

# NATIONAL PRO-FORMA ADULT SEXUAL OFFENCE EXAMINATION

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### Guidance on how to use this document

*The Medical assessment (from pages 2-15) should be undertaken in all cases and should not be submitted with forensic documentation*

*Pages 16 to 49 (Forensic examination consent form, the forensic exam, the forensic examination sexual offences form and the SPA forensic support form should be completed by the sexual offences examiner to support current or future police engagement. In self-referral cases, this form must be fully completed and retained securely in the event of future police engagement*

*Upon police engagement, all original sections of this form must be provided to the investigating officers*

*A copy of all forensic documentation will be retained securely by the sexual offences examiner to inform statement writing*

*Pages 46 to 48 must accompany samples taken for Toxicology analysis. SPA Forensic Services will not accept items unless accompanied by this form.*

**MEDICAL ASSESSMENT**

**MEDICAL IN CONFIDENCE - Not to be submitted with forensic documentation**

**MEDICAL IN CONFIDENCE – Not to be submitted with forensic documentation**

***Personal Details***

Last name:..... First name:.....

Date of birth: ...../...../..... Age: .....

CHI number.....

Ethnicity (see Appendix A for all ethnic group codes) .....

Male:  Female:  Transgender Other

Current address:.....

.....Postcode: .....

Contact telephone No:..... Preferred method of contact:.....

Consent to Examination: Yes  No

Consent Form Attached: Yes  No  If no, why?.....

**Vulnerabilities (tick as appropriate)**

- Dementia
- Mental Health Problems
- Learning Disability
- Physical & Sensory Disability
- Drugs
- Alcohol
- Elderly/Frail
- Neurological Condition (excluding Dementia)
- Autism

Additional support needs identified e.g.: learning disabilities / interpreter:

.....  
.....

Tick if phone seized as a production:

***Details of Incident***

Date(DD/MM/YYYY): .... / .... / ..... Approx. Time (HH:MM) ....

**Location** (for full details, please see Appendix B)

**MEDICAL ASSESSMENT**

**MEDICAL IN CONFIDENCE - Not to be submitted with forensic documentation**

- Home
- Residential institution
- School, other institution or public administrative area
- Sports and athletics area
- Street and highway
- Trade and service area
- Industrial or construction area
- Farm
- Other specified space – please specify

Police engagement: Yes  No

***Brief History of Incident***

.....

.....

.....

.....

.....

.....

.....

.....

Presenting Symptoms.....

.....

.....

.....

.....

.....

Height..... Weight..... Pulse..... BP.....

Relevant Medical Information.....

.....

.....

.....

.....

.....

Recent or ongoing mental health problems.....

**MEDICAL ASSESSMENT**

**MEDICAL IN CONFIDENCE - Not to be submitted with forensic documentation**

.....  
.....  
.....

Current medication.....  
.....  
.....

Drug allergies.....  
.....

History of FGM?      Yes       country of origin.....      No

***Emergency Contraception Risk Assessment and Management Plan***

Present Contraception

None       Implant(s)       Condom       Oral Contraception   
Injectable       IUDI/IUS       Sterilised       Menopause (natural/iatrogenic)   
Natural       Not previously sexually active

LMP: .....      Cycle: .....

Current gestation if pregnant:    /40

No. of Births:.....      No. of Dependent children at home.....

Full name and ages of all children at home:  
.....  
.....  
.....

***Pregnancy***

Unprotected sexual intercourse since LMP?      Yes       No   
Is pregnancy a possibility?      Yes       No

Pregnancy test carried out?      Yes       No

If Yes      +       -   
Batch No. \_\_\_\_\_

If post natal, is individual breast feeding?      Yes       No

*If pregnant or breast feeding consider adverse drug reactions and other issues in pregnancy*  
[www.medicinescomplete.com](http://www.medicinescomplete.com)

**MEDICAL ASSESSMENT**

**MEDICAL IN CONFIDENCE - Not to be submitted with forensic documentation**

**Emergency Contraception Action Plan:**

Not Indicated	
IUD recommended and declined	
Declined all methods	
Levonelle - <i>Double dose if BMI &gt; 70kg or IUD if enzyme inducing drugs prescribed</i>	
Ulipristal - <i>consider if returning for emergency IUD insertion BMI &gt;30 or midcycle ) contraindicated in severe asthma or with enzyme inducers</i>	
IUD inserted	
Referred For IUD - <i>Consider dispensing oral hormonal method if any delay in fitting IUD</i>	

[www.fsrh.org.uk](http://www.fsrh.org.uk)

Women should be advised to wait 5 days after taking Ulipristal before starting suitable hormonal contraception. They should then abstain or use condoms until their chosen method is effective.

**Assessment and Testing for Sexually Transmitted Infections**

**Declined**

Reason if declined.....

**Baseline NAAT Test for Chlamydia & Gonorrhoea at time of Forensic Exam**

Yes  No

(Consider if sample requires Chain of Evidence Form)

Type of Sample:

vulvo-vaginal  urine  pharyngeal  rectal

**Blood borne virus screening (HIV/Syphilis/ Hepatitis B/C):**

	Blood obtained	Declined	Deferred	Not indicated include reason eg vaccinated /already infected
Serum Save				
HIV				
Syphilis				
Hepatitis B				
HepatitisC				

HPV Vaccination History Not applicable  Yes  No  Don't know

Cervical cytology screening performed Not applicable  Yes  No  Not due

Referred for Bacterial Sexual Health Screen 2 weeks post incident?

Yes  Not Indicated  Prophylactic antibiotics prescribed

**HIV/PEPSE – RISK ASSESSMENT**

No. of hours since exposure:.....

