OHIO'S COSTS AFTER VIOLENCE

Collaboration between
Forensic Nursing Network,
Brain Injury Association of Ohio, and
Ohio Domestic Violence Network

Non-Fatal Strangulation, Suffocation, and Traumatic Brain Injury Policy/Procedure

Effective Date: 3/2/2026

PURPOSE OF THE POLICY:

Standardization and enhancement of the health care provider's ability to identify, evaluate, and treat patients who have experienced non-fatal strangulation, suffocation, and traumatic brain injury (TBI) following sexual assault (SA), intimate partner violence (IPV) or domestic violence (DV). Medical examination, treatment, emotional support, evidence collection, danger assessment, safety planning, and follow-up arrangements, in collaboration with the medical provider, emergency department staff, the hospital-based/community-based forensic nurse examiner (FNE), and the community, are needed to achieve positive patient outcomes.

Non-Fatal Strangulation methods include manual, ligature, positional, and hanging. Manual strangulation is a form of blunt neck trauma. The patient suffers from external pressure on the neck that occludes the airway and/or blood vessels, and nervous structures in the neck, which can lead to anoxia, disability, irreversible brain damage, and rapid death.

Suffocation is the obstruction or restriction of breathing by external mechanical forces. Suffocation does not require blunt force trauma" (Faugno et al., 2020, p. 4). Normal breathing is impeded. Suffocation is a form of asphyxia that deprives the brain of oxygen. Examples of suffocation: Covering of the mouth/nose, inhalation/ingestion of food or liquid causing obstruction (whether accidentally or purposefully), etc.

Section 2903.18 (1) of the Ohio Revised Code (ORC) states "Strangulation or suffocation" means any act that impedes the normal breathing or circulation of the blood by applying pressure to the throat or neck, or by covering the nose **and** mouth.

A traumatic brain injury (TBI) is an injury to the brain from an outside source. A TBI can be from a penetrating injury (bullet, bone fragments, etc.) that enters the skull, or from a non-penetrating injury (closed head injury or blunt TBI) that happens due to applied external force (bump, blow, shaking, or jolt to the head or body) that causes the brain to move within the skull. Primary causes of TBI: falls, blunt trauma accidents, vehicle-related injuries, assaults and violence, and explosions and blasts (National Institute of Neurological Disorders and Stroke, 2025).

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Non-Fatal Strangulation, Suffocation, and Traumatic Brain Injury Policy/Procedure

Policy

1. Each patient will be assessed for the purpose of medical diagnoses and treatment. This will include physical assessment, medical assault history (narrative), collection of biological and trace evidence as needed, and documentation of objective findings and subjective complaints.

2. If the patient discloses strangulation, inform the Provider. The Provider should consider using the following recommendations:
    a. RECOMENDATIONS FOR THE MEDICAL/RADIOGRAPHIC EVALUATION OF ACUTE ADULT/ADOLESCENT, NON/NEAR FATAL STRANGULATION (Resource 1)

    b. RECOMMENDATIONS for the MEDICAL/RADIOGRAPHIC EVALUATION of the PREGNANT ADULT PATIENT WITH NON-FATAL STRANGULATION (Resource 2)

Procedure

Physical Assault with Strangulation and/or Suffocation and/or Head, Neck or Face Injury

1. When triaging patients presenting with a chief complaint of physical assault, sexual assault, or neck/throat issues, the triage nurse/forensic nurse will ask,
    - "Did anyone place any pressure on or around your neck?"
    - "Was anything placed over your mouth and/or nose (smothered)?"
    - "Were you hit in the head, neck or face?"

    Patients presenting with a chief complaint of an assault with strangulation, suffocation and/or head, neck or facial injury will be triaged per ED policy. If community-based, referred to the Emergency Room prior to completing the forensic examination.

2. Contact the Forensic Nurse Examiner (FNE) on call with the following information:
    a. Are they medically cleared?
    b. Patient age
    c. Who is the patient accompanied by:
        i. Law enforcement
        ii. Family/other
    d. Date and time of assault
    e. Are they alert and oriented, and can hold a 15-minute conversation?
    f. Have any medications been given to alter the patient's ability to consent?
    g. Are they under the influence of alcohol or substances?
    h. Is there a concern for an acute mental health crisis?

3. Contact the local advocacy agency as per hospital policy.

4. Law Enforcement:
    a. Discuss with the patient any mandatory reporting requirements.
        i. Notify the patient that they are not required to speak to law enforcement when they arrive.
    b. Follow hospital-mandated reporting guidelines.

c. If not a mandated report, and the adult patient requests to report to law enforcement, call the jurisdiction **where the assault happened.**
d. Must be contacted for: ORC 2921.22 Failure to report a crime or knowledge of a death or burn injury.
    i. Patients under the age of 18.
    ii. Per the ORC (Examples)
        1) Gunshot wounds
        2) Stabbings
        3) Intentional second- or third-degree burns
        4) Life-threatening injuries
        5) Strangulation ORC 2903.18 Strangulation

5. Completion of Mandatory Reporting to the appropriate agency **where the patient resides** as needed.
    a. Child Protective Services
    b. Adult Protective Services
    c. Ohio Department of Developmental Disabilities

Preparation for Forensic Examination:

1. Assemble equipment.
    a. Patient labels
    b. Digital camera
    c. American Board of Forensic Odontologists (ABFO) ruler or measuring device
    d. Sterile normal saline or water (10ml or less)
    e. Gloves
    f. Evidence kit, paper bags, evidence tape
    g. If a premade evidence kit is not available, use the following:
        i. Sterile cotton swabs
        ii. Envelopes to put collection swabs in
        iii. Large envelope containing sealed envelopes.
        iv. Paper bags (large if clothing items need to be collected)
    h. Use evidence tape to seal all envelopes.
2. Wash hands.
3. Don gloves

Assessment and Documentation

1. Obtain verbal and written consent (Resource 3)
    a. If the patient is a minor, obtain consent from the custodial parent, guardian, or whoever has emergency custody of the minor.
    b. If the patient does not consent to a medical forensic examination, note this in the patient's medical record as well as your concern for strangulation, suffocation, and / traumatic brain injuries.
    c. Monitor for assent throughout the exam.
2. Utilize standardized paperwork: Strangulation, Suffocation, and Traumatic Brain Injury Nursing Assessment Form included. (Resource 4)
3. Obtain the medical assault history/narrative from the patient per pages 1-4.

