



REPUBLIC OF SOUTH AFRICA

Police Station:	CAS/ No / /
Name of Investigating officer:	Contact No:.....

REPORT ON A MEDICO-LEGAL EXAMINATION BY A HEALTH CARE PRACTITIONER

To be diligently completed electronically or in legible handwriting and signed on every page

PART I

CERTIFICATE IN TERMS OF SECTIONS 212(4), 212(8) AND 213(3) OF ACT 51 OF 1977 (AS AMENDED)

I,
(Full names and Surname)

hereby certify as follows:

- I am in the service of the *State/in the service of or attached to a university in the Republic in my capacity as *registered medical practitioner/nurse/other (please specify)
- On the day of (month) (year) at H..... (time of examination)
- and at (state place where examination took place), I examined the person indicated in Part II, Paragraph B.1 (page 2 of 6) of this **J88** form.
- I recorded my findings and observations on pages 2 to 6 of this **J88** form and any additional pages indicated. The facts recorded on pages 2 to 6 of this **J88** form, including any additional pages used where indicated, were established by means of an examination requiring skill in anatomy and pathology.
- In the performance of my official duties:
 - * a) I received and collected from (name of person/institute/ State department or body) clothing; object/s; specimens and/or tissue described in this **J88** form.
 - * b) I delivered or dispatched to (name of person/institute/ State department or body) the clothing, object/s, specimens and/or tissue specified in this **J88** form.
- * I packed and marked the clothing; object/s; specimens and/or tissue in the manner described in this **J88** form.

The contents of this **J88** form is true to the best of my knowledge and belief and I am making this statement knowing that, if it were tendered in evidence, I would be liable to prosecution if I willfully stated in it anything I knew to be false or which I do not believe to be true.

DATED AT (place) ON THE DAY OF (month) (year)
AT H (time).

.....
SIGNATURE OF	PRINT NAME AND SURNAME	STAMP OF
HEALTH CARE PRACTITIONER		HEALTH CARE PRACTITIONER

(NB: Section 212(4) and 212(8) provide for a certificate issued in terms of either of these sections to constitute, upon its production at criminal proceedings, prima facie proof of the facts alleged.)

* Delete which is/are not applicable

PART II

DETAILS OF MEDICO-LEGAL EXAMINATION

A. DETAILS OF PRACTITIONER AND FACILITY

1. Name of health facility/practice:	2. Physical address of facility/practice:
3. Telephone number of facility/practice:	4. Fax number of facility/practice:
5. Qualifications of practitioner:	6. Registration number of practitioner:
7. Cellular phone number of practitioner:	8. Email of practitioner:
9. Fax number for practitioner:	10. Health care facility/practitioner's patient record no:

B. PATIENT INFORMATION

1. Full names and surname (of patient):		Consent to Examination: <i>Signature of patient</i>		
2. Gender of patient:	<table border="1"> <tr> <td>Male</td> <td>Female</td> </tr> </table>	Male	Female	3. Date of birth/age of patient:
Male	Female			
4. Patient accompanied by:		5. People present during examination and capacity:		

C. MEDICAL HISTORY

1. Intellectual disability noted: None Possible impairment Definite impairment Specify:	<table border="1"> <tr><td>Yes</td><td>No</td></tr> <tr><td>Yes</td><td>No</td></tr> <tr><td>Yes</td><td>No</td></tr> </table>	Yes	No	Yes	No	Yes	No	2. Other impairments or disabilities noted: Hearing impairment Visual impairment Mental illness Other disability Specify:	<table border="1"> <tr><td>Yes</td><td>No</td></tr> <tr><td>Yes</td><td>No</td></tr> <tr><td>Yes</td><td>No</td></tr> <tr><td>Yes</td><td>No</td></tr> </table>	Yes	No	Yes	No	Yes	No	Yes	No
Yes	No																
Yes	No																
Yes	No																
Yes	No																
Yes	No																
Yes	No																
Yes	No																
3. Relevant medication taken:																	
4. Relevant medical history that can assist with differential diagnosis (State source & method of obtaining information e.g. patient him/herself, third persons: e.g. parent or caregiver, medical records or combination. Indicate if an interpreter was used as well as the language that was interpreted):																	
5. History of the alleged assault and/or rape e.g. date and time (State source & method obtaining information e.g. patient him/herself, third persons: e.g. parent or caregiver, medical records or combination. Indicate if an interpreter was used as well as the language that was interpreted):																	

Signature of health care practitioner

D. HISTORY OF RELEVANCE TO A SEXUAL OFFENCE (delete if not applicable)

1. Since the alleged offence took place has the patient:

Wiped	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bathed/washed	<input type="checkbox"/> Yes <input type="checkbox"/> No
Urinated	<input type="checkbox"/> Yes <input type="checkbox"/> No	Defecated	<input type="checkbox"/> Yes <input type="checkbox"/> No
Showered	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swam	<input type="checkbox"/> Yes <input type="checkbox"/> No
Been exposed to rain	<input type="checkbox"/> Yes <input type="checkbox"/> No		

