



Royal Kingdom of Cambodia

Nation Religion King

Ministry of Health

Phnom Penh, 30th, August, 2004

No. 031 ABPh/ChP

Minister of Health

To

- Director of Provincial-Capital Health Department
- Director of National Hospital
- Director of Center
- And All authorized private sector

Objective: Guidelines on Sexual abuse examination file

Reference: - Due to many sexual abuses at the current situation, which led to the difficulty in juridical decision of authority.

- Based on the Meeting of Gynecology Specialists collaborated with legal and medical Working Groups

Ministry of Health has developed the sexual abused examination file for official use. Therefore, all Referral Hospitals, including authorized private clinics shall adhere to filing this sexual abused examination file for every case of woman and children sexual abuse according to the instructions of Hospital Department.

Sincerely Yours,

CC:

- Ministry of Justice
- Ministry of Interior
- Directorate of Ministry of Health
- Directorate of Admin and Finance, Ministry of Health
- National Medical Council
- Capital-Provincial Medical Council
- Document, archive

(Stamped and Signature)

Touch Sokhom

The Kingdom of Cambodia



Nation-Religion-King



Ministry of Health
Facility:.....
No. :.....

Confidential

Sexual Abuse Examination File

(female: done by obstetric-gynaecologist physician, male: can be done by general physician)

-Patient examination files must be kept originally in the original facility or provincial/ municipal forensic committee. This file consists of a total of 7 pages.

- The provincial/municipal forensic committee can provide a copy of this form unless there is a formal written request from: Judiciary police that have duty in the investigation, judge, prosecutor, and lawyer. The copied file must be kept in the sealed envelop in order to ensure confidentiality.

- Operational facility:Phone No.....

- Provincial/municipal committee:Phone No

Fax:.....Email.....

- National forensic committee (MoH):Phone No

Fax:.....Email.....

Sexual Abuse Examination File

Name and surname of victim:Nickname:Sex: Male Female

Date of birth:/...../..... Current Address :

.....Code number:

Phone number:

Date of examination:/...../.....Hour:

Place of examination:

Suspected sexual abuse (provided by victim)

- Rape
- Incest
- Indecent Assault
- Other sexual abuses:

Date of abuse:/...../.....Hour:

Accompanied persons

- Self Police
- Friend Relatives(what) :
- Others (specify).....

Name:

Phone:

Informed consent for medical examination

(read to the victim or the guardian with witness)

I totally agree on this medical examination including genital examination and record of the results of this examination. I allow: to collect all necessary analysis samples for laboratory test and take any necessary pictures on the injured parts that are relevant to this medication examination.

Date:...../...../.....

Signature or right thumb print

Victim or guardian



Victim's name.....

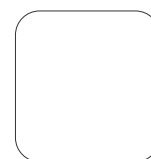
Relationship with victim

- Self Police Friend
- Relatives (what)
- Others (specify):

.....

Signature or right thumb print

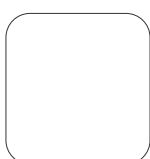
Witness



Witness' name.....

Signature or right thumb print

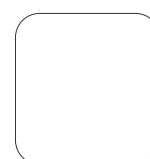
Physician-clinical examiner



Name of Physician:

Signature or right thumb print

Physician Witness



Name of Physician witness.....

Career:

Victim Examination



Name:Place of examination.....

Name of physician:Hour of examination.....

Address of facility:

1. History and interrogation:

1.1 Antecedent:

- | | | | | | |
|-------------------------|------------------------------|-----------------------------|-------------------|------------------------------|-----------------------------|
| A-Heart: | yes <input type="checkbox"/> | no <input type="checkbox"/> | B- Liver: | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| C- High blood pressure: | yes <input type="checkbox"/> | no <input type="checkbox"/> | D-STD: | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| E- Surgery: | yes <input type="checkbox"/> | no <input type="checkbox"/> | F- Mental health: | yes <input type="checkbox"/> | no <input type="checkbox"/> |

G- Others (specify) :

