questions, ask whether (e) ejaculation occurred, where it contacted the patient's body, and if a (f) condom was used.
- This information is used by the crime lab to properly interpret findings.
- **Do NOT record any other information regarding sexual history on this form** (e.g. prior sexual assaults, number of sexual partners, etc.)**.**

4. POST-ASSAULT HYGIENE ACTIVITY. Record post-assault hygiene activity that occurred within 5 days of the examination, as it can affect the interpretation of findings.

- Ask if patient urinated, defecated, removed/inserted any objects, gargled, brushed teeth, bathed/showered, vomited, ate/drank or used any creams/ointments.
- Ask the patient if a douche, tissues, wipes, clothing or anything else was used to cleanse any part of the body after the assault.
- Ask if patient changed clothing or body piercings.
- If possible, collect these items (douche, tissues, wipes, clothing or anything else that was used to cleanse any part of the body). Air dry, package in paper bags or envelopes, label and seal. Do not place biological specimens in plastic bags or containers. In Unrestricted Reports, if these items are not available from the patient, notify MCIO, as they may be able to collect them.
- The examiner should collect samples regardless of whether the patient has bathed, showered, douched or engaged in other post-assault hygiene activities.

DD FORM 2911, SECTION F. ASSAULT HISTORY

1. Enter date and time of the assault. If the assault took place over an extended period of time, ask the patient the order in which each of the injuries occurred.

2. Describe pertinent physical surroundings that may have come in contact with the patient.
   - During the examination look for pattern injuries associated with the physical surroundings and/or for trace evidence (e.g., grass, sand, pavement) that may have been transferred from the scene to the patient.

3. **PHYSICAL EFFECTS OF THE ASSAULT.** If any of the boxes are marked “yes,” use the space provided to describe.
   - Injury, pain and bleeding complaints should prompt the examiner to look for injury and evidence not readily visible.
   - Obtaining information about loss of memory, lapse of consciousness, vomiting, and involuntary ingestion may assist the examiner in determining whether drugs or alcohol were used to subdue or incapacitate the patient. Collect the toxicology portion of the kit as soon as possible.
   - Take photographs of areas with complaint of pain/tenderness. If such resources are available, request ultraviolet photography to document bruises and bite marks that may have recently occurred, but are no longer visible on the skin.
4. **INJURIES INFLICTED UPON THE ASSAILANT(S) DURING THE ASSAULT**
   - Complete this section by checking “yes” or “no” in the appropriate box. If yes is checked, describe the injuries to the perpetrator, possible locations on his/her body, and how they were inflicted.
5. **NUMBER OF ASSAILANT(s)**
   a) Annotate the number of assailant(s) and relationship to the patient.
   b) If there was more than one assailant, then indicate their relationship to patient by noting the appropriate number in the boxes provided. For example, if there were four assailants, and one was an acquaintance and three were strangers, place a “1” in the acquaintance box and a “3” in the stranger box.

DD FORM 2911, SECTION G. PATIENT’S DESCRIPTION OF THE ASSAULT. Ask the patient or other person providing the history of the assault to describe the incident(s) to the extent possible. Add additional pages if necessary. This information is helpful to guide the forensic examination and to better interpret crime laboratory findings.

NOTES ON HISTORY TAKING:

- At first, it’s best to allow the patient to freely recall the events without interruption. Use questions such as "Then what happened?” or “I’m not sure I understand, can you repeat that for me?” to prompt for additional information.
- Listen to the patient’s account, identify terms that he or she uses, and then use those terms in your narrative of the patient’s description of the assault. For example, if the patient uses particular words for body parts or sexual acts, use those terms. Do not “clean up” or eliminate “offensive” language used by the patient.
- After the patient recalls the incident, follow-up questions may be necessary. Open ended questions that start with Who, What, Where, and How are best. Avoid asking questions that start with “why,” as the patient may not always know the reason for an assailant’s motives or behaviors.
- Another technique for asking follow up questions is called “cueing.” Cue the patient’s memory with something that he or she said before, and then ask for additional information. For example, “You said that he held you down, would you please describe what parts of his body he used to accomplish that?”
- Avoid asking questions that call for a “yes” or “no” answer. Instead, start your questions with Who, What, Where, and How. The goal is to have the narrative be in the patient’s words and tone, not to be summarized by the examiner—this adds to the patient’s credibility.
- When the patient describes acts during the history that may have left marks or evidence on his or her body, ensure that you closely examine and document findings (or their absence) in these areas.
- The examiner must understand that some patients may be reluctant to describe all acts committed, particularly those acts the patient finds embarrassing or contrary to personal beliefs about appropriate sexual conduct, e.g. oral or anal penetration. After the patient provides an initial account of the incident, acknowledging this embarrassment may be helpful and yield additional information. You might say, “Sometimes perpetrators force people to do things during an assault that are very embarrassing or humiliating. These acts may be particularly hard to talk about because they go against our beliefs or we're concerned that people will think worse of us for this having happened. However, I want you to know that it's very important for you to tell us as much as you possibly can about the incident. Your doing this improves our chances of discovering evidence. Is there anything that the perpetrator did that you haven’t talked about yet?” Note responses in the narrative of Section G.
- NOTE: When the patient knows the identity of the suspect(s), you should put that information in the history. When the patient does not know his or her attacker(s), it may help to identify each by a letter to remain consistent in documenting the incident.
- While details of the crime are important, a patient’s reaction to trauma may prevent full or immediate recall of the incident. For Unrestricted Reports, inform the patient that should additional information be recalled following the examination, he or she should contact the criminal investigators as soon as possible.