**MEDICAL ASSESSMENT**

**MEDICAL IN CONFIDENCE - Not to be submitted with forensic documentation**

**PEPSE**

Not Indicated  Declined  Indicated but >72hrs

Type of exposure:

Not known  Receptive/Vaginal (0.1 - 0.2%)   
Receptive/Anal (0.1-3.0%)  Receptive/Oral (0-0.047%)   
Other

Protected? Not Known  Yes  No

**Assailant HIV Risk Category:**

Positive  Negative  Unknown  High

Risk of transmission as discussed with individual: 1 in.....

*Risk of transmission = risk that source is positive x risk of exposure  
e.g. 1. Risk of transmission from penile/vaginal penetration by Scottish male of unknown HIV status = 1 in 1000 x 0.2%, risk = 1 in 500,000  
e.g. 2. Risk if penile/vaginal penetration by HIV positive male = 100% x 0.2% risk = 1 in 500  
See: <http://www.bashh.org/> for updated prevalence data*

**PEPSE indicated**

Give details of reasons for delay in considering if indicated but >72 hours since exposure:

.....

Weight:..... if < 40kg seek dosing advice from HIV Consultant/Pharmacist

Potential interactions with current prescribed or over the counter preparations explored

Check interactions at [www.hiv-druginteractions.org](http://www.hiv-druginteractions.org)

Details.....

.....

*Advise condoms if using COCP, POP, Implant, Patch (explain possible side effects- seek medical advice if fever, rash, myalgia, lymphadenopath)*

Individual has been made aware that PEPSE efficacy is unproven

Does patient want to initiate PEPSE following discussion? Yes  No

**Baseline Investigations**

**HIV Testing:** Done  Declined

*All patients should have an HIV test prior to starting PEPSE - if declined state why*

**MEDICAL ASSESSMENT**

**MEDICAL IN CONFIDENCE - Not to be submitted with forensic documentation**

.....

U&E,	
LFT,	
Urinalysis (white top bottle if positive for protein)	
Syphilis	
Hep B Core	
Hep C Ag	
Pregnancy Test	

**Hep B Vaccination**

Not Indicated     Already Vaccinated     1<sup>st</sup> Dose Given     Declined

If declined, why?.....

Give details of Hepatitis A risk below if Twinrix or Hep A vaccine prescribed.....

.....

**MEDICAL ASSESSMENT**

**MEDICAL IN CONFIDENCE - Not to be submitted with forensic documentation**

***Psychosocial Risk Assessment***

**Coping and Social Support**

What are your main concerns and anxieties?

.....  
.....  
.....

Domestic Abuse    Yes     No

if yes consider Safe Lives RIC

Are you sleeping/eating as usual?    Yes     No

Who have you disclosed to?

.....  
.....

Are you using drugs, including psychoactive substances (legal highs) or alcohol

Yes     No

Details if provided.....

in a problematic way?    Yes     No

If yes: How much? .....

Which substances? .....

How often? .....

Duration of problem.....

Do any of these problems predate the incident?    Yes     No

Has this changed recently? If so, when?

.....  
.....  
.....  
.....



**MEDICAL ASSESSMENT**

**MEDICAL IN CONFIDENCE - Not to be submitted with forensic documentation**

**Self harm risk**

Have you ever self harmed? Yes  No

When was the most recent self harm incident?

*Harmful coping may pre date assault so ask if history of self harm generally then explore if recurrence /concerns of recurrent harmful coping following incident.*

.....  
.....

Method used to self harm

overdose  cutting  burning  other

What was the intention in doing this?

To hurt oneself  ease emotional pain  to die  other

Did you tell anyone? Details.....

.....

Did you seek medical attention? Details.....

.....

Have you considered or self harmed since the sexual assault? Yes  No

Details:.....

If Yes, have you told anyone?

Details.....

.....

.....

**Suicide risk**

Have you ever tried to take your own life? Yes  No

Details:.....

.....

.....

Since the sexual assault have you at any point felt suicidal? Yes  No

**MEDICAL ASSESSMENT**

**MEDICAL IN CONFIDENCE - Not to be submitted with forensic documentation**

If yes, has this been:

Fleeting thoughts  persistent thoughts  vague plans  specific plans

If specific plans, what are these:.....  
.....

Do you have the means to carry these plans out? Yes  No

Is there anything that would stop you acting on these thoughts? Yes  No

If yes what?.....

**Where appropriate suggest they consider putting Samaritans Number/Support Services number into their phone.**

**Safety on leaving medical examination**

Where does Individual intend to go after leaving?.....

Are there concerns regarding safety? Yes  No

Other social concerns, returning home, returning to work, school, university:.....  
.....  
.....

If yes give details and any advice given or referrals made.....  
.....  
.....

Any concerns perceived by clinician which have not been raised by Individual? (*consider including demeanour*)

.....  
.....  
.....  
.....

With Individual's consent details of any issues that Individual wishes to be highlighted with GP /other health /social professional

.....  
.....  
.....

**MEDICAL ASSESSMENT**

**MEDICAL IN CONFIDENCE - Not to be submitted with forensic documentation**

Any child protection issues identified? Yes  No

If yes, give details of issues.....

.....  
.....

**MEDICAL ASSESSMENT**

**MEDICAL IN CONFIDENCE - Not to be submitted with forensic documentation**

**ACTION PLAN**

**SAFETY ASSURED**

Details of local support services/referral made: Yes  No

Risk assessment in medical summary forwarded to GP for future reference: Yes  No

**Rape Crisis Number 08088010302 / 0141 552 3200**

**Samaritans 08475 909090 / 0141248 4488**

**Information Provided to Individual:**

Individual Handbook Yes  No

Samaritans number Yes  No

Rape Crisis Number Yes  No

Declined

Other.....