1.2 Menstrual history: Non pubertal:Date of first menstruation.....

Date of last menstruation

1.3 History of sexual intercourse: first intercourse, date:
last intercourse, date:.....

1.4 History of Birth Spacing: Methods:.....numbers:.....when:.....

1.5 Pregnancy history:

- | | | | | | |
|------------------------|------------------------------|-----------------------------|-------------------------|----------------------|-------|
| A. pregnancy: | yes <input type="checkbox"/> | no <input type="checkbox"/> | B. Number of pregnancy: | <input type="text"/> | times |
| C. Number of delivery: | <input type="text"/> | times | D. Number of abortion: | <input type="text"/> | times |

1.6 Methods of intercourse:

- | | | | | | |
|---------------------------|------------------------------|-----------------------------|-----------------------------|------------------------------|-----------------------------|
| A. Insert penis in vagina | yes <input type="checkbox"/> | no <input type="checkbox"/> | B. Insert fingers in vagina | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| C. Insert penis in mouth | yes <input type="checkbox"/> | no <input type="checkbox"/> | D. Insert penis in anus | yes <input type="checkbox"/> | no <input type="checkbox"/> |
- E. Others:

1.7 Behaviours after sexual intercourse:

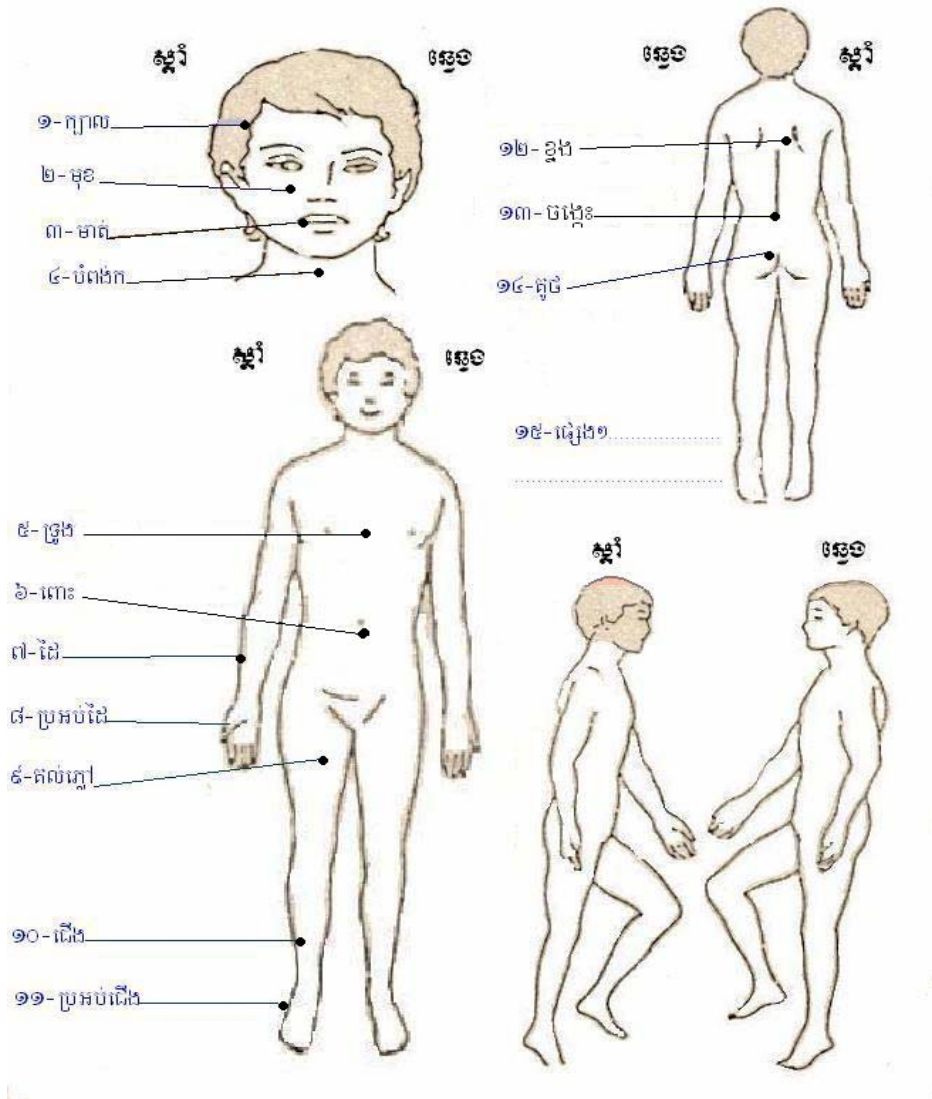
- | | | | | | |
|-------------------|------------------------------|-----------------------------|-----------------|------------------------------|-----------------------------|
| A. Wash vagina | yes <input type="checkbox"/> | no <input type="checkbox"/> | B. Urinate | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| C. Defecate | yes <input type="checkbox"/> | no <input type="checkbox"/> | D. Shower | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| E. Clean mouth | yes <input type="checkbox"/> | no <input type="checkbox"/> | F. Clean Teeth | yes <input type="checkbox"/> | no <input type="checkbox"/> |
| G. Change dresses | yes <input type="checkbox"/> | no <input type="checkbox"/> | H. Others:..... | | |