DD FORM 2911, SECTION H. ACTS DESCRIBED BY THE PATIENT. Once you have obtained the history from the patient in Section G, use this section to identify all acts the patient described. Document any contact and/or penetration of the mouth, genitals or anus, no matter how slight or brief. **Identify and distinguish acts performed by multiple assailants using the numbering system started in the history obtained in Section G.**

- Mark the appropriate box for "no," "yes," "attempted" or "unsure."
- Mark "attempted" if the patient's statement indicates that the act was attempted:
  - But thwarted by the patient or an intervening occurrence, or
  - The offender was unable to accomplish the act for any reason.
  - If "attempted" or "unsure" is checked, provide a description in the adjacent space.
- If more than one assailant was involved, identify each one by number in the description section. You may also choose to place the assailant's letter in the appropriate box(es), indicating their behavior during the incident.
- If an object was used, describe it.

NOTES ON INJURIES AND OTHER EVIDENCE:

- **Strangulation.** The patient may refer to the act of "strangulation" as "choking." Ask the patient about the act by using both terms, but document the patient's word choice and what the perpetrator used to accomplish the act (hands, arm, ligature, etc.) in the description box.
- **Suction Injury**. The term "suction injury" refers to what is commonly called a "hickey."
- **Bite Marks**. If the patient indicates that he/she was bitten, bite marks should be swabbed for saliva, measured, and photographed with and without a scale. Whenever possible, use an "ABFO Ruler Number 2" as a scale (See Figure 1), which allows for accurate photographic reproduction. Investigators may have one of these rulers. Bite marks can provide very specific evidence and require immediate preservation. If possible, consider calling in an experienced provider from the MTF dental clinic or a forensic odontologist to help document bite marks.

Figure 1 - American Board of Forensic Odontologists (ABFO) Ruler No. 2

- **Ejaculation.** If ejaculation occurred, note where. Include body parts, clothing, bedding and any other surface(s). If more than one assailant ejaculated, identify each one by number. Also ask the patient if and where the suspect's saliva, blood or other biological material may have made contact with the patient's body. Be sure to follow up with an examination of those areas for recovery of evidence.
- **Contraceptive or lubricant products used** – ask patient if any contraceptive, such as a condom, or a lubricant was used. In Unrestricted Reports, these items, including wrappers and containers, should be collected by MCIO if possible.

STEP 3: GENERAL PHYSICAL EXAMINATION, FOREIGN MATERIAL AND CLOTHING COLLECTION (DD Form 2911, Sections I - J). Record all findings using diagrams, the legend provided, and a consecutive numbering system. **Photograph all injuries described, remarkable findings, or other signs of possible trauma. Keep a log of all photographs taken (See DD Form 2911, Section Q). Also photograph pre-existing injuries or signs of chronic illness that may be mistaken for injuries whenever present; annotate these on the diagrams as well.**

DD FORM 2911, SECTION I. GENERAL PHYSICAL EXAMINATION

1. Record vital signs.
2. Record the date and time the examination was started and completed.
3. Describe the patient's general physical appearance. Use observations **not** conclusions. NOTE: An observation describes physical features (e.g. dirt on left cheek, tear on right shirt sleeve, near elbow); a conclusion *renders an opinion or makes an assumption (e.g. patient looks like she's been raped). Also describe any odors or signs of intoxicants, if present.*
4. Describe the patient's general demeanor. Use observations, not conclusions.
   - Describe observed behaviors and avoid using conclusions or vague terms such as "hysterical," "strange," "spacey," etc.
   - Make your own observations. However, here is a recommended format for noting observed behaviors:
     - Patient is quiet, but breaks into tears at times.
     - Patient wrings hands occasionally.
     - Patient startles when hears noises.
     - Patient raises voice and turns red in face when describing some parts of assault history.
     - Patient slurs words; eyes appear bloodshot; odor of alcohol present in breath.
5. Describe the condition of clothing upon arrival (e.g., rips, tears, presence of foreign materials). Document if patient has changed clothes since the assault. In Unrestricted Reports, investigators will want to obtain clothing worn at the time of the assault.

NOTES ON COLLECTION OF CLOTHING AND FOREIGN MATERIAL:

- Wet or damp clothing must be *air dried* before packaging.
- If the patient is not wearing the clothing worn at the time of the assault, collect only the items that are in direct contact with the patient's genital area, or items that have come in contact with parts of the patient's body where the suspect may have deposited biological materials.
- **For Unrestricted Reports**: If the patient changed clothing after the assault, inform the investigators so that the clothing worn at the time of the assault may be collected.
- Do not cut through any existing holes, rips or stains in patient's clothing.
- Do not shake out patient's clothing, as this may dislodge microscopic evidence.
- If additional clothing bags are required than what are provided in the kit, use only new paper (grocery-type) bags.