**SAFETY NOT ASSURED**

Referred to on call psychiatrist: Yes  No

Details of information shared and method:

.....  
.....  
.....  
.....  
.....  
.....

## MEDICAL ASSESSMENT

**MEDICAL IN CONFIDENCE - Not to be submitted with forensic documentation**

**Medication Prescribed**

**Date:**

**Name:**

Drug	Dose	Route	Frequency	Duration	Prescribed by	Dispensed by	Batch & Expiry
Levonogestrel	1.5g	oral	stat				
Ulipristal	30mg	oral	stat				
TT380Slimline IUD							
Other IUD							
Contraceptive Implant							
Truvada tablets	245mg/200	Oral	<i>One tablet daily at same time each day</i>	5 day pack			
Raltegravir tablets	400mg	Oral	<i>One tablet twice daily every 12 hours</i>	5 day pack			
Twinrix Prefilled syringe	20mcg	intramuscular	<i>Day 0,7, 21 &amp; 12 months</i>				
Enerix B Prefilled syringe	20mcg	intramuscular	<i>Day 0,7, 21 &amp; 12 months</i>				

**MEDICAL ASSESSMENT**

**MEDICAL IN CONFIDENCE - Not to be submitted with forensic documentation**

**Follow Up Requirements**

Follow up:    Accepted                     Declined

**Key concerns & outstanding issues if client wishes to return for follow up:**

Advised to have STI screen for bacterial infections 14 days after incident. STI screening involves Vulvo-vaginal swab for gonorrhoea/ Chlamydia NAAT test for females and first pass urine sample for males. Rectal and /or oral swabs dependent on incident details)  
Yes     No

Advised to consider interim HIV testing four weeks post incident (*or 8 weeks post incident if on HIV PEPSE) if particularly anxious or high risk See BASHH.org.uk for up to date guidelines.*  
Yes     No

Advised to have Blood Borne Virus screening 12 weeks after incident (*including syphilis serology or 12 weeks after completion of HIV PEPSE if prescribed*)  
Yes     No

Any additional information:

.....  
.....  
.....  
.....  
.....  
.....  
.....  
.....  
.....

**MEDICAL ASSESSMENT**

**MEDICAL IN CONFIDENCE - Not to be submitted with forensic documentation**

I hereby consent to my information being shared with / referrals be made (with consent) to the following agencies / services:

- |  |                  |                              |                             |
|--|------------------|------------------------------|-----------------------------|
| 3 <sup>rd</sup> Sector Organisations               | Rape Crisis      | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
|  | Common Knowledge | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
|  | People First     | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Advocate   |                  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| General Practitioner                               |                  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Support Worker                                     |                  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Sexual Health Services                             |                  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Fast Track for Emergency Contraception             |                  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Accident and Emergency                             |                  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Gynaecology  |                  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Psychiatry   |                  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Social Work – Adult Protection                     |                  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Social Work – Child Protection                     |                  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Social Work – Pre-existing allocated social worker |                  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Sexual Health Advisor (PEPSE follow up)            |                  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Sexual Health Advisor (BBV screening)              |                  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Trafficking Awareness Project e.g. TARA            |                  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| MARAC  |                  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Named Person                                       |                  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Other: please specify .....                        |                  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Summary of attendance forwarded (with consent)

- to sexual health services for inclusion onto other patient record
- others: .....

**FORENSIC EXAMINATION**

- Pages 16 to 41 to be completed by the sexual offences examiner to support current or future police engagement. In self-referral cases, this form must be fully completed and retained securely in the event of future police engagement
- Upon police engagement, all original sections of this form must be provided to the investigating officers
- A copy of all forensic documentation will be retained securely by the sexual offences examiner to inform statement writing

**Consent to Forensic Examination**

I have been advised that I may cross out any of the below before I sign and that I can stop the examination at any time,

I ....., consent to examination as explained to me by Dr.....to be held at ..... at (HH:MM)

and to include the following (tick as appropriate):

1. Forensic Examination
2. Collection of forensic specimens / clothing with the following in attendance: 
  - a) Doctor
  - b) Nurse
  - c) Police Officer (police officer will be screened from the examination)
  - d) Other e.g. Crisis Worker / Rape Centre Advocate
3. Taking digital images, photographs or colposcopy images for evidential, diagnostic or training purposes
4. A copy of this report will be held by health and a summary will be forwarded to my GP with my consent
5. A written report by the examining doctor will be provided to the police and / or Procurator Fiscal with my consent
6. Material used for teaching, training publication or peer review will remain anonymous
7. Forensic specimens/clothing will be retained as per national agreement\*

**I understand that the information recorded in case notes and any photographs may be required as evidence in preparation for court proceedings.**

Individual .....(Signed) Date (DD/MM/YYYY):.....

Doctor .....(Signed) Date (DD/MM/YYYY):.....

Guardian .....(Signed) Date (DD/MM/YYYY):.....

Interpreter .....(Signed) Date (DD/MM/YYYY):.....

\* Work is ongoing to establish agreement about retention of materials, particularly in cases where there is no police engagement, detail to follow.