2. Clinical examination:

2.1 General examination: use the diagram for details on all abrasion, swelling, scratch and tear

	Normal	Abnormal (please indicate the size of the wound)
1.	<input type="checkbox"/> Head	<input type="checkbox"/> :
2.	<input type="checkbox"/> Face	<input type="checkbox"/> :
3.	<input type="checkbox"/> Mouth	<input type="checkbox"/> :
4.	<input type="checkbox"/> Neck	<input type="checkbox"/> :
5.	<input type="checkbox"/> Chest	<input type="checkbox"/> :
6.	<input type="checkbox"/> Abdomen	<input type="checkbox"/> :
7.	<input type="checkbox"/> Arm	<input type="checkbox"/> :
8.	<input type="checkbox"/> Hand	<input type="checkbox"/> :
9.	<input type="checkbox"/> Thigh	<input type="checkbox"/> :
10.	<input type="checkbox"/> Leg	<input type="checkbox"/> :
11.	<input type="checkbox"/> foot	<input type="checkbox"/> :
12.	<input type="checkbox"/> Back	<input type="checkbox"/> :
13.	<input type="checkbox"/> Waist	<input type="checkbox"/> :
14.	<input type="checkbox"/> Buttock	<input type="checkbox"/> :
15.	<input type="checkbox"/> Others	<input type="checkbox"/> :

Please indicate the place, the size in cm of the wound



2.2 External genital examination:

-Vulva:

- Lubrificant Semen Blood
- Mucus Pus Others

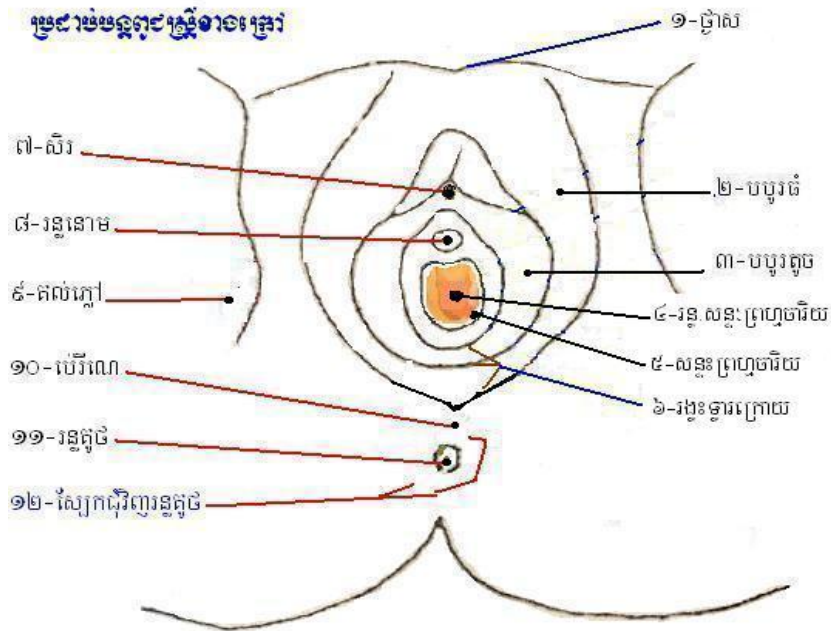
-External genital:

- Mature Pubertal Pre-pubertal

-Examination record any pain or tenderness

	Normal	Abnormal (please indicate the size of the wound)
1-	<input type="checkbox"/> Mons	<input type="checkbox"/> :
2-	<input type="checkbox"/> Labia majora	<input type="checkbox"/> :
3-	<input type="checkbox"/> Labia minora	<input type="checkbox"/> :
4-	<input type="checkbox"/> Introitus	<input type="checkbox"/> :
5-	<input type="checkbox"/> Hymen	<input type="checkbox"/> :
6-	<input type="checkbox"/> Posteriour anus	<input type="checkbox"/> :
7-	<input type="checkbox"/> Clitoris	<input type="checkbox"/> :
8-	<input type="checkbox"/> Meat	<input type="checkbox"/> :
9-	<input type="checkbox"/> Inner thighs	<input type="checkbox"/> :
10-	<input type="checkbox"/> Perineum	<input type="checkbox"/> :
11-	<input type="checkbox"/> Anus	<input type="checkbox"/> :
12-	<input type="checkbox"/> Perianal skin	<input type="checkbox"/> :

Please indicate the place, the size in cm of the wound



- Take analysis samples to detect presence of blood cell or semen
- Procedure before internal genital examination, please take sample by cotton smear for forensic medicine purpose and documentation.

2.3 Internal genital examination:

A. with speculum:

Normal

- 1- Cul de sac
- 2- Cervic
- 3- Anterior vagina membrane
- 4- Posterior vagina membrane

Abnormal (please indicate the size of the wound)

- :
- :
- :
- :