6. Using the following procedures, collect outer and under clothing worn during and/or immediately after the incident. At the conclusion of the following steps, the patient will be completely unclothed. Take steps to ensure patient's privacy before beginning.
   - **Wear gloves**. Gloves should be changed between each step of the examination to prevent cross-contamination of evidence.
   - Create a clean area for the patient to undress by placing two sheets of table paper on the floor, one overlapping the other.
   - In the Sexual Assault Exam Kit, find the bag labeled "STEP 3 FOREIGN MATERIAL." Remove the paper sheet from the bag, unfold, and place over the top of the table paper.
   - Instruct the patient to disrobe while standing on the paper sheet from the bag. Have patient remove shoes before stepping on the paper. If indicated as a source of evidence, shoes may be collected and packaged separately from clothing in a paper bag.
   - Collect each item as removed and place in the bags labeled "STEP 3 OUTER CLOTHING" (2 bags), "STEP 3 BRA," and "STEP 3 UNDERPANTS." Package each garment in an individual paper bag, fill out the bag's label, note date/time, and seal. **Underpants are to be stored in the SAFE kit box.**
   - After the patient has completely undressed, instruct him or her to step off the foreign material paper sheet. Carefully fold the paper sheet into a druggist's fold (See Figure 2), being careful to keep any materials that fell off the patient in the center of the folded paper. Place the folded sheet back into the bag labeled "STEP 3 FOREIGN MATERIAL." Fill out the label of the bag, note date/time, and seal.

- In most circumstances, the table paper on the floor may be discarded at the end of the examination. However, if biological or other evidence falls onto the table paper, it may need to be sent to the lab for analysis, too.
- Except for the underpants, do not attempt to enclose clothing bags into the Sexual Assault Exam Kit box. Sealed clothing bags may be placed in a larger paper bag and handed over to the proper authority.

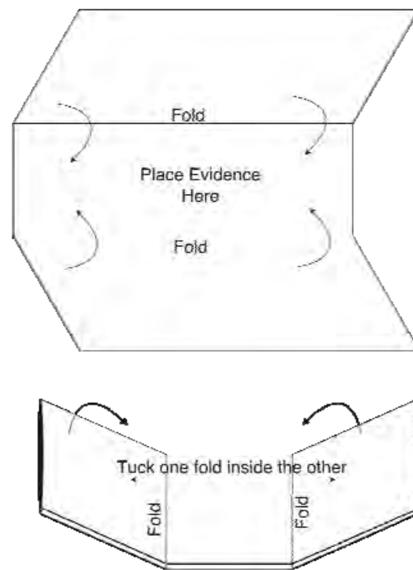


Figure 2 - Folding a Druggist's Fold

STEP 3: GENERAL PHYSICAL EXAMINATION (Continued) and STEP 4: DEBRIS COLLECTION

DD FORM 2911, SECTION I, Blocks 7, 8, 9, and 10

NOTE: FINDINGS IN SECTION I.7 AND I.8 OF DD Form 2911 MUST BE DOCUMENTED USING THE DIAGRAMS AND LEGEND PROVIDED ON THE FORM. Record size and appearance of injuries and other findings using the diagrams, the legend and a consecutive numbering system. Describe in as much detail as possible (e.g., size, shape and color of bruises). Use the legend to list and describe the injury/finding drawn on the diagram. Show the diagram letter followed by the finding number. Use the abbreviations in the legend to describe the type of finding (e.g., A-1, CT 2x3 cm red/ purple indicates that the first finding on Diagram A is an contusion (bruise) that is 2x3 cm in size, and has a reddish purple color.

7. Using the history you obtained as a guide, conduct a general physical examination and record all findings on the form and photographically. Work as efficiently as possible to minimize the amount of time that the patient is undraped.
   - Change gloves now to avoid cross contaminating the patients body with trace evidence.
   - A physical finding includes observable and palpable tissue injuries, physiologic changes, or foreign material (e.g., grass, sand, stains, dried or moist secretions, or fluorescence).
   - If no physical findings can be observed at this time, mark “no findings observed”.
   - Look for erythema (redness), abrasions, bruises, swelling, lacerations, bite marks, and burns.
   - Ensure that you closely examine the torso, arms, and legs for the presence and/or absence of injury or other evidence for corroboration with information in the patient’s history.
   - Record all findings and evidence recovered on the diagrams and the legend. Record the locations of swab collection sites.
   - **Fractures.** Consider use of radiographs when fractures are indicated. It takes approximately five to seven days for some non-displaced fractures to begin appearing on radiographs. Consider follow-up radiographs at ten to fourteen days when indicated. Consult with a radiologist for additional information.

NOTES ON PHOTOGRAPHY:

- Photograph injuries and other findings. Using proper forensic photographic techniques (long-range or "establishing shots", medium-range shots, and close ups).
- Use an appropriate light source and a scale near the finding (A recommended scale is depicted in Figure 3). Photograph the injury with and without scale. Do not press the scale into the skin or injury.
- In order for accurate reproduction later, the plane of the film (or back of the camera) must be held parallel to the plane of the object being photographed. In other words, don't take photos at an angle to the injury. Take the photograph "straight on" to the injury and fill the entire frame of the camera shot when taking close up shots (See Figure 3).
- Avoid using Polaroid and low-quality digital cameras.