2. Menstruating

At time of alleged sexual offence:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Since the alleged sexual offence:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Currently menstruating:	<input type="checkbox"/> Yes <input type="checkbox"/> No

3. During alleged sexual offence was:

Condom used:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lubricant used:	<input type="checkbox"/> Yes <input type="checkbox"/> No

4. Currently pregnant:

Yes No

If yes, indicate Duration: __ weeks

5. Ever had vaginal delivery:

Yes No

If yes, indicate Number: __

E. GENERAL EXAMINATION

1. Physical Appearance

a. Height _____ cm

b. Weight _____ kg

c. General body build: *Frail /Normal /Muscular /Obese /Other: _____ Percentiles (children only): _____

2. Clothing

a. Left clothes at the scene: Yes No (If yes, move to section E 3)

b. Changed clothes: Yes No

If clothing is available:

c. Torn/ripped/damaged: Yes No Specify item of clothing: _____

Describe:

d. Stained: Yes No Specify item of clothing: _____

Possibly blood: Yes No Swabbed: Yes No

Describe where on clothing:

Possibly semen Yes No Swabbed: Yes No

Describe where on clothing:

Other: Yes No Swabbed: Yes No

Nature of specimen: _____

Describe where on clothing:

e. Clothing collected for Forensic analysis Yes No } Record sample seal number in Section H

If yes, list the items:

3. Clinical evidence of drugs / alcohol at time of examination (e.g. Nystagmus, ataxia, slurred speech, dilated pupils):

Intoxicated / drugged

Blood samples taken

Alcohol evidence collection kit completed

Urine samples taken

Yes	No
Yes	No
Yes	No
Yes	No

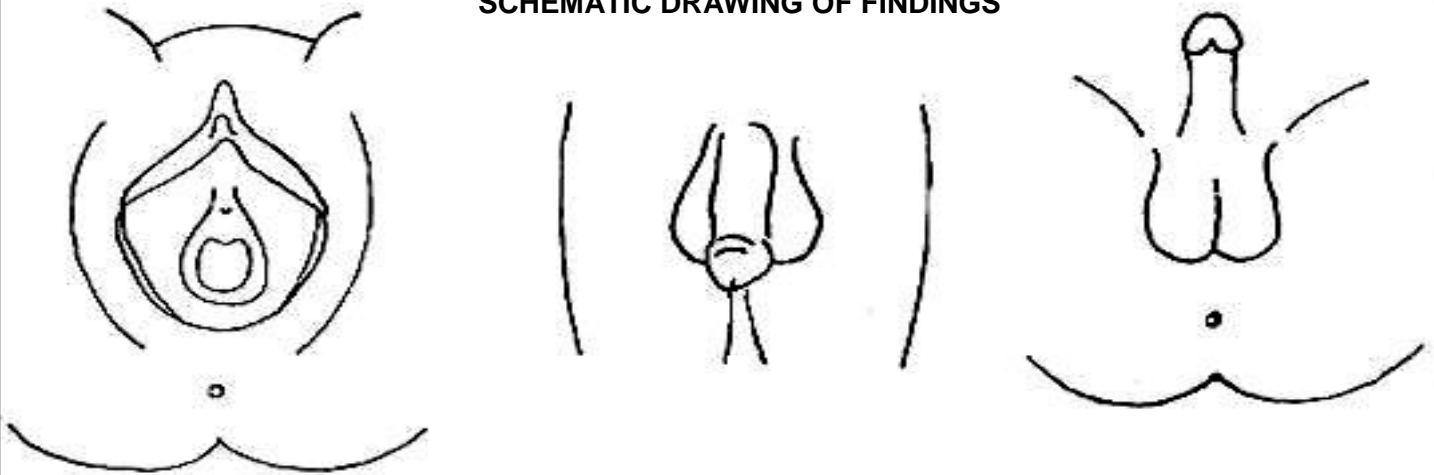
} Record sample seal number in Section H

* Delete which is/are not applicable
Mark appropriate block

Signature of health care practitioner

G.4 GYNAECOLOGICAL EXAMINATION (delete if not applicable)	
1. Breast development (children) Tanner stage 1-5: <input type="checkbox"/>	2. Pubic hair (children) Tanner Stage 1-5: <input type="checkbox"/>
3. Mons Pubis	4. Clitoris
5. Frenulum of clitoris	6. Urethral orifice
7. Labia Majora	8. Labia Minora
9. Posterior fourchette/Commissure	10. Vestibule Fossa navicularis Paraurethral area
11. Hymen Configuration: Posterior rim: Margin or edge of hymen:	
12. Vagina	13. Discharge (describe)
14. Cervix	15. Other injuries noted:

SCHEMATIC DRAWING OF FINDINGS



H. SPECIMENS COLLECTED FOR INVESTIGATION (delete if not applicable)	
1. Sexual assault evidence collection kit seal no./ sticker	2. Alcohol collection kit seal no./ sticker
3. Clothing kit seal no./ sticker	4. Urine and/or other samples (specify & provide seal no.)