## FORENSIC EXAMINATION

### Details of Sexual Offences Liaison Officer

Name			
Date of Birth (DD/MM/YYYY)		Age	
Contact Details			
Preferred Method of Contact	Telephone <input type="checkbox"/>	By Post <input type="checkbox"/>	
	Email <input type="checkbox"/>	Other <input type="checkbox"/>	

### Forensic Examination Details

Date of Examination (DD/MM/YYYY)			
Start Time (HH:MM)		Finish Time (HH:MM)	
Location of examination (including room if applicable)			
Time of consent (HH:MM)			

### Details of Examiner

Gender of Examiner	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Was gender of FME offered?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Was gender of FME requested?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Was gender of FME request met?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

### Details of Health Professionals (1) – Lead Health Professional

Name			
Date of Birth (DD/MM/YYYY)		Age	
Contact Details			
Preferred Method of Contact	Telephone <input type="checkbox"/>	By Post <input type="checkbox"/>	
	Email <input type="checkbox"/>	Other <input type="checkbox"/>	
Qualifications			
GMC / Identifier			
Postings / Experience			

**FORENSIC EXAMINATION**

**Details of Health Professionals (2) – Supporting Health Professional**

Name			
Date of Birth (DD/MM/YYYY)		Age	
Contact Details			
Preferred Method of Contact	Telephone <input type="checkbox"/>	By Post <input type="checkbox"/>	
	Email <input type="checkbox"/>	Other <input type="checkbox"/>	
Qualifications			
GMC / Identifier			
Postings / Experience			

**Additional Information**

Details of Other Persons present during medical examination	
Reason for attendance	

**Vulnerabilities (tick as appropriate)**

Dementia	<input type="checkbox"/>
Mental Health Problems	<input type="checkbox"/>
Learning Disability	<input type="checkbox"/>
Physical & Sensory Disability	<input type="checkbox"/>
Drugs	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>
Elderly/Frail	<input type="checkbox"/>
Neurological Condition (excluding Dementia)	<input type="checkbox"/>
Autism	<input type="checkbox"/>

**FORENSIC EXAMINATION**

**Body Survey of Individual**

Include details on body diagrams of any piercings, tattoos, lesions, pigmentation etc.

	Description / Details (if applicable)		Tick if Body Diagram Used (if applicable)	Injured?	
				Yes	No
Missing or damaged clothing items / jewellery			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scalp / Hair			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hair colour (head)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Face			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ears			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mouth (include details of any dentures / retainers)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lips			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck / Throat			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Buttocks			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arms			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hands			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fingers			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Length of Fingernails (Left / Right)	L	R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Front of chest			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breasts			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdomen			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legs			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thighs			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feet			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Disability			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**FORENSIC EXAMINATION**

<b>Systems Examination</b>	
<b>Signs of Intoxication?</b> (alcohol and / or drugs)	Yes <input type="checkbox"/> No <input type="checkbox"/>
If <b>Yes</b> , please comment:	
<b>Abdominal Examination</b> (where appropriate)	
<b>Central Nervous System</b> (where appropriate)	
<b>Cardio Vascular System</b> (where appropriate)	
<b>Respiratory System</b> (where appropriate)	

<b>Female Genital Examination</b>					
<b>Position used for examination</b>					
Lithotomy <input type="checkbox"/>	Supine <input type="checkbox"/>	Left lateral <input type="checkbox"/>	Knee chest <input type="checkbox"/>		
	<b>Injured?</b>			<b>Injured?</b>	
	Yes	No		Yes	No
<b>Pubic Area</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Labia Majora</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Labia Minora</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Clitoris / Hood</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Urethra</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Perineum</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Vaginal Wall</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Cervix</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Hymen Tissue / Remnants</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Posterior Fourchette</b> (Junction of labia minora posteriority)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Vestibule</b> (Concavity containing openings of urethra, vagina and Bartholin's gland)	<input type="checkbox"/>	<input type="checkbox"/>	<b>Fossa Navicularis</b> (Lowest part of vestibule from vaginal orifice to posterior fourchette)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Bleeding?</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<b>Menstruation</b> <input type="checkbox"/>	<b>Injury</b> <input type="checkbox"/>	
<b>Pubic Hair Present?</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<b>Piercings?</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>Speculum used?</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<b>PV examination?</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<b>Genital Examination Findings</b>					

**FORENSIC EXAMINATION**

**Male Genital Examination**

**Position used for examination**

Supine  Other (specify)

	Injured?			Injured?	
	Yes	No		Yes	No
Pubic Area	<input type="checkbox"/>	<input type="checkbox"/>	Penile Shaft	<input type="checkbox"/>	<input type="checkbox"/>
Penis	<input type="checkbox"/>	<input type="checkbox"/>	Urethral Orifice	<input type="checkbox"/>	<input type="checkbox"/>
Foreskin	<input type="checkbox"/>	<input type="checkbox"/>	Scrotum / Testes	<input type="checkbox"/>	<input type="checkbox"/>
Glans Penis	<input type="checkbox"/>	<input type="checkbox"/>	Perineum	<input type="checkbox"/>	<input type="checkbox"/>

**Genital Examination Findings**

**FORENSIC EXAMINATION**

**Anal Examination – Male or Female**

**Position used for examination**

Supine     Left lateral     Knee chest

**External Examination**

	Injured?			Injured?	
	Yes	No		Yes	No
Natal folds	<input type="checkbox"/>	<input type="checkbox"/>	Anal margin	<input type="checkbox"/>	<input type="checkbox"/>
Perianal findings	<input type="checkbox"/>	<input type="checkbox"/>			

**Internal Examination**

Proctoscope    Yes     No     Declined     Not Applicable

**Anal Examination Findings**

**FORENSIC EXAMINATION**

<b>Colposcopy examination?</b>	<b>Yes</b> <input type="checkbox"/>	<b>If yes, by whom?</b>				
	<b>No</b> <input type="checkbox"/>	<b>Date</b> (DD/MM/YY YY)			<b>Time</b> (HH:MM)	
	<b>If no, state reason</b>				<b>Intimate examine not performed</b> <input type="checkbox"/>	
					<b>Equipment not available</b> <input type="checkbox"/>	
				<b>Other, please specify.....</b> .....		
<b>Where stored</b>						
<b>Reference Number</b>						
<b>Police Photographer</b>	Attended <input type="checkbox"/>	<b>Time</b> (HH: MM)	:		Deferred <input type="checkbox"/>	
<b>Medical Illustrations</b>	Attended <input type="checkbox"/>	<b>Time</b> (HH: MM)	:		Deferred <input type="checkbox"/>	