   a. Use the patient's own words, verbatim.
4. Complete a thorough head-to-toe assessment, including subjective and objective findings that occurred during the event as well as currently, utilizing pages 5-6.
5. If the patient is reporting signs or symptoms of a TBI, inform the medical provider and consider additional procedures, as indicated, referencing the HEADS UP to Health Care Providers: Tools for Providers (Centers for Disease Control and Prevention, 2025).
6. Record any injuries on the anatomical diagram pages 7-9.
7. Complete the forensic injury documentation log on page 10
8. Photo documentation of all injuries.
   a. Consent is required for photography. Follow hospital guidelines.
   b. All photographs should ensure modesty and privacy as much as possible through draping.
   c. Initial presentation of injury and upon completion of repair, if completed (sutures or staples), to include the number of staples or sutures placed.
   d. First photo is patient label.
   e. Second photo is patient's face/full body with clothing/hospital gown.
   f. Photographs of **all injuries** according to the rule of 3:
      i. Distance picture to ensure the location of the injury on the body.
      ii. Close-up picture of injury.
      iii. Close-up picture of injury with measure.
   g. If the patient complains of tenderness, take one photo of the tender area on the patient's body.
   h. Strangulation injuries
      i. Take circumferential photos of injuries of the neck per policy, with or without injury noted.
      ii. Any areas of petechia: (Petechia may or may not be seen above the level of applied pressure)
         1) Head
         2) Face
         3) Eyes
         4) Nose
         5) Mouth
         6) Under chin
         7) Ears
         8) Neck

Evidence Collection

1. Obtain verbal and written consent
   a. If the patient is a minor, obtain consent from the custodial parent, guardian, or whoever has emergency custody of the minor.
   b. If the patient does not consent to evidence collection, note this in the patient's medical record.
   c. Monitor for assent throughout the exam
2. Evidence may be collected for anyone 13 years and older up to 96 hours. Evidence for pediatric (prepubescent) up to 72 hours.

3. For each swab collected:
    a. Place each swab in a separate swab box or envelope.
    b. Label with patient label.
    c. Seal with evidence tape
    d. Place nurse collector's signature on swab box or envelope.
    e. Document the area where the specimen was collected.
4. Obtain a buccal swab using one swab, rotate the inside of one cheek for 5-10 seconds. This swab is for the patient's DNA reference swab.
5. Lightly moisten 2 swabs in sterile normal saline or sterile water and obtain evidence swabs as per patients assault history. Gently rotate both swabs on the patient's skin. These swabs are for foreign DNA to the patient. (Examples include but are not limited to:)
    a. Neck with reported strangulation
    b. Fingernails
    c. Reported bite marks
    d. Other associated injuries
6. Obtain a large envelope; chain of custody information needs to be on the envelope.
    a. Use collection kit label and place on large envelope. (Resource 5)
    b. Complete the required information on the form.
    c. Make 2 copies of the completed Strangulation, Suffocation, and Traumatic Brain Injury Nursing Assessment Form.
    d. In the large envelope, place the following and seal with evidence tape:
        i. Consent form
        ii. Swab boxes / evidence collection swabs
        iii. One copy of the paperwork
            1. Second copy placed in additional envelope for law enforcement.
            2. Original documentation is kept at the hospital.
7. Complete chain of custody form (Resource 6)
8. Consider a lethality risk assessment tool, such as the Danger Assessment-5. Danger Assessment
    a. Danger Assessment -5 (DA-5) (Resource 7)
9. Discuss a Safety Plan with the patient as applicable.
10. Provide advocacy resources for additional supportive services.
    a. Center on Partner-Inflicted Brain Injury
    b. Intimate Partner Violence and Brain Injury — The Brain Injury Association of Ohio
11. Provide Strangulation / Suffocation / TBI discharge paper (Resource 8)

Non-Fatal Strangulation, Suffocation, and Traumatic Brain Injury Policy/Procedure

References:

Academy of Forensic Nursing. (2017). *Position statement: Non-fatal strangulation (NFS) practice recommendations for forensic nurses*. Academy of Forensic Nursing | AFN. Retrieved January 5, 2026, from https://www.goafn.org/_files/ugd/3ebece_78852b48f93d4f609dcca12f2c1af836.pdf

Centers for Disease Control and Prevention. (2025, September 29). *Health care provider resources*. HEADS UP. Retrieved January 5, 2026, from https://www.cdc.gov/heads-up/hcp/providers/index.html

Centers for Disease Control and Prevention. (2025, September 3). *About intimate partner violence*. Intimate Partner Violence Prevention. Retrieved January 5, 2026, from https://www.cdc.gov/intimate-partner-violence/about/index.html

Evaluation of acute adolescent/ adult, non-fatal strangulation. (2022). https://www.familyjusticecenter.org/resources/recommendations-for-the-medical-radiographic-evaluation-of-acute-adult-adolescent-non-near-fatal-strangulation/

Faugno, D. K., Sievers, V., Shores, M., Smock, B., Smock, W. S., & Speck, P. M. (2020). *Domestic violence/strangulation assessment for health care providers and first responders*. STM Learning.

International Association of Forensic Nurses. (2023). *Non-Fatal strangulation documentation toolkit*. International Association of Forensic Nurses. Retrieved December 5, 2025, from https://www.forensicnurses.org/wp-content/uploads/2024/05/IAFN-Strangulation-Toolkit-2023-1.pdf

Messing JT, Campbell JC, Snider C. Validation, and adaptation of the danger assessment-5: A brief intimate partner violence risk assessment. J Adv Nurs. 2017 Dec;73(12):3220-3230. doi: 10.1111/jan.13459. PMID: 28921610.

