

Victorian Forensic Paediatric Medical Service

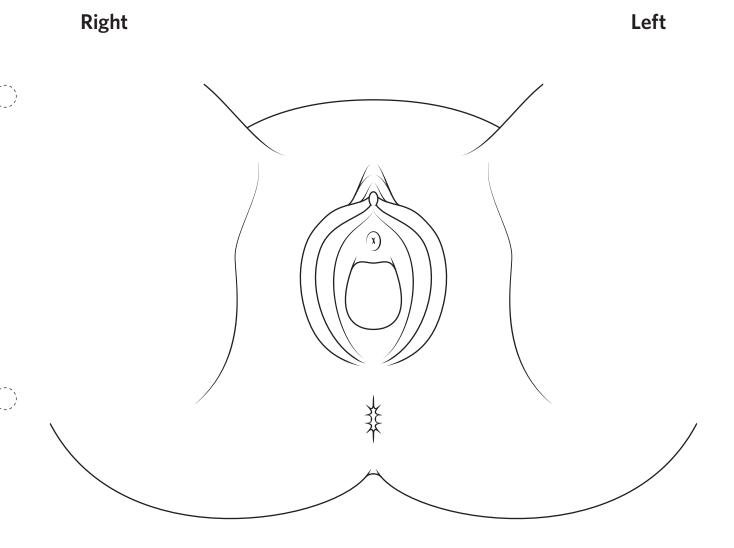
Body Chart Female Genitalia AFFIX PATIENT LABEL HERE ↑

UR NUMBER

SURNAME

GIVEN NAME(S)

DATE OF BIRTH



Date

Time

Signature of assessing doctor

UR NUMBER

SURNAME

GIVEN NAME(S)

DATE OF BIRTH

AFFIX PATIENT LABEL HERE $\, \uparrow \,$

Videocolposcopy performed	○ Yes	○ No	Colposcopy performed (no video)	Yes	\bigcirc I
Speculum examination conducted	Yes	○No	Proctoscopy conducted	Yes	\bigcirc ı
Examination position(s)					
Findings (comment on any injury, disch	narge or bleed	ing)			

Initial

Date