<b>Photography Advised / Taken For Injuries Present?</b>	<b>Yes</b> <input type="checkbox"/>	<b>If yes, by whom?</b>				
	<b>No</b> <input type="checkbox"/>	<b>Date</b> (DD/MM/YY YY)			<b>Time</b> (HH:MM)	
<b>Where stored</b>						
<b>Reference Number</b>						
<b>Police Photographer</b>	Attended <input type="checkbox"/>	<b>Time</b> (HH: MM)	:		Deferred <input type="checkbox"/>	
<b>Medical Illustrations</b>	Attended <input type="checkbox"/>	<b>Time</b> (HH: MM)	:		Deferred <input type="checkbox"/>	

<b>Examination Finish Time (HH:MM)</b>		:	hours
--	--	---	-------

**FORENSIC EXAMINATION**

**Summary of Lead Health Professional's Examination**

[Empty box for summary of examination]



## FORENSIC EXAMINATION

### Findings and Professional Opinion of Lead Health Professional

*(This should include an interpretation of the presence or absence of injuries and whether findings are consistent with the account provided by the individual.)*

<b>Signature of Lead Health Professional</b>	
<b>Print Name</b>	
<b>Signature of Second Health Professional</b>	
<b>Print Name</b>	
<b>Signature of Other NHS Clinical Staff (if applicable)</b>	
<b>Print Name</b>	

**FORENSIC EXAMINATION SEXUAL OFFENCES FORM – ADULT**  
**RESTRICTED**

Referral Source			
Police Enquiry	<input type="checkbox"/>	Self-Referral	<input type="checkbox"/>
		Agency	<input type="checkbox"/>
Details of referrer			
Date referral received (DD/MM/YYYY)		Time referral received (HH:MM)	
Reason for forensic examination			
Date of examination (DD/MM/YYYY)		Time of examination (HH:MM)	
Was the examination delayed?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
If yes, length of delay (HH:MM)			
Reason for delay			
Place of examination			
Individual Details			
Name			
Date of Birth (DD/MM/YYYY)		Age	
Gender	Male	<input type="checkbox"/>	Transgender
	Female	<input type="checkbox"/>	Other
Address			
Preferred Method of Future Contact	Telephone	<input type="checkbox"/>	By Post
	Email	<input type="checkbox"/>	Other
Contact Details			
Additional Information			
1 <sup>st</sup> language		Details of interpreter	
Learning disability		Details of appropriate adult	
Adult with incapacity		Details of Guardian	
Other need			

**FORENSIC EXAMINATION SEXUAL OFFENCES FORM – ADULT**  
**RESTRICTED**

**Details of Police Officers (in Police engagement cases)**

Officer Name		Rank		PSI	
Contact Details					
Officer Name		Rank		PSI	
Contact Details					
Date briefed (DD/MM/YYYY)		Time briefed (HH:MM)			

**Incident Details provided by Police (in Police engagement cases)**

Date of disclosure (DD/MM/YYYY)		Time of disclosure (HH:MM)	
Disclosure to police made by			
Statement taken	Full <input type="checkbox"/>	Interim <input type="checkbox"/>	No <input type="checkbox"/>
Date of incident (DD/MM/YYYY)		Time of incident (HH:MM)	
Address of incident		No of Suspects	

*Summary of briefing provided by police officers*

**FORENSIC EXAMINATION SEXUAL OFFENCES FORM – ADULT**  
**RESTRICTED**

**Forensic Samples taken prior to Examination**

Urine <input type="checkbox"/>	Pad / Tampon <input type="checkbox"/>	Condom <input type="checkbox"/>	Mouth Swab / Saliva / Mouth Rinse <input type="checkbox"/>
Phone <input type="checkbox"/>	Clothes <input type="checkbox"/>		DNA 2 <input type="checkbox"/>
Skin Swabbing <input type="checkbox"/>			
Other			

**Incident Details provided by Individual (If no police engagement)**

Date account provided (DD/MM/YYYY)		Time account provided	
---------------------------------------	--	--------------------------	--

**FORENSIC EXAMINATION SEXUAL OFFENCES FORM – ADULT**  
**RESTRICTED**

		(HH:MM)	
Date of incident (DD/MM/YYYY)		Time of incident (HH:MM)	
Address of incident		No of Suspects	

*Additional details provided by individual or summary in self referred cases*

**FORENSIC EXAMINATION SEXUAL OFFENCES FORM – ADULT**  
**RESTRICTED**

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**Details of any presenting Symptoms**

Other details e.g. did individual volunteer that their genital area or any other area of body felt damp?