I. TECHNOLOGY USED (delete if not applicable)	
Photographs taken <input type="checkbox"/> Yes <input type="checkbox"/> No Name of photographer:	Colposcope used <input type="checkbox"/> Yes <input type="checkbox"/> No Toluidine Blue used <input type="checkbox"/> Yes <input type="checkbox"/> No Other (specify):

J. ADDITIONAL PAGES USED AND ATTACHED

Number of pages added:

K. CONCLUSIONS (take account of history and all findings, both positive and negative)

Motivate reasons for conclusions made:

.....

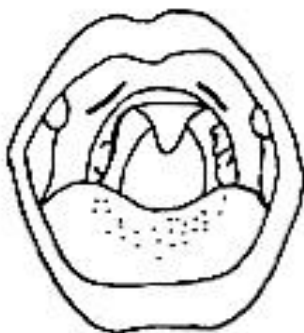
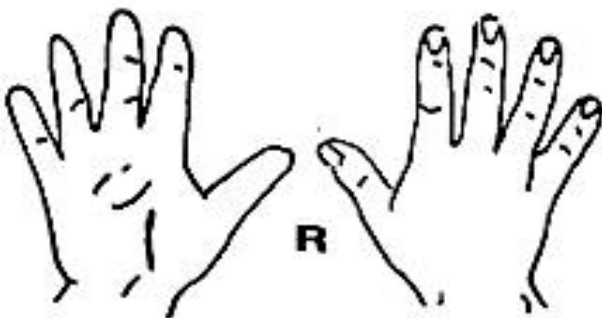
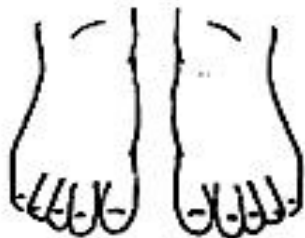
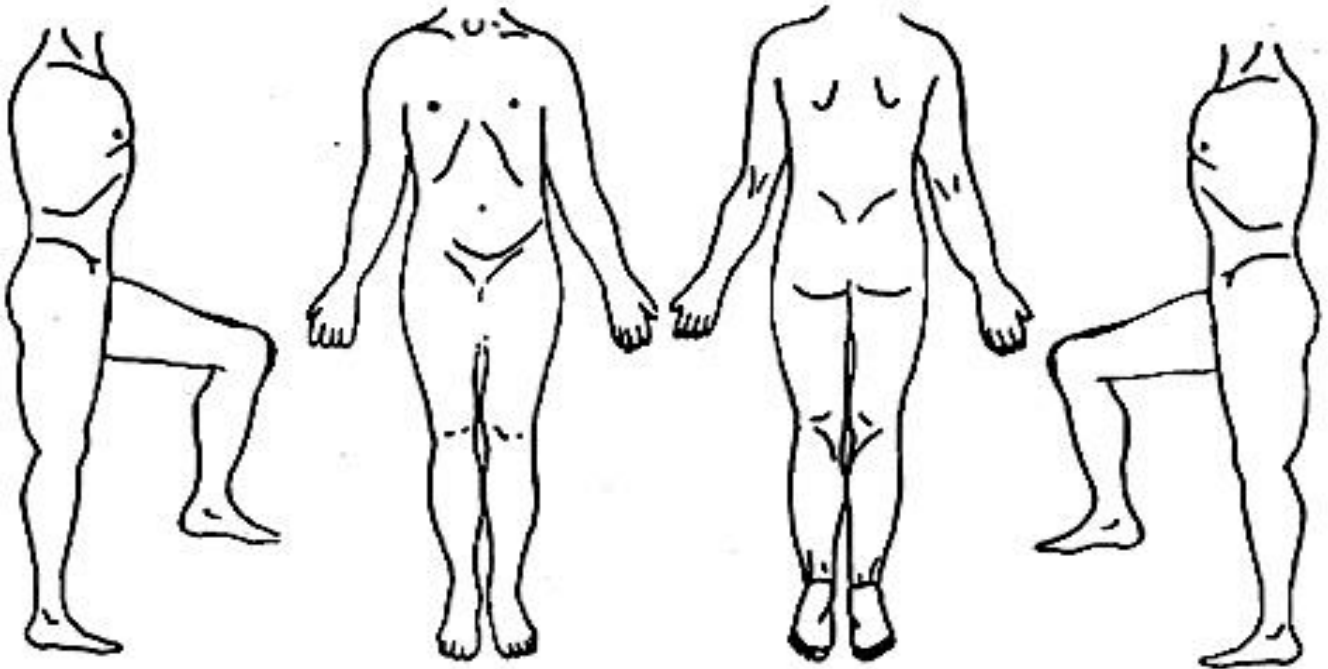
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L. TRANSFER DETAILS

J88 form handed to:	
Name:	Rank:
Signature:	Contact No.:

Signature of health care practitioner



Signature of health care practitioner