B. Vaginal examination:

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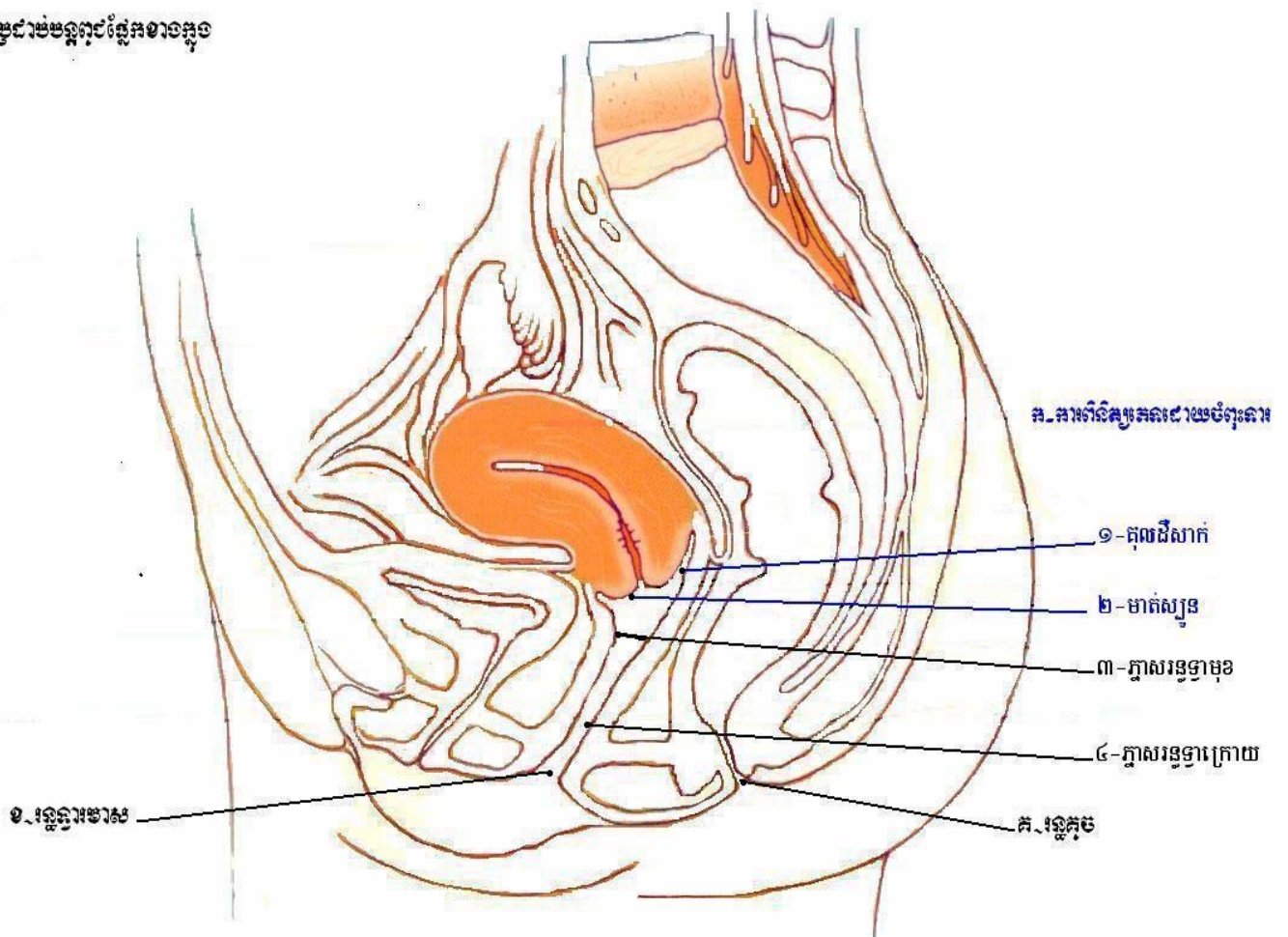
C. Rectal examination:

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Please indicate location, size in cm, of the wound

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Note: For male or monosexual man, please indicate the wound in the conclusion below:

3. Analysis samples:

- Vagina mucus
- Anal mucus
- Nails
- Cervical mucus
- Hair
- Other specify :
- Blood
- Body hair

4. Laboratory examination:

- | | | | |
|--------------|--------------------------|------------------|--------------------------|
| -Wet Mount | <input type="checkbox"/> | -Pregnancy Test | <input type="checkbox"/> |
| -Gram Stain | <input type="checkbox"/> | - Urine Analysis | <input type="checkbox"/> |
| -Sperm Check | <input type="checkbox"/> | - HIV Test | <input type="checkbox"/> |
| -RPR | <input type="checkbox"/> | -Others..... | |

5. Conclusion and recommendation:

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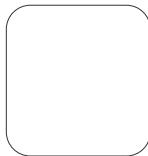
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**Consent Form for Information Delivery to:
Judiciary police that have duty in investigation, judges, prosecutors, lawyers**

I, undersigned, permit the hospitalor doctor named to provide a copy of my sexual abuse examination form and other relevant laboratory reports to judiciary police that have role in investigation, judges, prosecutors, lawyers, that request for the forensic purpose. If needed, the provincial/municipal forensic committee can provide this copy with written request from judiciary polices, judges, prosecutors, lawyers.

Date.....

Signature or right thumb print
of victim

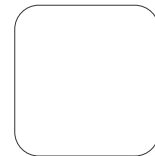


Name (Victim).....

Relationship of witness
with victim:

- Parents/Guardian
- Relatives
- Others (please specify)
.....
- Self (if no witness)

Signature or right thumb print
of witness



Name (Witness).....

Seen and approved

Date.....

Signature-Provincial/municipal forensic committee

.....

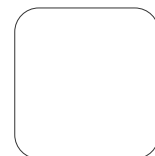


Director.....

Date.....

Signature with seal

Hospital-OD.....



Director.....