--

**Details of any relevant medical information**

None <input type="checkbox"/>	Dysuria <input type="checkbox"/>	Abdo Pain <input type="checkbox"/>	Pain on Defecation <input type="checkbox"/>
Vagina: Pain/Soreness <input type="checkbox"/>	Bleeding <input type="checkbox"/>	Itching <input type="checkbox"/>	Discharge <input type="checkbox"/>
Rectum: Pain/Soreness <input type="checkbox"/>	Bleeding <input type="checkbox"/>	Itching <input type="checkbox"/>	Discharge <input type="checkbox"/>
Penile: Pain/Soreness <input type="checkbox"/>	Bleeding <input type="checkbox"/>	Itching <input type="checkbox"/>	Discharge <input type="checkbox"/>

*For example; skin condition, bruising tendency, physical disability*

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## SCOTTISH POLICE AUTHORITY FORENSIC SUPPORT FORM

- **Pages 31 to 41 must be completed and a copy submitted to SPA Forensic Services with the productions. SPA Forensic Services will not accept items unless accompanied by this form.**

Senior Investigating Officer (SIO)					
Officer Name		Rank		PSI	
Contact Details					
Date of incident (DD/MM/YYYY)		Date of examination (DD/MM/YYYY)		Start Time (HH:MM)	
				Finish Time (HH:MM)	
Police Reference No.					
Health Reference No.					
Lab Reference No.					

Nature of Incident					
Drug facilitated sexual assault (DFSA)	<input type="checkbox"/>	Amnesia of events	<input type="checkbox"/>		
Oral / skin	<input type="checkbox"/>	Fellated by assailant	<input type="checkbox"/>		
Fellation on assailant	<input type="checkbox"/>	Cunnilingus	<input type="checkbox"/>		
Digital / vaginal	<input type="checkbox"/>	Digital / anal	<input type="checkbox"/>		
Penile / vaginal	<input type="checkbox"/>	Penile / anal	<input type="checkbox"/>		
Object / anal	<input type="checkbox"/>	Object / oral	<input type="checkbox"/>		
Object / vaginal	<input type="checkbox"/>				
Other contact (e.g. kissing, licking, biting)	<input type="checkbox"/>	Specify			
Condom used?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>		
Lubricant used?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>		
Did ejaculation take place?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>		
If Yes, location of ejaculation:					
Mouth <input type="checkbox"/>	Vagina <input type="checkbox"/>	Anus <input type="checkbox"/>	Other <input type="checkbox"/>		
Additional details of possible sites of ejaculation (or other fluids) (e.g. did the individual state that their genital or any other area of the body felt damp?)					

**SCOTTISH POLICE AUTHORITY FORENSIC SUPPORT FORM**

Genital Bleeding			
Site of Bleeding			
Traumatic	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Uncertain <input type="checkbox"/>
Menstrual	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Uncertain <input type="checkbox"/>

Ethnicity of Assailant (codes below)			
0 – Unknown	1 – White North European	2 – White South European	3 – Black
4 – Asian	5 – Chinese, Japanese or any other South East Asian		6 – Arabic or North African

Relationship With Assailant(s)	1	2	3	4	5
<b>Stranger</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>New Acquaintance</b> (known to individual for less than 24 hours)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Acquaintance</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Work Colleague</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Partner</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Ex-Partner</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Family Member</b> (if family member, specify relationship)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Previous Sexual Activity?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Timing of sexual activity prior to the incident and post incident *</b>					



**SCOTTISH POLICE AUTHORITY FORENSIC SUPPORT FORM**

**Additional information to assist the forensic biologist in interpreting presence of DNA profiles from consensual contact**

*\* Number of hours if <48 hours, number of days if 2 – 14 days, number of weeks, number of months.*

**Details of sexual activity 7 days prior to incident and until medical examination (other than with assailant)**

<b>Date (DD/MM/YYYY) and Time (HH:MM)</b>			
<b>Prior to Incident? (Y / N)</b>			
<b>Gender of Contact (F / M/ Other )</b>			
<b>Nature of Sexual Contact</b>			
<b>Vasectomy? (Y, N, N/A, Not known)</b>			
<b>Condom Used? (Y, N, N/A)</b>			
<b>Lubrication Used? (Y / N)</b>			

**Post Incident Information**

*Approximately how often have the following activities been carried out since the incident? (Complete as relevant)*

	Urinated	Washed	Bathed	Showered	Changed Tampon / Pad / Diaphragm	Douched Vaginal / Anal	Defecated	Brushed Teeth / Mouth Wash
No of Times								

**Any other details relevant to Forensic Scientist**

*(e.g. known history of vasectomy in sexual contacts)*

**Completed by**

**Print Name**

**SCOTTISH POLICE AUTHORITY FORENSIC SUPPORT FORM**

**Samples to be considered**

\*Recommended for consideration if intoxication, suspected DFSA, amnesia or uncertain of events.

**This list includes the routinely taken samples, however the consideration of the case circumstances will dictate which ones are appropriate to take as not all samples are required in all cases. Samples to be sequentially numbered if more than one, and taken in line with the current FFLM guidelines.**

**\*Early Evidence Samples**

Early Evidence Urine (3/4 full, shake) <input type="checkbox"/> Evidence Bag Number .....	Toilet Paper <input type="checkbox"/> Evidence Bag Number .....
Early Evidence Mouth Swab (for semen) <input type="checkbox"/> Evidence Bag Number .....	Early Evidence Mouth Rinse (10ml gargled sterile water) <input type="checkbox"/> Evidence Bag Number .....

**Toxicology Samples**

*Preserved Blood (10ml, shake) within 3 days <input type="checkbox"/> Evidence bag number .....	*Urine 2 (taken within 1 hour of Early Evidence Urine if possible) and within 24 hours of incident (3/4 full, shake) <input type="checkbox"/> Evidence bag number .....
Head Hair for Toxicology (4 to 6 weeks, and up to 6 months after incident) for DFSA only <input type="checkbox"/> Evidence bag number .....	

*Sanitary Wear (specify) Tampon, Pad, Other Evidence bag number .....	
--	--

Please note when removed, and who by	
--------------------------------------	--

**\*Mouth (for the presence of semen – defer police taking DNA2 sample until forensic samples taken)**

Mouth Swab <input type="checkbox"/> Evidence bag number .....
Mouth Rinse (10mls gargled sterile water) <input type="checkbox"/> Evidence bag number .....
Saliva <input type="checkbox"/> Evidence bag number .....