National Institute of Neurological Disorders and Stroke. (2025, July 21). *Traumatic brain injury (TBI)*. Retrieved January 20, 2026, from https://www.ninds.nih.gov/health-information/disorders/traumatic-brain-injury-tbi

Section 2903.18: Strangulation. Section 2903.18 - Ohio Revised Code | Ohio Laws. (2023). https://codes.ohio.gov/ohio-revised-code/section-2903.18

Stellpflug, S. J., Weber, W., Dietrich, A., Springer, B., Polansky, R., Sachs, C., Hsu, A., McGuire, S., Gwinn, C., Strack, G., & Riviello, R. (2022). Approach considerations for the management of strangulation in the emergency department. *JACEP Open*, *3*(2),e12711. https://doi.org/10.1002/emp2.12711

Training Institute on Strangulation Prevention. (2023, October 13). *Recommendations for the medical/Radiographic evaluation of acute adult non/Near fatal strangulation*. Alliance for HOPE International. Retrieved January 5, 2026, from https://www.allianceforhope.org/training-institute-on-strangulation-prevention/resources/recommendations-for-the-medicalradiographic-evaluation-of-acute-adult-nonnear-fatal-strangulation

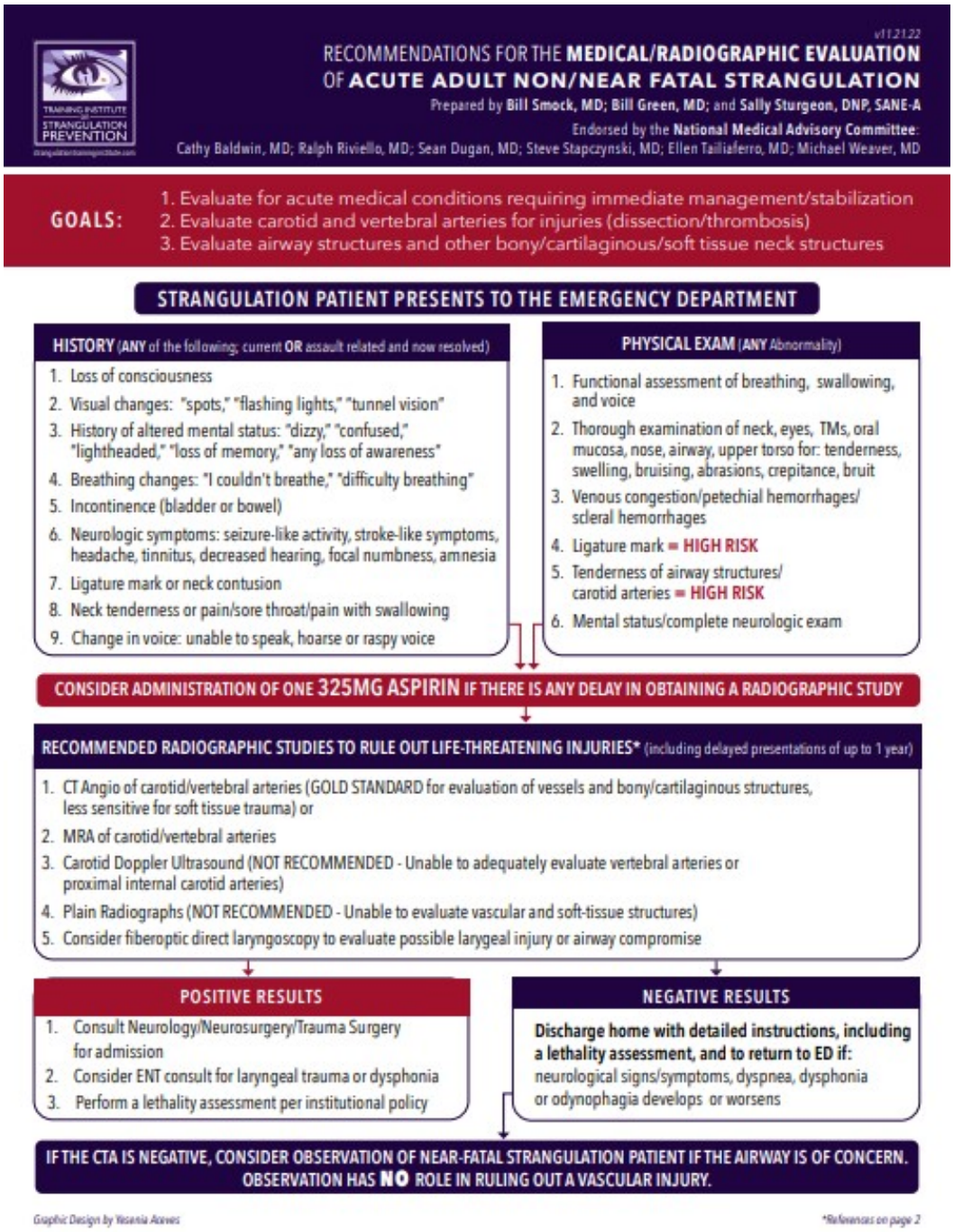
Training Institute on Strangulation Prevention. (2018). *Recommendations for the medical/radiographic evaluation of the pregnant adult patient with non-fatal strangulation*. Retrieved January 5, 2026, from https://www.familyjusticecenter.org/wp-content/uploads/2018/09/Recommendations-for-Pregnant-Victim-v4.1.pdf

Original policy produced by Dr. Jennifer L. Johnson, DNP, MSN, APRN, WHNP-BC, AFN-BC, SANE-A, SANE-P, AFN-C, DF-AFN

Non-Fatal Strangulation, Suffocation, and Traumatic Brain Injury Policy/Procedure

Resources:

