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**REPORT OF MEDICAL EXAMINATION IN SEXUAL OFFENCE**

**(MALESUBJECT)**

1. **Case Registration No.:**
2. **Name of the Office referred for examination:**
	1. **Reference number**
	2. **Date**
3. **Name of the accompanying Police Personnel:**

**DETAIL ABOUT THE EXAMINEE**

1. **Name/ Code Name (To maintain confidentiality):**
2. **Age and Sex:**
3. **Address:**
	1. **Permanent**
	2. **Temporary**
4. **Marital status:**
5. **Guardian′s Name and relation:**
6. **Date and time of examination:**
7. **Attendants Name ⁄ address:**
8. **Identification marks:**
9.
10.
11. **Consent for examination:**
12. **Brief History of the incident, as stated by examinee or guardian**
13. **Medical history:**
14. **Clothes changed or not after incident:**
15. **Whether clothes and body parts washed or not after the incident:**
16. **Description of the examination of clothes:**

**EXAMINATION**

1. **General physique and vitals:-**
2. **Height:**
3. **Weight:**
4. **Pulse:**
5. **Temperature:**
6. **Respiratory rate:**
7. **Degree of consciousness:**
8. **Any disability:**
9. **Injuries on the bodies:**
10. **Genital injuries**
11. **Perineum:**
12. **Penis:**
13. **Scrotum:**
14. **Peri-anal area and anal orifice:**
15. **Oral cavity:**
16. **Conditions of pubic hair: -**
17. **Bite marks:-**
18. **Specimen preserved for further analysis:-**
19. **Blood:**
20. **Urine:**
21. **Swab from stains:**
22. **Swab from penis:**
23. **Foreign hairs/debris:**
24. **Hair from the examinee:**
25. **Nail scrapings:**
26. **Others:**
27. **Investigation and reports:**
28. **Treatment:**
29. **Referral:**
30. **Follow up:**
31. **Psychiatric evaluation and psychosocial counseling:**
32. **Condition of teeth**

|  |  |  |
| --- | --- | --- |
|  |  | **S = \_\_\_ Total Teeth (Permanent/Deciduous/Mixed)** |
|  |  |

1. **Opinion of the expert:**
2. **Opinion about the injuries on body:**
3. **Opinion about the condition of genital organs:**
4. **Opinion about the age of the examinee:**
5. **Other opinion, if any: -**

**Signature of Medical Officer/Expert:**

Name:

Designation:

N.M.C. Reg. No.:

Date:

**Seal of the Hospital:**