**SCOTTISH POLICE AUTHORITY FORENSIC SUPPORT FORM**

<b>Hair</b>	Head	Pubic
Visible debris (collect with forceps)	<input type="checkbox"/>	<input type="checkbox"/>
Evidence bag number		
Body fluid (cut out / swab)	<input type="checkbox"/>	<input type="checkbox"/>
Evidence bag number		
Hair combings	<input type="checkbox"/>	<input type="checkbox"/>
Evidence bag number		
Control Hair Sample (for visual comparison only)	<input type="checkbox"/>	<input type="checkbox"/>
Evidence bag number		

<b>Nails</b>	
*Fingernail swabbing	Left – wet and dry <input type="checkbox"/>
	Evidence bag no.....
	Right – wet and dry <input type="checkbox"/>
	Evidence bag no.....
Fingernail clipping (only required if debris visible after swabbing or for comparison with a broken nail)	Left <input type="checkbox"/>
	Evidence bag no.....
	Right <input type="checkbox"/>
	Evidence bag no.....
*Right hand swabs	<input type="checkbox"/>
Evidence bag number .....	
*Left hand swabs	<input type="checkbox"/>
Evidence bag number.....	
<b>Skin – Swabs x 2: 1 wet (1), 1 dry (2) from each site</b>	
*Peri-oral	<input type="checkbox"/>
Evidence bag number .....	
*Face	<input type="checkbox"/>
Evidence bag number .....	
*Neck Swabs	<input type="checkbox"/>
Evidence bag number .....	

**SCOTTISH POLICE AUTHORITY FORENSIC SUPPORT FORM**

*Right Breast		<input type="checkbox"/>
Evidence bag number .....		
*Left Breast		<input type="checkbox"/>
Evidence bag number .....		
*Inner Thighs		<input type="checkbox"/>
Evidence bag number .....		
*Pubic Region (if shaved)		<input type="checkbox"/>
<b>*Female Genital Swabs (x 2)</b>	Vulval / Perineal	<input type="checkbox"/>
	Evidence bag number .....	
	Perianal Swabs	<input type="checkbox"/>
	Evidence bag number .....	
	Low Vaginal Swabs	<input type="checkbox"/>
	Evidence bag number .....	
	High Vaginal Swabs	<input type="checkbox"/>
	Evidence bag number .....	
	Endocervical Swabs	<input type="checkbox"/>
Evidence bag number .....		
<b>*Anal / Rectal Swabs (x 2)</b>	Perianal Swabs	<input type="checkbox"/>
	Evidence bag number .....	
	Anal Canal Swabs	<input type="checkbox"/>
	Evidence bag number .....	
	Rectal Swabs	<input type="checkbox"/>
Evidence bag number .....		
<b>*Penile Swabs (x 2)</b>	Shaft Swabs	<input type="checkbox"/>
	Evidence bag number .....	
	Coronal Sulcus Swabs	<input type="checkbox"/>
	Evidence bag number .....	
	Glans Swabs	<input type="checkbox"/>
	Evidence bag number .....	
	Scrotum swabs (if shaved)	<input type="checkbox"/>
Evidence bag number .....		

**SCOTTISH POLICE AUTHORITY FORENSIC SUPPORT FORM**

<b>If fluid has been accumulated:</b>	
<b>Speculum Swabs x 2 – 1 dry (2) from inside and outside of blades</b>	<input type="checkbox"/>
Evidence bag number .....	
<b>Proctoscope Swabs x 2 – from scope and obturator</b>	<input type="checkbox"/>
Evidence bag number .....	
<b>NB – if tampon in place take external genital swabs before removal</b>	

Clothing (specify items)	Washed?	
	Yes	No
Underpants	<input type="checkbox"/>	<input type="checkbox"/>
Evidence bag number .....		
Ground sheet if event is recent or individual wearing same clothes and / or not washed since the event.	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
Evidence bag number .....		
	<input type="checkbox"/>	<input type="checkbox"/>
Evidence bag number .....		
	<input type="checkbox"/>	<input type="checkbox"/>
Evidence bag number .....		

<b>Other Productions - E.g. other skin swabs, genital piercing, condom, gown (if staining / material visible), standing floor sheet (only required if examinee presenting directly from the incident)</b>	
<input type="checkbox"/>	<input type="checkbox"/>
Evidence bag number .....	Evidence bag number .....
<input type="checkbox"/>	<input type="checkbox"/>
Evidence bag number .....	Evidence bag number .....
<input type="checkbox"/>	<input type="checkbox"/>
Evidence bag number .....	Evidence bag number .....
<input type="checkbox"/>	<input type="checkbox"/>
Evidence bag number .....	Evidence bag number .....
<input type="checkbox"/>	<input type="checkbox"/>
Evidence bag number .....	Evidence bag number .....

**SCOTTISH POLICE AUTHORITY FORENSIC SUPPORT FORM**

<input type="checkbox"/>	<input type="checkbox"/>
Evidence bag number .....	Evidence bag number .....

<b>Lubricant used in Vaginal examinations?</b>		<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
Batch No.		Date	
<b>Lubricant used in Ano-rectal examination?</b>		<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
Batch No.		Date	
<b>Water used to moisten swabs?</b>		<b>Yes</b> <input type="checkbox"/>	<b>No</b> <input type="checkbox"/>
Batch No.		Date	

**SCOTTISH POLICE AUTHORITY FORENSIC SUPPORT FORM**

- Pages 46 to 48 must accompany samples taken for Toxicology analysis. SPA Forensic Services will not accept items unless accompanied by this form.