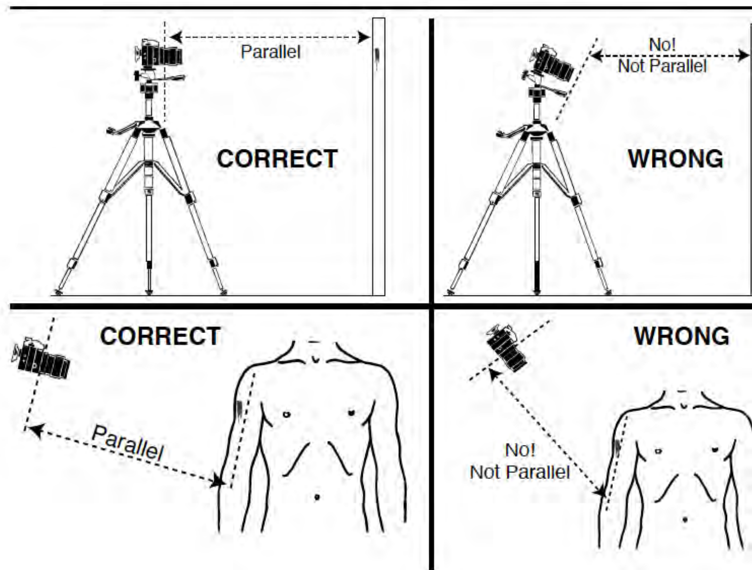


Figure 3 - Proper orientation of the camera when photographing evidence or injury.

Debris Collection:

- Remove folded paper sheet from the STEP 4 DEBRIS COLLECTION envelope.
- Unfold paper sheet and place on flat surface.
- Collect foreign materials such as fibers, hair, soil, sand, grass, and other forms of vegetation and place in the center of the paper sheet.
- Fold paper sheet into a druggist's fold, keeping the debris in the center.
- Return the folded paper sheet to the STEP 4 DEBRIS COLLECTION envelope (a larger envelope may be used if necessary). Note locations where debris collections were collected from on the anatomical drawing on envelope. Seal and fill out all information requested on envelope.
- See the front of the STEP 4 DEBRIS COLLECTION envelope for the information to be noted on each supplemental envelope.

8. Alternate Light Source Examination.
   - Dim the lights in the room.
   - Change gloves now to avoid cross-contaminating evidence with substances that may have gotten on the gloves during the previous portion of the examination.
   - Scan the entire body with an Alternate Light Source (such as a Woods Lamp), looking for substances that fluoresce.
   - Note fluorescent areas on the diagram and record in legend as "ALS" for Alternate Light Source.
   - Swab dried stains and/or areas that fluoresced under the ALS using the STEP 4 DRIED SECRETIONS supplies (below). Label and air dry the evidence swab(s) completely before packaging.

Dried Secretions:

- Remove swabs, swab boxes, and folded paper sheet from the STEP 4 DRIED SECRETIONS envelope.
- Foreign debris such as dried semen, dried blood, dried saliva, etc., should be collected by lightly moistening the swabs provided with 1 to 2 drops sterile water, then thoroughly swabbing the area with the swabs.
- Swab moist secretions with a dry swab to avoid dilution.
- **NOTE: DO NOT use a heat source for drying swabs as this may destroy the evidence.** Allow swabs to **air dry** then place one swab in each swab box. Check off DRIED SECRETION on swab boxes and note area collected from on swab boxes. Place swab boxes in STEP 4 DRIED SECRETIONS envelope. Note location where dried secretions were collected from on the anatomical drawing on envelope. Seal and fill out all information requested on envelope.
- If there are several locations on the body with secretions, use a STEP 10 OTHER SAMPLES envelope.

9. Fingernail Scrapings and Clippings, if indicated by history.
   - NOTE: Change gloves now to avoid cross contamination.
   - Obtain the Right and Left Hand Fingernail Scrapings envelopes from the "STEP 4 FINGERNAIL SCRAPINGS AND CLIPPINGS" envelope.
   - Remove folded paper sheet from the left/right fingernail scrapings and clippings envelope.
   - Unfold paper sheet and place on flat surface.
   - Hold patient's left/right hand over the paper and using the fingernail scraper provided, scrape under all fingernails allowing any debris present to fall onto paper.
   - Next, clip nails with fingernail clipper provided, letting nails fall onto the same paper.
   - If there are insufficient fingernails to clip, swab the fingernails/fingertips, using the STEP 4 FINGERNAIL SWABS envelope.
   - Fold the paper sheets in a druggist's fold, return them to their respective envelopes, and place these envelopes into the STEP 4 FINGERNAIL SCRAPINGS AND CLIPPINGS envelope. Seal and fill out all information requested on envelope.

Finger Swabs:

- If there are insufficient fingernails to clip, then collect finger swabs.
- Obtain the swabs and swab boxes from the STEP 4 FINGER SWABS envelope.
- **NOTE: DO NOT use a heat source for drying swabs as this may destroy the evidence.** Lightly moisten one swab with 1 to 2 drops of sterile water, then thoroughly swab each fingernail and fingertip of the patient's left hand. Allow to **air dry** and place in one of the swab boxes. Check off LEFT HAND FINGERS on swab box.
- Repeat the above procedure on the patient's right hand. Allow swab to **air dry** and place in remaining swab box. Check off RIGHT HAND FINGERS on swab box.
- Place swab boxes in the STEP 4 FINGER SWABS envelope. Seal and fill out all information requested on envelope.