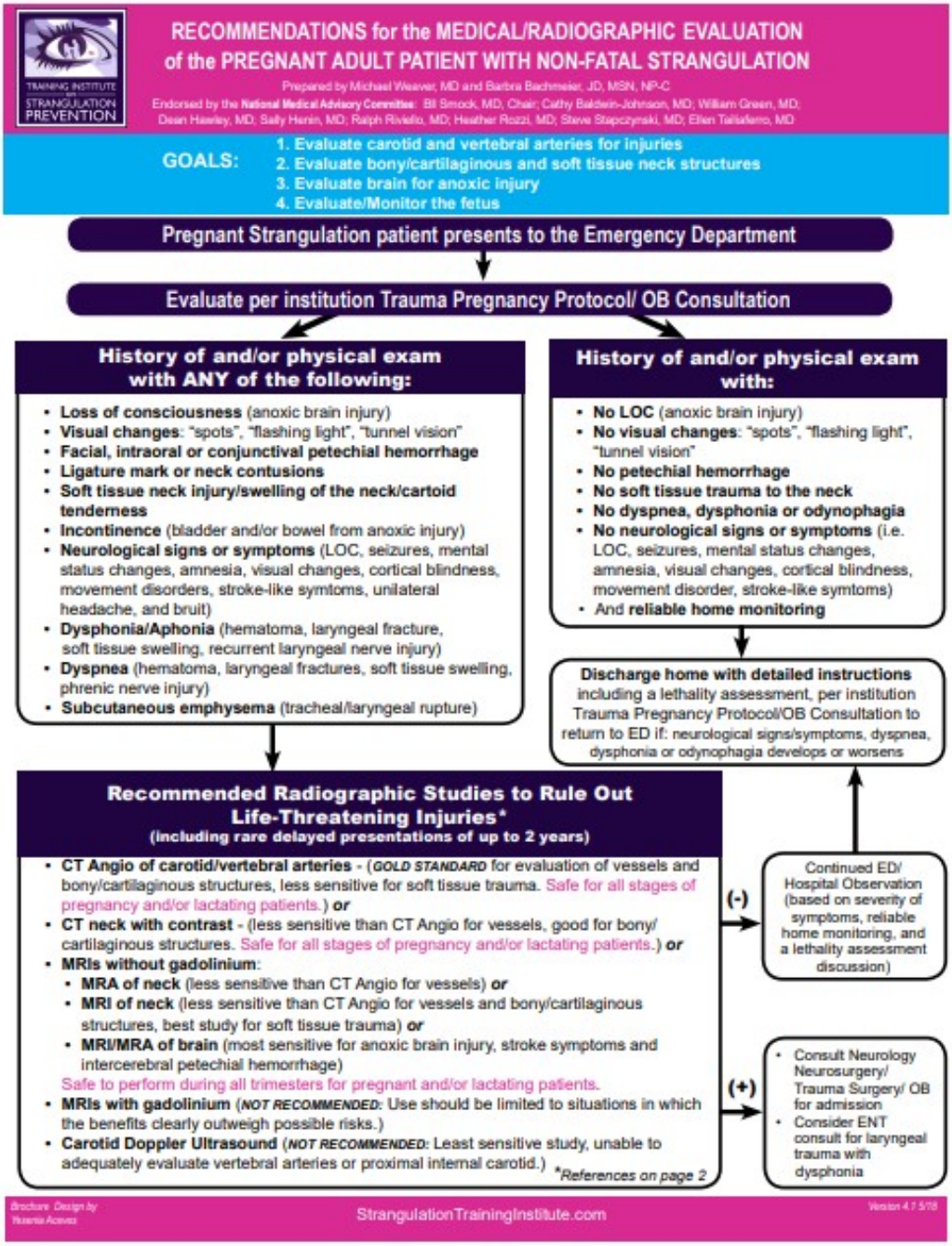
Resource 1: Recommendations for the medical and radiographic evaluation of acute adult and adolescent non-fatal and near fatal strangulation



Alliance for Hope International. *Recommendations for the medical and radiographic evaluation of acute adult non-fatal and near fatal strangulation*. Training Institute on Strangulation Prevention. https://www.allianceforhope.org/training-institute-on-strangulation-prevention/resources/recommendations-for-the-medicalradiographic-evaluation-of-acute-adult-nonnear-fatal-strangulation

Non-Fatal Strangulation, Suffocation, and Traumatic Brain Injury Policy/Procedure

Resource 2: Recommendations for the medical and radiographic evaluation of the pregnant adult patient with non-fatal strangulation



Alliance for Hope International. *Recommendations for the medical and radiographic evaluation of the pregnant adult patient with non-fatal strangulation*. Training Institute on Strangulation Prevention. https://www.allianceforhope.org/training-institute-on-strangulation-prevention/resources/recommendations-for-pregnant-victim

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Resource 7: Danger Assessment 5 (DA-5)

DANGER ASSESSMENT-5 (DA-5)
BRIEF RISK ASSESSMENT FOR CLINICIANS

The DA-5 is a brief risk assessment that identifies victims at high risk for homicide or severe injury by a current or former intimate partner.[1-3] It should be used when intimate partner violence has been identified in the Emergency Department or other health care settings, protective order or child custody hearings, or other brief-treatment/practice settings. Presence of these risk factors could mean the victim is in danger of serious injury and/or homicide. Evidence-based risk assessments should be used in combination with survivor self-determination and practitioner expertise to collaboratively develop the best way forward for each individual.

Mark **Yes** or **No** for each of the following questions.

_____ 1. Has the physical violence increased in severity or frequency over the past year?
_____ 2. Has your partner (or ex) ever used a weapon against you or threated you with a weapon?
_____ 3. Do you believe your partner (or ex) is capable of killing you?
_____ *4. Has your partner (or ex) ***ever tried*** to choke/strangle you or cut off your breathing?
4a. If yes, did your partner ever choke/strangle you or cut off your breathing? check here: ____
4b. About how long ago? ____
4c. Did it happen more than once? ____
4d. Did it make you pass out of black out or make you dizzy? ____
_____ 5. Is your partner (or ex) violently and constantly jealous you?
_____ **Total "Yes" answers**

*can be asked instead of or in addition to: Have you ever been beaten by your partner (or ex) while you were pregnant?

Scoring Instructions

4 or 5 "yes" responses:
- Tell the victim they are in danger. Give them the choice of reporting to the police and/or a confidential hotline (800-799-7233). Make the call with the victim and/or complete an in-person hand-off to a knowledgeable advocate.

3 "yes" responses:
- If the victim is female and you are trained to use the DA:
  - Complete the full DA using the calendar and weighted scoring. Inform the victim of her level of danger. Do safety planning based on the full DA results.
- If the victim is female and you are NOT trained to use the DA:
  - Refer and hand-off the victim to someone certified to administer the full DA (in-person or voice-to-voice hand-off is preferable).

2 "yes" responses:
- Tell the victim there are 2 risk factors for serious injury/assault/homicide. If victim agrees, refer and hand-off to a knowledgeable advocate (in-person or voice-to-voice hand-off is preferable).

0-1 "yes" responses:
- Proceed with normal referral/procedural processes for domestic violence.

Brief Strangulation Protocol

If the victim answered **yes to 4a**, follow this strangulation protocol for further assessment and/or refer to someone who is trained to conduct the following assessment.

If the strangulation was less than a week ago:
- Examine the inside of the throat, neck, face, and scalp for physical signs of strangulation.
- Refer to the strangulation assessment and radiographic evaluation information at www.strangulationtraininginstitute.com
- Proceed with emergency medical care for strangulation, especially if loss of consciousness or possible loss of consciousness (victims are commonly unsure about loss of consciousness) particularly if they became incontinent—ask if the victim "wet themselves".

If there were multiple strangulations:
- Conduct a neurological exam for brain injury or refer for examination. Inform the victim of increased risk for homicide.