**Individual Details**

<b>Height (cm)</b>		<b>Weight (kgs)</b>	
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**Does the individual think they were given drugs?** Yes  No

**If Yes, Police must complete page 48 of the Toxicology Support Form**

**Details of alcohol / drugs consumed in the 3 days before the incident, and until medical examination**

<b>Time (24 hr clock) and Date Alcohol / Drugs Consumed</b>	<b>Alcohol (Details to be obtained from Briefing Officer)</b>	<b>Recreational Drugs Other than Alcohol (Details to be obtained from Briefing Officer)</b>	<b>Prescribed Drugs (Details from Individual)</b>	<b>Over the Counter Medicines (Details from Individual)</b>

**Sample Storage Information**

<b>Sample</b>	<b>Storage Requirements</b>	<b>Collection Date / Time</b>	
<b>Blood (collect within 72 hours)</b> Use only <b>alcohol-free</b> wipes on skin. 10mls blood in glass vials containing preservative	Mix for 30 seconds Refrigerate	Date	
		Time	

**SCOTTISH POLICE AUTHORITY FORENSIC SUPPORT FORM**

<b>Urine (collect within 14 days)</b> Samples to be submitted in a glass bottle coated with preservative	Mix for 30 seconds  Refrigerate	Early Evidence Urine (Urine 1)	Date	
			Time	
Has the individual urinated since the incident but prior to the Early Evidence Urine sample?	Yes <input type="checkbox"/>  No <input type="checkbox"/>			
If yes, what time was the most recent urination?				
<b>Urine 2</b> sample ideally collected <b>within 1 hour</b> of Urine 1, and within 24h of incident (if outwith 24hr only urine 1 is required)	Mix for 30 seconds Place toilet tissue in separate, labelled, tamper-evident bag  Store frozen	<b>Urine 2</b>	Date	
			Time	
<b>Hair (collect within 6 months)</b> Sample to be taken ideally 4-6 weeks post incident. Pencil thickness of hair from vertex of head using appropriate toxicology kit	Store dry at room temperature.	Date		
		Time		
<b>Vomit</b> Collect in suitable sterile container	Refrigerate	Date		
		Time		

Where **Volatile Substances** are involved (e.g. chloroform, aerosols, glues, poppers) take an additional blood sample and **freeze** as soon as possible, **keep frozen** in transit to lab.

Samples should be refrigerated and sent for analysis as soon as possible to avoid loss of evidence due to drug instability. Otherwise, for longer term storage retain in a freezer.



**SCOTTISH POLICE AUTHORITY FORENSIC SUPPORT FORM**

To be completed by the Police at time of sampling and submitted to SPA with the samples for alcohol / drugs analysis.

<b>Police Officer(s) Seizing Productions</b>	
Name (1)	
Police Scotland Identifier (PSI)	
Contact Email Address	
Contact Telephone No.	
Name (2)	
Police Scotland Identifier (PSI)	
Contact Email Address	
Contact Telephone No.	

<b>What makes you think you have been drugged?</b> Attach a copy of statement if available.

<b>How do you think a drug has been administered?</b> (e.g. spiked drink, forced to consume tablet etc.)

<b>What symptoms did you experience?</b>

<b>Were you unconscious?</b> If <b>yes</b> , do you recall when you fell asleep and woke up?

<b>Do you know the assailant?</b> If <b>yes</b> , what drugs might they have had available to use?

## **Appendices**

### **Appendix A**

#### **Ethnic Group (Code order)**

##### **Group A - White**

- 1A Scottish
- 1B Other British
- 1C Irish
- 1K Gypsy/ Traveller
- 1L Polish
- 1Z Other white ethnic group

##### **Group B - Mixed or multiple ethnic groups**

- 2A Any mixed or multiple ethnic groups

##### **Group C - Asian, Asian Scottish or Asian British**

- 3F Pakistani, Pakistani Scottish or Pakistani British
- 3G Indian, Indian Scottish or Indian British
- 3H Bangladeshi, Bangladeshi Scottish or Bangladeshi British
- 3J Chinese, Chinese Scottish or Chinese British
- 3Z Other Asian, Asian Scottish or Asian British

##### **Group D - African**

- 4D African, African Scottish or African British
- 4Y 4Y Other African

##### **Group E - Caribbean or Black**

- 5C Caribbean, Caribbean Scottish or Caribbean British
- 5D Black, Black Scottish or Black British
- 5Y Other Caribbean or Black

##### **Group F - Other ethnic group**

- 6A Arab, Arab Scottish or Arab British
- 6Z Other ethnic group

##### **Group G - Refused/Not provided by patient**

- 98 Refused/Not provided by patient

##### **Group H - Not Known**

- 99 Not Known

## Appendices

### Appendix B

1. **Home** – apartment, caravan, house (residential), driveway, garage, garden to home
2. **Residential Institution** – children’s home, hospice, military camp, nursing home, old people’s home, prison, reform school
3. **School, other institution or public administrative area** – church, cinema, college, courthouse, hospital, institute for higher education, library, museum, school, theatre, university
4. **Sports and athletics area** – golf course, stadium, swimming pool etc
5. **Street and highway** – motorway, pavement, road
6. **Trade and service area** – airport, casino, bank, café, commercial garage, hotel, market, office building, petrol station, restaurant, shop, shopping centre, bus or rail station, supermarket, warehouse, pub
7. **Industrial or construction area** – building under construction, factory, mine, oil rig
8. **Farm** – building, land
9. **Other specified place** – beach, campsite, canal, derelict house, forest, harbour, hill, lake, marsh, park, railway line, river, sea, stream, zoo