10. Collect swabs of the corresponding parts of the body when there is a history of kissing, licking, and/or sucking.
    - NOTE: Change gloves now to avoid cross contamination.
    - Remove swabs and swab boxes from the STEP 4 ORAL CONTACT WITH BODY envelope.
    - Following the history provided by the patient, swab the areas of the patient's body that suspect contacted with his/her mouth. Use a swab (or multiple swabs for large areas), lightly moistened with 1 or 2 drops of sterile water.
    - **NOTE: DO NOT use a heat source for drying as this may destroy the evidence.** Allow swabs to **air dry** then place one swab in each swab box. Check off DRIED SECRETIONS on swab boxes and note area collected from on swab boxes. Place swab boxes in the STEP 4 DRIED SECRETIONS envelope. Note location where dried secretions collected from on the anatomical drawing on envelope. Seal and fill out all information requested on envelope.

DD FORM 2911, SECTION J. Head, Neck, Throat and Oral Examination. Record all findings, including tenderness and pain, using diagrams, legend, and a consecutive numbering system. **Photograph all injuries described, remarkable findings, or other signs of possible trauma. Change gloves now to avoid cross contamination.**

1. Examine the face, head, hair, scalp, neck, and throat for injury and foreign materials. Document findings or no findings observed.
2. Using the instructions in STEP 4 for Part 7 of Section 1 above, collect dried and moist secretions, stains, and foreign materials from the face, head, hair, neck, mouth, throat and scalp. Record findings.
3. Examine the oral cavity for injury and foreign material. Collect foreign material if present using one of the oral swabs in STEP 8, below. Record findings on DD Form 2911.
4. Oral and external mouth swabs will be taken during Step 8, below.
5. Head hair combings.
   - **If patient has head hair**, use the "STEP 5 HEAD HAIR COMBING" envelope in the kit.
   - Remove paper towel and comb provided in the Head Hair Combings envelope.
   - While the patient is on the examination table, place towel under patient's head.
   - Using the comb provided, gently comb head hair in downward strokes so that any loose hairs and/or debris will fall onto paper towel.
   - Carefully remove towel from under patient's head, and place used comb in center of towel.
   - Refold towel into a druggist's fold (See Figure 1) retaining both comb and any evidence present in center of the fold and return to Head Hair Combings envelope.
   - Seal envelope and fill out all information requested on the envelope.

Note: Known head hairs standards are no longer routinely collected. However, gentle combing as a practice to collect foreign material is still recommended."

NOTE: FINDINGS IN J.1, J.2 AND J.3 MUST BE DOCUMENTED USING THE DIAGRAMS AND LEGEND PROVIDED. Record size and appearance of injuries and other findings using the diagrams, the legend, and a consecutive numbering system. Describe in as much detail as possible (e.g., size, shape and color of bruises). Use the legend to list and describe the injury/finding drawn on the diagram. Show the diagram letter followed by the finding number. Use the abbreviations in the legend to describe the type of finding. (e.g., A-1, CT 2x3 cm red/purple indicates that the first finding on Diagram A is a contusion (bruise) that is 2x3 cm in size, and has a reddish purple color.

STEP 5 GENITAL EXAMINATION (PUBIC HAIR COMBING OR SWABS)
FEMALE: DD Form 2911, Section K (Complete BLOCKS 1 THROUGH 3 - Genital Examination – Female)
MALE: Section L (Complete BLOCKS 1 THROUGH 4 – Genital Examination – Male)

Record all findings, including tenderness and pain, using diagrams, legend, and a consecutive numbering system. Photograph all injuries described, remarkable findings, or other signs of possible trauma. If toluidine blue dye is used, photograph the injury before and after the application of the dye.

Change outer gloves now to avoid cross contamination.

1. Examine the inner thighs and external genitalia. Document findings.
2. Scan the area with an Alternate Light Source (such as a Wood’s Lamp). Collect dried and moist secretions, and foreign materials. Document findings.
3. If there is pubic hair, collect pubic hair combings.

PUBIC HAIR COMBINGS: Pubic hair standards are no longer routinely collected. However, gentle combing as a practice to collect foreign material is still recommended.

- Remove paper towel and comb provided in the STEP 5 PUBIC HAIR COMBINGS envelope.
- Place towel under patient's buttocks.
- Using comb provided, gently comb pubic hair in downward strokes so that any loose hairs and/or debris will fall onto paper towel.
- Refold towel into a druggist's fold, retaining both comb and any evidence present in the center of the fold (see Fig. 2).
- Return to STEP 5 PUBIC HAIR COMBINGS envelope. Seal and fill out all information requested on envelope.

If there is closely cropped or no pubic hair, swab the pubic mound/area surrounding base of penis:

- Remove the swabs and swab box from the STEP 5 SWABS - PUBIC MOUND envelope.
- **NOTE: DO NOT use a heat source for drying swabs as this may destroy the evidence.** Lightly moisten one swab with 1 to 2 drops of sterile water then thoroughly swab the pubic mound/lower abdomen around the base of the penis.
- Allow swabs to **air dry** then place swabs in swab box. Check off PUBIC MOUND on swab box. Place swab box in STEP 5 PUBIC MOUND SWABS envelope. Seal and fill out all information requested on envelope.