If the victim wants, notify police and/or prosecutors
- Know state/local law on strangulation and mandatory reporting and inform the victim.

For more information, visit www.dangerassessment.org

[1] This is a brief adaptation of the Danger Assessment (2003). The full DA with weighted scoring provides the most accurate assessment of risk. The DA and its revisions are evidence-based risk assessments intended for use with survivors to educate them and their supports about their risk of lethality or reassault and to inform their decision-making. [2] Snider, C., Webster, D., O'Sullivan, S.C., & Campbell, J. (2009). Intimate partner violence: Development of a brief risk assessment for the emergency department. *Society for Academic Emergency Medicine, 16*, 1209-1216. [3] Messing, J.T., Campbell, J.C., & Snider, C. (2017). Validation and adaptation of the Danger Assessment-5 (DA-5): A brief intimate partner violence risk assessment. *Journal of Advanced Nursing, 73*, 3220-3230.

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Campbell, J. C., et al. *Danger Assessment (DA 5)*. Johns Hopkins University School of Nursing. https://www.dangerassessment.org/uploads/DA-5_Format_2019_r1.pdf

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2025 Ohio
Strangulation, Suffocation, and Traumatic Brain Injury
Nursing Assessment Form

This assessment form was developed by a collaboration of forensic nurses, a brain injury specialist, law enforcement, and sexual / domestic violence advocates to integrate assessment for strangulation, suffocation and traumatic brain injury in situations of violence.

Use of this COSTS document is encouraged to maintain standardized documentation. Please do not make any changes or additions without first contacting information@forensicnursingnetwork.org.

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Page 1		
Assault Date/Time:	**Assault Location:**	Place Patient Label Here
Exam Date:	**Time:**	
Hospital:	**City:**	
Patient Preferred Name:		
Law Enforcement Agency:	**Officer:**	

Assailant Information	Relationship to Patient	Age	Injured or bleeding?

Section 1:

Did anyone place any pressure on or around your neck? ☐ Unknown ☐ No ☐ Yes (If no, skip to section 2)

Did this happen one time or more than one time during this incident? ☐ Unknown ☐ No ☐ Yes

Describe_____

How was pressure applied to your neck? ☐ Unknown ☐ Left hand ☐ Right hand ☐ Both hands

☐ Forearm(s) ☐ Knee/foot ☐ Ligature (describe):_____☐ Other

Describe_____

_____

Describe the neck pressure during strangulation on a 0-10 scale (0=no pressure and 10= crushing pressure)

_____

Have you been strangled in the past? ☐ Unknown ☐ No ☐ Yes

Were you lifted off the ground or suspended by your neck? ☐ Unknown ☐ No ☐ Yes

Describe _____

Was your neck stretched or twisted? ☐ Unknown ☐ No ☐ Yes

Describe _____

_____

Do you know if you lost consciousness? ☐ Unknown ☐ No ☐ Yes

If yes, describe_____

Nurse or Clinician Name (Print)	**Nurse or Clinician Signature**

Page 2

Did the assault take place in multiple locations:

☐ Unknown ☐ No ☐ Yes (describe) _____

_____

Place Patient Label Here

Do you remember waking up somewhere else:

☐ Unknown ☐ No ☐ Yes (describe) _____

_____

Section 2:

Was anything placed over your mouth and/or nose (smothered)? ☐ Unknown ☐ No ☐ Yes

Describe _____

Was liquid, food, or anything else used to restrict your breathing? ☐ Unknown ☐ No ☐ Yes

Describe– include what breathing felt like at that time _____

Did the assailant use their body weight or put pressure on you in any other way that affected your ability to breathe?

☐ Unknown ☐ No ☐ Yes

If yes, describe your breathing at that time: _____

Section 3:

Does your head hurt? ☐ Unknown ☐ No ☐ Yes

Describe the pain on a 0-10 scale (0=no pain and 10= severe pain) _____

Were you hit or hurt in the head, neck, or face? ☐ Unknown ☐ No ☐ Yes

Describe _____

How many times was your head, neck or face hit or hurt?_____ ☐ Unknown

Were you shaken? ☐ Unknown ☐ No ☐ Yes Describe _____

Was your head struck against anything? ☐ Unknown ☐ No ☐ Yes

Describe _____

Were you slapped, stomped, kicked, or bitten anywhere? ☐ Unknown ☐ No ☐ Yes

Describe _____

Did you fall or hit your head on anything? ☐ Unknown ☐ No ☐ Yes Describe _____

Did the assailant hit or hurt your head in any other way? ☐ Unknown ☐ No ☐ Yes

Describe_____

Nurse or Clinician Name (Print)	**Nurse or Clinician Signature**

Place Patient Label Here

Jewelry on assailant's hands or wrists? ☐ Unknown ☐ No ☐ Yes Describe _____

Jewelry on patient's hands, wrists, or neck? ☐ Unknown ☐ No ☐ Yes Describe _____

How did the ☐ strangulation ☐ suffocation ☐ assault stop? _____

What were you thinking during the ☐ strangulation ☐ suffocation ☐ assault? _____

_____

What did the assailant say before, during, or after the ☐ strangulation ☐ suffocation ☐ assault? _____

_____

Was a weapon used or were you threatened with a weapon? ☐ Unknown ☐ No ☐ Yes Describe _____

Did the assailant use their body weight or anything else to restrain you (or keep you from moving)?
☐ Unknown ☐ No ☐ Yes

Describe_____

Since the assault has the patient:

Bathed/Showered: ☐ No ☐ Yes

Are the clothes you are wearing the same clothes you were wearing at the time of the strangulation/assault?