STEP 6 GENITAL EXAMINATION - GENITAL SWABS
FEMALE GENITAL EXAMINATION - DD Form 2911, Part 1 Section K.

BLOCK 4:

Examine the vagina, cervix, labia majora, labia minora, clitorial hood and surrounding area, peri-urethral tissue/urethral meatus, hymen, fossa navicularis, and posterior fourchette (See Figure 4). Use of magnification, such as that offered by a digital camera or a colposcope, if available, is recommended to help visualize and photograph injuries. If available and appropriate, toluidine blue dye may be used to help visualize injury during the external vaginal exam. Document findings and use of toluidine blue dye in the diagrams and legend.

Collect Swabs:

- Remove swabs and swab boxes from the STEP 6 GENITAL SWABS envelope.
- **NOTE: DO NOT use a heat source for drying swabs as this may destroy evidence.**
- Using two swabs simultaneously, carefully swab the vaginal vault, then put used swabs aside to air dry.
- Using two swabs simultaneously, carefully swab the cervix, then put used swabs aside to air dry (you will need to use a speculum to access the cervix).
- If any additional fluid is present in the vaginal vault, collect fluid using the additional supplied swabs.

After the swabs have air-dried:

- Place the first two swabs collected in one of the swab boxes provided. Check off VAGINAL on swab box.
- Place the second two swabs used in one of the swab boxes provided. Check off CERVICAL on swab box.
- Place any other swabs obtained in the remaining swab box and note where collected from.
- Place swab boxes in the STEP 6 GENITAL SWABS envelope. Seal and fill out all information requested on the envelope.

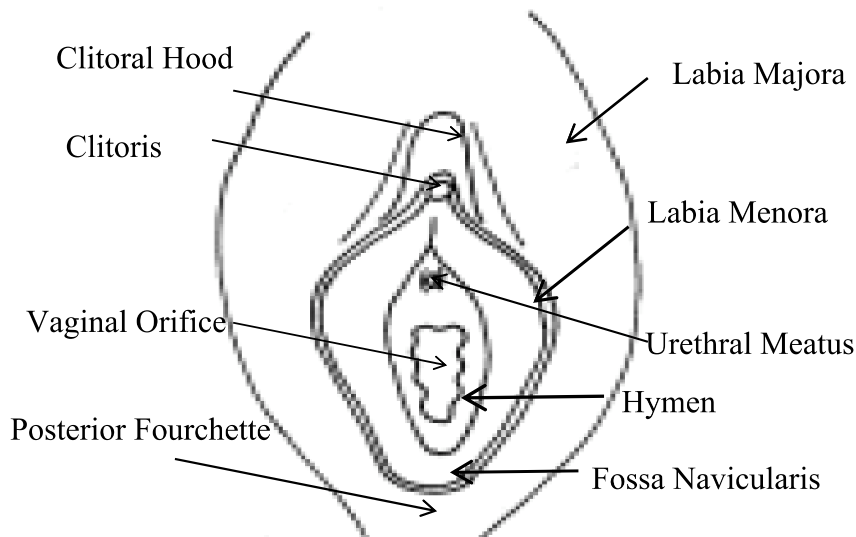


Figure 4, Female Anatomy

Figure 5, Supine Lithotomy Position

NOTE: FINDINGS IN BLOCKS K.1, K.2, K.4, K.5, and K.7 MUST BE DOCUMENTED USING THE DIAGRAMS AND LEGEND PROVIDED. Record size and appearance of injuries and other findings using the diagrams, the legend and a consecutive numbering system. Describe in as much detail as possible (e.g., size, shape and color of bruises). Use the legend to list and describe the injury/finding drawn on the diagram. Show the diagram letter followed by the finding number. Use the abbreviations in the legend to describe the type of finding (e.g., A-1, CT 2x3 cm red/ purple indicates that the first finding on Diagram A is a contusion (bruise) that is 2x3 cm in size, and reddish purple in color).

MALE GENITAL EXAMINATION - DD Form 2911, Part 1, Section L

BLOCK 5:

Examine the abdomen, buttocks, thighs, foreskin, urethral meatus, shaft, scrotum, perineum, glans, and testes. Use of magnification, such as that offered by a digital camera, is recommended to help visualize and photograph injuries.

If available and appropriate, toluidine blue dye may be used to help visualize injury.

Document findings and use of toluidine blue dye in the diagrams and legend.

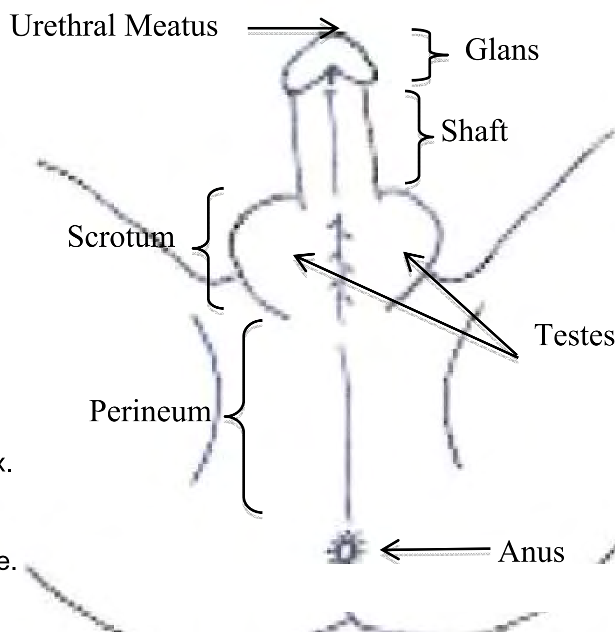
Swab Collection - If indicated by assault history, collect 2 penile and 2 scrotal swabs:

- Remove swabs and swab boxes from the STEP 6 GENITAL SWABS envelope.
- **NOTE: DO NOT use a heat source for drying swabs as this may destroy the evidence.** Allow all swabs

- After moistening with 1 to 2 drops of sterile water, carefully swab the shaft and glans of the penis using two swabs simultaneously, then put used swabs aside to air dry.
- After moistening with a few drops of sterile water, carefully swab the entire scrotum of the penis using two swabs simultaneously, then put used swabs aside to air dry.

After the swabs have air-dried:

- Place the first two swabs collected in one of the swab boxes provided. Check off PENILE on swab box.
- Place the second two swabs collected in one of the swab boxes provided. Check off SCROTAL on swab box.
- Place any other swabs collected in the remaining swab box and note where collected from.
- Place swab boxes in STEP 6 GENITAL SWABS envelope. Seal and fill out all information requested on envelope.



NOTE: FINDINGS IN BLOCKS L.1, L.2, L.3, and L.6 MUST BE DOCUMENTED USING THE DIAGRAMS AND LEGEND PROVIDED. Record size and appearance of injuries and other findings using the diagrams, the legend and a consecutive numbering system. Describe in as much detail as possible (e.g., size, shape and color of bruises). Use the legend to list and describe the injury/finding drawn on the diagram. Show the diagram letter followed by the finding number. Use the abbreviations in the legend to describe the type of finding (e.g., A-1, CT 2x3 cm red/ purple indicates that the first finding on Diagram A is a contusion (bruise) that is 2x3 cm in size, and reddish purple in color).

STEP 7 ANAL EXAMINATION
DD Form 2911, Section K, Blocks 5 through 7 - Genital Examination – Female
DD Form 2911, Section L, Blocks 6 through 8 - Genital Examination – Male

Anal/Perineal Examination

- Examine the buttocks, perineum, perianal skin, and anal folds for injury, foreign materials, and other findings. If available and appropriate, toluidine blue dye may be used to help visualize injury. Collect dried and moist secretions, and foreign materials. Document findings and use of toluidine blue dye in the diagrams and legend.
- Remove swabs and swab boxes from the STEP 7 ANAL/PERINEAL AND RECTAL SWABS envelope.
- Moisten a set of swabs supplied with the kit with 1 or 2 drops of sterile water and swab the anus and perineum. Set aside to air dry.

After swabs have dried:

- **NOTE: DO NOT use a heat source for drying swabs as this may destroy the evidence.** Allow swabs to **air dry**. Place swabs in one of the swab boxes provided and check off ANAL/PERINEAL on swab box.

RECTAL EXAMINATION - Collect AFTER anal/perineal swabbing and only if indicated by history or injury.

- Use the remaining pack of swabs and swab boxes provided in the STEP 7 ANAL/PERINEAL AND RECTAL SWABS envelope. **Do NOT** moisten swabs.
- Using both swabs simultaneously, swab rectum, being sure to collect any additional fluid in the rectal canal.
- Allow swabs to **air dry**. Place swabs in swab box and check off RECTAL on swab box.
- Place swab boxes in the STEP 7 ANAL/PERINEAL AND RECTAL envelope. Seal and fill out all information requested on envelope.
- Conduct an anoscopic exam if rectal injury is suspected or there is any sign of rectal bleeding. Document findings.
- The supine lithotomy position is shown in Figure 5.

STEP 8 EXTERNAL MOUTH AND ORAL SWABS
EXTERNAL MOUTH SWAB - Collect an external mouth swab if oral-genital contact occurred. Collect oral swabs (interior of mouth) only if oral-genital contact occurred within 4 hours of this examination.

- Remove swabs and swab boxes from the STEP 8 EXTERNAL MOUTH AND ORAL SWABS envelope.
- External Mouth Swab: Lightly moisten one swab with 1 to 2 drops of sterile water, then thoroughly swab the lips and face around the mouth.
- **NOTE: DO NOT use heat source for drying swabs as this may destroy the evidence.** Allow swabs to **air dry**. Place swab in one of the swab boxes provided and check off EXTERNAL MOUTH on swab box.

ORAL SWABS - Collect oral swabs (interior of mouth) only if oral-genital contact occurred within four hours of this examination.