☐ No ☐ Yes

If clothing changed, why?_____

Clothing collected: No Yes (list what was collected)

Bag 1: _____

Bag 2:_____

Were any children present at the residence during the incident?
☐ No ☐ Yes ☐ N/A

If yes, a report must be made to Child Protective Services. CPS Case #:_____

Nurse or Clinician Name (Print)	**Nurse or Clinician Signature**

Narrative History (in patient's own words—use quotes) *Please write legibly*	Place Patient Label Here

Note General Appearance (including condition of clothing)

Note Emotional Status

Nurse or Clinician Name (Print)	**Nurse or Clinician Signature**

Page 5

	Place Patient Label Here

Section 4: Assessment

Respiratory

	During	Currently	Describe
Coughing	☐ No ☐ Yes ☐ Unknown	☐ No ☐ Yes	
Shortness of Breath	☐ No ☐ Yes ☐ Unknown	☐ No ☐ Yes	
Pain/trouble swallowing	☐ No ☐ Yes ☐ Unknown	☐ No ☐ Yes	
Sore Throat	☐ No ☐ Yes ☐ Unknown	☐ No ☐ Yes	
Unable to speak	☐ No ☐ Yes ☐ Unknown	☐ No ☐ Yes	
Painful to speak	☐ No ☐ Yes ☐ Unknown	☐ No ☐ Yes	
Difficult speaking	☐ No ☐ Yes ☐ Unknown	☐ No ☐ Yes	
Raspy/hoarse voice	☐ No ☐ Yes ☐ Unknown	☐ No ☐ Yes	
Swollen tongue	☐ No ☐ Yes ☐ Unknown	☐ No ☐ Yes	

Neurological

	During	Currently	Describe
Disoriented	☐ No ☐ Yes ☐ Unknown	☐ No ☐ Yes	
Lightheaded/dizzy	☐ No ☐ Yes ☐ Unknown	☐ No ☐ Yes	
Combative/irritable	☐ No ☐ Yes ☐ Unknown	☐ No ☐ Yes	
Facial Droop	☐ No ☐ Yes ☐ Unknown	☐ No ☐ Yes	
Unilateral weakness	☐ No ☐ Yes ☐ Unknown	☐ No ☐ Yes	
Headache	☐ No ☐ Yes ☐ Unknown	☐ No ☐ Yes	
If yes, describe the pain on a 0-10 scale (0=no pain and 10= severe pain)			
Loss of sensation	☐ No ☐ Yes ☐ Unknown	☐ No ☐ Yes	
Numbness/tingling	☐ No ☐ Yes ☐ Unknown	☐ No ☐ Yes	
Changes in vision	☐ No ☐ Yes ☐ Unknown	☐ No ☐ Yes	
Sensitive to light	☐ No ☐ Yes ☐ Unknown	☐ No ☐ Yes	
Sensitive to noise	☐ No ☐ Yes ☐ Unknown	☐ No ☐ Yes	
Changes in hearing	☐ No ☐ Yes ☐ Unknown	☐ No ☐ Yes	
Balance problems	☐ No ☐ Yes ☐ Unknown	☐ No ☐ Yes	
Loss of Consciousness	☐ No ☐ Yes ☐ Unknown	☐ No ☐ Yes	
Memory Loss	☐ No ☐ Yes ☐ Unknown	☐ No ☐ Yes	
Last memory before strangulation/assault:			
Next memory after strangulation/assault:			

Gastrointestinal

	During	Currently	Describe
Nausea	☐ No ☐ Yes ☐ Unknown	☐ No ☐ Yes	
Vomiting	☐ No ☐ Yes ☐ Unknown	☐ No ☐ Yes	

Genitourinary

	During	Currently	Describe
Involuntary Urination	☐ No ☐ Yes ☐ Unknown	☐ No ☐ Yes	
Involuntary Defecation	☐ No ☐ Yes ☐ Unknown	☐ No ☐ Yes	

Nurse or Clinician Name (Print)	**Nurse or Clinician Signature**

Place Patient Label Here

Section 4: Assessment (Continued): See anatomical drawings to correlate injuries with photographs

Head	Currently
Swelling	☐ No ☐ Yes
Lacerations	☐ No ☐ Yes
Abrasions	☐ No ☐ Yes
Bruising	☐ No ☐ Yes
Hair Missing	☐ No ☐ Yes
Pain/Tenderness	☐ No ☐ Yes
Petechiae	☐ No ☐ Yes
Other	☐ No ☐ Yes

Face	Currently
Petechiae	☐ No ☐ Yes
Swelling	☐ No ☐ Yes
Lacerations	☐ No ☐ Yes
Abrasions	☐ No ☐ Yes
Bruising	☐ No ☐ Yes
Redness/Flushed	☐ No ☐ Yes
Pain/Tenderness	☐ No ☐ Yes
Other	☐ No ☐ Yes

Eyes	Currently
Subconjunctival hemorrhage	☐ No ☐ Yes
Periorbital edema	☐ No ☐ Yes
Ptosis	☐ No ☐ Yes
Bruising	☐ No ☐ Yes
Petechiae	☐ No ☐ Yes
Pain/Tenderness	☐ No ☐ Yes
Other	☐ No ☐ Yes

Nose	Currently
Swelling	☐ No ☐ Yes
Lacerations	☐ No ☐ Yes
Abrasions	☐ No ☐ Yes
Bruising	☐ No ☐ Yes
Redness/Flushed	☐ No ☐ Yes
Pain/Tenderness	☐ No ☐ Yes
Petechiae	☐ No ☐ Yes
Other	☐ No ☐ Yes

Mouth	Currently
Swollen Lips	☐ No ☐ Yes
Swollen Tongue	☐ No ☐ Yes
Petechiae	☐ No ☐ Yes
Lacerations	☐ No ☐ Yes
Abrasions	☐ No ☐ Yes
Bruising	☐ No ☐ Yes
Pain/Tenderness	☐ No ☐ Yes
Other	☐ No ☐ Yes

Under Chin	Currently
Erythema	☐ No ☐ Yes
Lacerations	☐ No ☐ Yes
Abrasions	☐ No ☐ Yes
Bruising	☐ No ☐ Yes
Linear Marks	☐ No ☐ Yes
Pain/Tenderness	☐ No ☐ Yes
Petechiae	☐ No ☐ Yes
Other	☐ No ☐ Yes

Ears	Currently
Petechiae	☐ No ☐ Yes
Swelling	☐ No ☐ Yes
Lacerations	☐ No ☐ Yes
Abrasions	☐ No ☐ Yes
Bruising	☐ No ☐ Yes
Bleeding	☐ No ☐ Yes
Pain/Tenderness	☐ No ☐ Yes
Other	☐ No ☐ Yes

Neck	Currently
Petechiae	☐ No ☐ Yes
Swelling	☐ No ☐ Yes
Lacerations	☐ No ☐ Yes
Abrasions	☐ No ☐ Yes
Bruising	☐ No ☐ Yes
Linear Marks	☐ No ☐ Yes
Ligature Marks	☐ No ☐ Yes
Pain/Tenderness	☐ No ☐ Yes
Other	☐ No ☐ Yes