- Use the remaining pack of swabs and swab box provided in the STEP 8 EXTERNAL MOUTH AND ORAL SWABS envelope. **DO NOT** moisten swabs.
- Using both swabs simultaneously, carefully swab the gum line.
- Allow swabs to **air dry**. Place swabs in remaining swab box and check off ORAL on swab box.
- Place swab boxes in the STEP 8 EXTERNAL MOUTH AND ORAL SWABS envelope. Seal and fill out all information requested on the envelope.

STEP 9 KNOWN BLOOD SAMPLES (For DNA TYping)

- Remove the FTA Card, lancet, alcohol pad, adhesive bandage and gauze pad from the STEP 9 KNOWN BLOOD SAMPLE envelope.
- Clean the patient's finger with the alcohol pad, then stick finger with the lancet and fill the two circles on the FTA Card with blood.
- Allow the blood stains to completely **air dry**.
- Discard used lancet, alcohol pad and gauze pad.
- Place the FTA Card in the STEP 9 KNOWN BLOOD SAMPLE envelope. Seal and fill out all information requested on the envelope.

FINAL STEP SEALING THE KIT

- Review the kit contents to ensure that all items, including unused items, are sealed in the box.
- Locate the two red evidence seals and orange biohazard label. Use the two red evidence seals to seal both sides of the box in the indicated locations.
- Once the seals have been affixed, initial and date both seals.
- Affix the orange biohazard label where indicated on top of the kit box.
- Maintain chain of custody on the kit in accordance with your Service instructions.
- Ensure that the kit is provided to the appropriate official or forwarded to the appropriate storage facility for safekeeping, in accordance with your Service instructions.

ADDITIONAL STEPS:

DD FORM 2911 – SECTION M - Toxicology. Toxicology samples must be collected as soon as possible due to the limited time frame in which some substances may be detected.

FOR ALL REPORTS OF SEXUAL ASSAULT: If the assault happened within 96 hours of the examination and the answer to any of the questions in Section M is Yes or unsure, obtain a *clinical* toxicology.

- When indicated, order the clinical toxicology lab for blood that is typically used by your military treatment facility for patient care. This lab is intended to inform your treatment and care of the patient.
- Document if patient reports loss of memory.
- Document if patient reports having vomited.
- Indicate by marking the appropriate box on DD Form 2911 if patient reports voluntary or involuntary ingestion of alcohol and/or drugs.

FOR UNRESTRICTED REPORTS ONLY: If the assault happened within 96 hours of the examination and the answer to any of the questions in Section M is Yes or Unsure, obtain a *forensic* toxicology from the Armed Forces Institute of Pathology:

- Use the DoD Toxicology Kit to obtain blood and urine samples for forensic testing and send for forensic examination by the Armed Forces Institute of Pathology.
- Indicate in Section M of DD Form 2911 if DoD Toxicology Kit was completed and time of completion.
- **See Part II OF DD Form 2911 – DOD TOXICOLOGY KIT – for additional instructions and documentation.**

DD FORM 2911 – SECTION N - Record Exam Methods. Record all methods used to perform this forensic exam.

DD FORM 2911 – SECTION O - Findings. This section is a description of the findings that you documented earlier in the report. Taking all the findings as a whole, describe in as much detail as possible. **NOTE: Do not indicate if findings are consistent with sexual assault or rape. These are legal conclusions and may not be determined by the examiner.**

DD FORM 2911 – SECTION P - Evidence Collected.

- Document who completed toxicology kit, time completed, and to whom the kit was released.
- Document what clothing was placed in kit and/or other evidence bags, by whom, time completed, and to whom the clothing was released.
- Document all foreign material collected, by whom, time collected, and to whom foreign materials were released.
- Document who completed oral, genital, anal and rectal samples, time completed.
- Document who completed blood card reference sample and time.

DD FORM 2911 – SECTION Q - Photo Documentation Methods.

- Document type of camera used.
- Document disposition of film/disk, e.g. who is keeping the originals (retained in kit, turned over to MCIO, etc.).
- Document photo list. Use additional sheets, if necessary.

DD FORM 2911 – SECTION R - Other Documents Included.

List any other documents included with the report (e.g. a copy of the Standard Form 600, *Chronological Record of Medical Care,* documenting the patient encounter, a print out of the AHLTA patient encounter, additional sheets of information, addendums, etc).

DD FORM 2911 – SECTION S - Personnel Involved.
- Name and phone number of person who took the history.
- Name and phone number of person who performed forensic exam.
- Name and phone number of person who labeled and sealed specimens.
- Name of person(s) who assisted the examiner and their role in assistance. Attach another sheet as necessary. Be sure to include the names of anyone that assisted you in photographing or handling the evidence.

DD FORM 2911 – SECTION T - Evidence Distribution.
- Name of person to whom the toxicology kit was given.
- Name of person to whom the sexual assault forensic exam kit was given, and specify the number of evidence bags provided as well.
- Document what items were returned to patient.
- Document the release of any other items of evidence and whom they were given.

DD FORM 2911 – SECTION U - Person Receiving Evidence.
For Unrestricted Reports:
- Give to Military Criminal Investigative Organization representative (Army CID, NCIS, AFOSI).

For Restricted Reports, see service-specific policy.
- Signature of person receiving evidence.
- Printed name and ID/badge number (if MCIO).
- Agency (Army CID, Sexual Assault Response Coordinator, etc.).
- Date/time.
- Telephone number of person receiving evidence.