Hands and Fingers	Currently
Erythema	☐ No ☐ Yes
Lacerations	☐ No ☐ Yes
Abrasions	☐ No ☐ Yes
Bruising	☐ No ☐ Yes
Broken fingernails	☐ No ☐ Yes
Pain/Tenderness	☐ No ☐ Yes
Other	☐ No ☐ Yes

Arms	Currently
Erythema	☐ No ☐ Yes
Lacerations	☐ No ☐ Yes
Abrasions	☐ No ☐ Yes
Bruising	☐ No ☐ Yes
Pain/Tenderness	☐ No ☐ Yes
Other	☐ No ☐ Yes

Nurse or Clinician Name (Print)	Nurse or Clinician Signature

Page 7

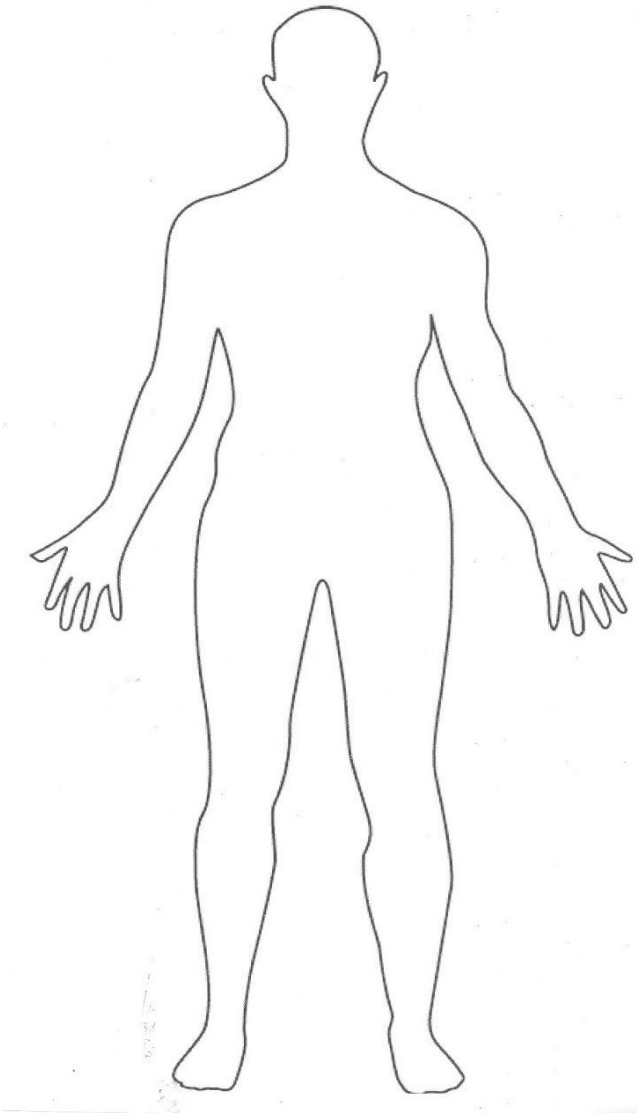
Place Patient Label Here

Record injuries on anatomical diagrams.
Complete during the physical examination.

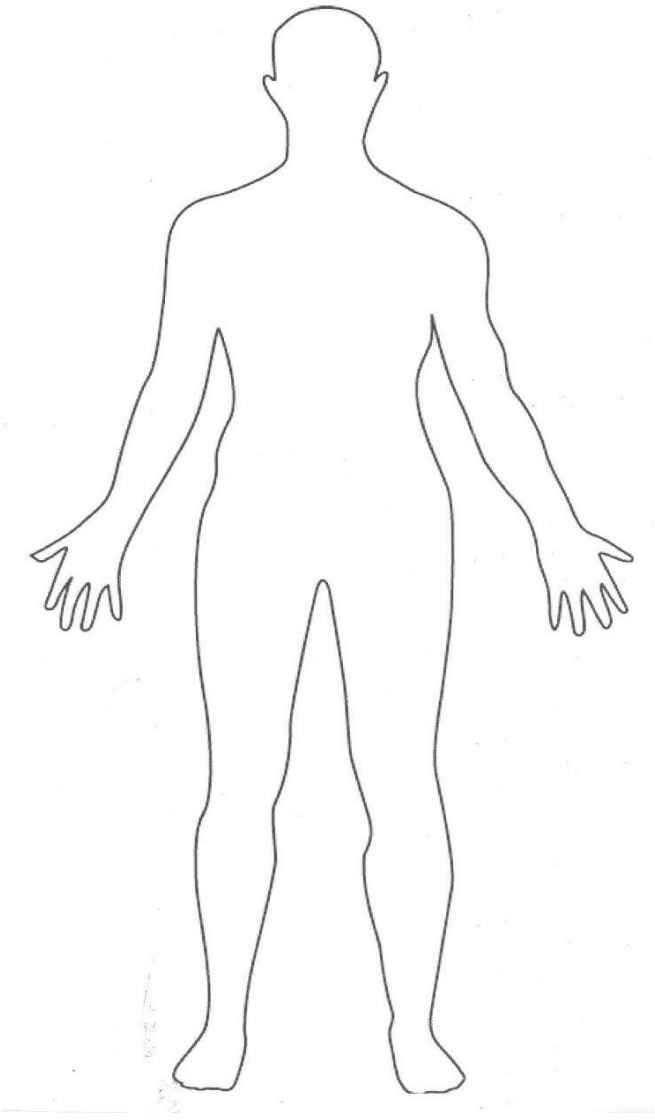
Check method used:

☐ Direct visualization ☐ Alternative Light Source

☐ Photograph ☐ Other:_____



Front



Back

NPTT = No physical trauma noted at this time

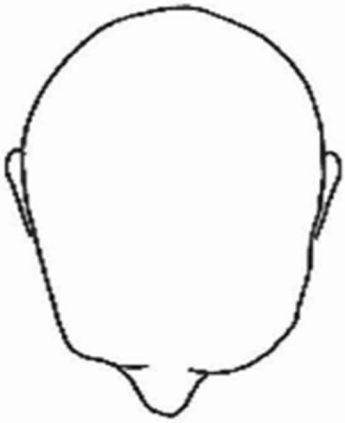
DSC = Dried stain collected

Nurse or Clinician Name (Print)	Nurse or Clinician Signature

Page 8

Place Patient Label Here

Top of Head



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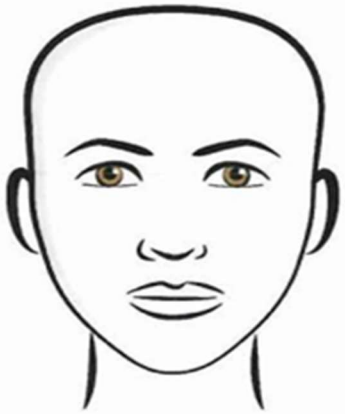
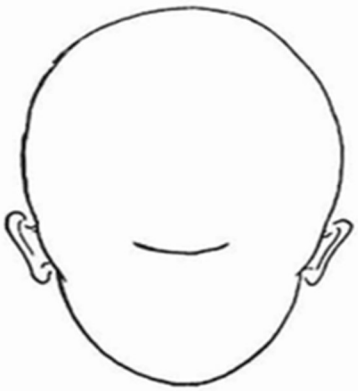


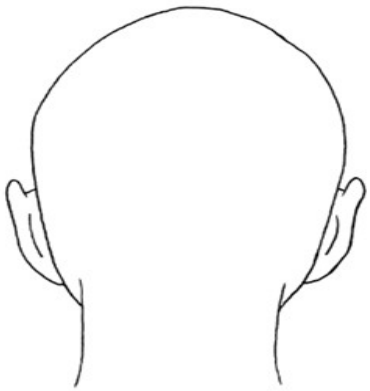
Neck & Chin

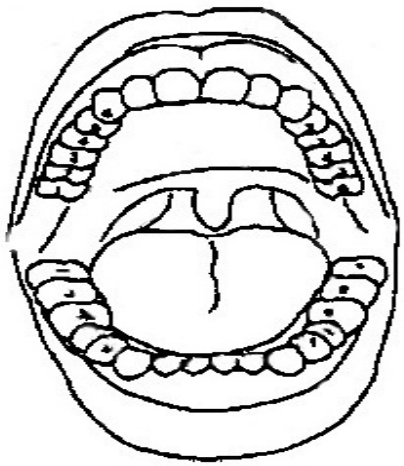
Left Side

Right Side

Back of Head







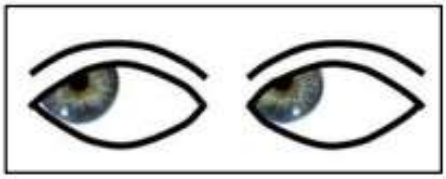
Indicate the location, shape, and type of injury: lacerations, erythema, abrasions, redness, and swelling.

NPTT = No physical trauma noted at this time.

DSC = Dried stain collected

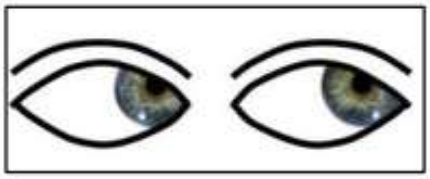
Nurse or Clinician Name (Print)	**Nurse or Clinician Signature**

Page 9	Place Patient Label Here



Up and to the right

Elevation



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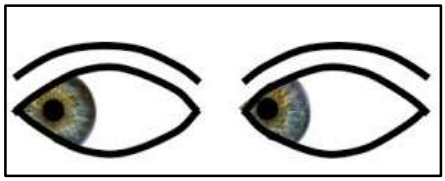
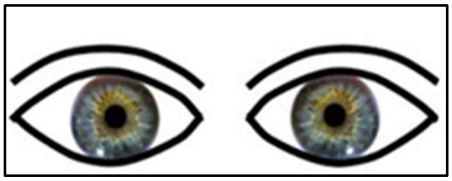
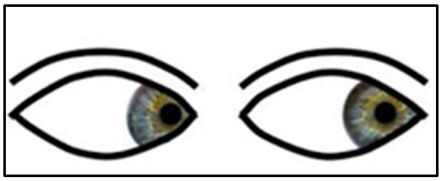


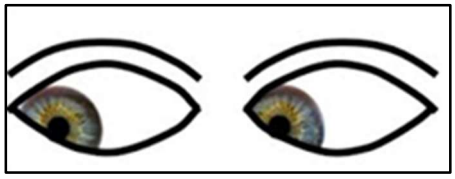
To the right



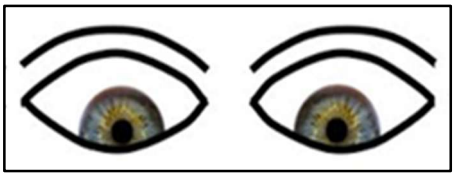
Primary Position



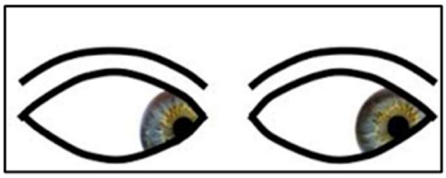
To the left



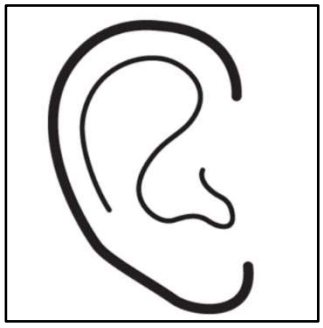
Down and to the right



Depression



Down and to the left



Right ear

Behind right ear

Left ear

Behind left ear

NPTT = No physical trauma noted at this time.
DSC = Dried stain collected

Nurse or Clinician Name (Print)	**Nurse or Clinician Signature**

	Place Patient Label Here

Section 7: Forensic Injury Documentation: See anatomical drawings to correlate injuries with photographs

Indicate the location, shape, and type of injury: tears (lacerations), erythema, abrasions, redness, and swelling.

Injury #	Location	Description	Size	Dried Stain Collected?
				☐ No ☐ Yes
				☐ No ☐ Yes
				☐ No ☐ Yes
				☐ No ☐ Yes
				☐ No ☐ Yes
				☐ No ☐ Yes
				☐ No ☐ Yes
				☐ No ☐ Yes
				☐ No ☐ Yes
				☐ No ☐ Yes
				☐ No ☐ Yes
				☐ No ☐ Yes
				☐ No ☐ Yes
				☐ No ☐ Yes
				☐ No ☐ Yes
				☐ No ☐ Yes
				☐ No ☐ Yes

Photos taken by:	**Date:**
Nurse or Clinician Name (Print)	**Nurse or Clinician Signature**