National Forensic Sciences University
Knowledge | Wisdom | Fulfilment
An Institution of National Importance
(Ministry of Home Affairs, Government of India)

Indian Nursing Council
8th Floor, NBCC Centre,
Plot No. 2, Community Centre
Okhla Phase-I
New Delhi - 110020

GUIDELINES

For Forensic Nurse

Specialist in

medico-legal cases

INDEX

Sr. No.	Drafts
1	Animal / Insect / Snake Bite Victim Examination
2	Chemical / Poison Ingestion Victim Examination
3	Injury Assault Victim Examination
4	Post Mortem Examination
5	Initial Examination for Victim of Burns
6	Sexual Assault Victim Examination
7	General Assault Victim Examination
8	Standard Protocols for Medicolegal Case Management
9	Reporting and Collaboration with Experts
10	Forensic Nurse Specialist Medicolegal Incident Report format
11	Forensic Evidence Checklist

FORENSIC NURSING ASSESSMENT

INITIAL NURSING ASSESSMENT (Animal / Insect Bite)

Name: _____

Age: _____

Gender: _____

Address: _____

Date Of Birth: _____

Religion: _____

Nationality: _____

Language: _____

Mobile No: _____

Date & Time Of incident: _____

Date of admission: _____

Ward And Cot No: _____

M.L.C. No.: _____

Vital Sign: _____

Temperature: _____

Blood Pressure: _____

Pulse: _____

Respiration: _____

SPO_2: _____

Pupils: _____

Time of Arrival: _____

Time of Assessment: _____

Other Patient Brought by: Self/ 108/ Police/ Relative/ Others/ _____

Patient Arrival: Ambulatory/ Wheelchair/ Stretcher/ Other/ _____

Transported with: Oxygen Monitor/ IV Line /Catheter Others /_____

_____

_____

Loss of Consciousness:

Grade I: Drowsy/ Responds to Verbal Commands/ _____

Grade II: Unconscious/ Responds only to minimal stimuli/ Shaking/ Shouting/ _____

Grade III: Unconscious/ Responds Only to maximally Painful stimuli/ _____

Grade IV: Unconscious/ No Response Whatever/ _____

Given Treatment (first aid treatment): _____

_____

_____

_____

General Condition of victim: _____

_____

_____

_____

_____

_____

Past Health History: _____

_____

_____

_____

_____

_____

Genogram:

Hearing Aid: Yes/ No/ _____

Built: Fair/ Poor/ _____

Nutrition: Good/ Fair/ Poor/ _____

Cyanosis: No/ Yes **and if** yes _____Central/ Peripheral/ Mixed _____

Pallor: Yes/ No/ _____

Oedema: Yes/ No/ _____Pitting/ Non-pitting/ Varicose veins/ _____

Type Of Skin: Dry/ Moist/ Thick/ Thin/ Pinched/ _____

Skin-color: Pale/ Flushed/ Cyanosed/ Yellow/ _____

Pigmentation: Hypopigmented/ Hyperpigmented/ _____

Eruptions: Yes/ No/ _____

Hair: Falling/ Hair loss/ Excessive hair/ _____

Nails: Pallor/ Koilonychia/ Onychia/ Discoloration/ Clubbing/ Cyanosis/
Haemorrhages/ Trophic changes/ _____

Musculoskeletal and Joints in gait: Yes/ No/ _____

Fracture: Yes/ No/ _____

Swelling: Yes/ No/ _____

Stiffness: Yes/ No/ _____

Pain: Yes/ No/ _____

Spasm: Yes/ No/ _____

Back pain: Yes/ No/ _____

Amputation: Yes/ No/ _____

Affected Site: _____

_____

_____

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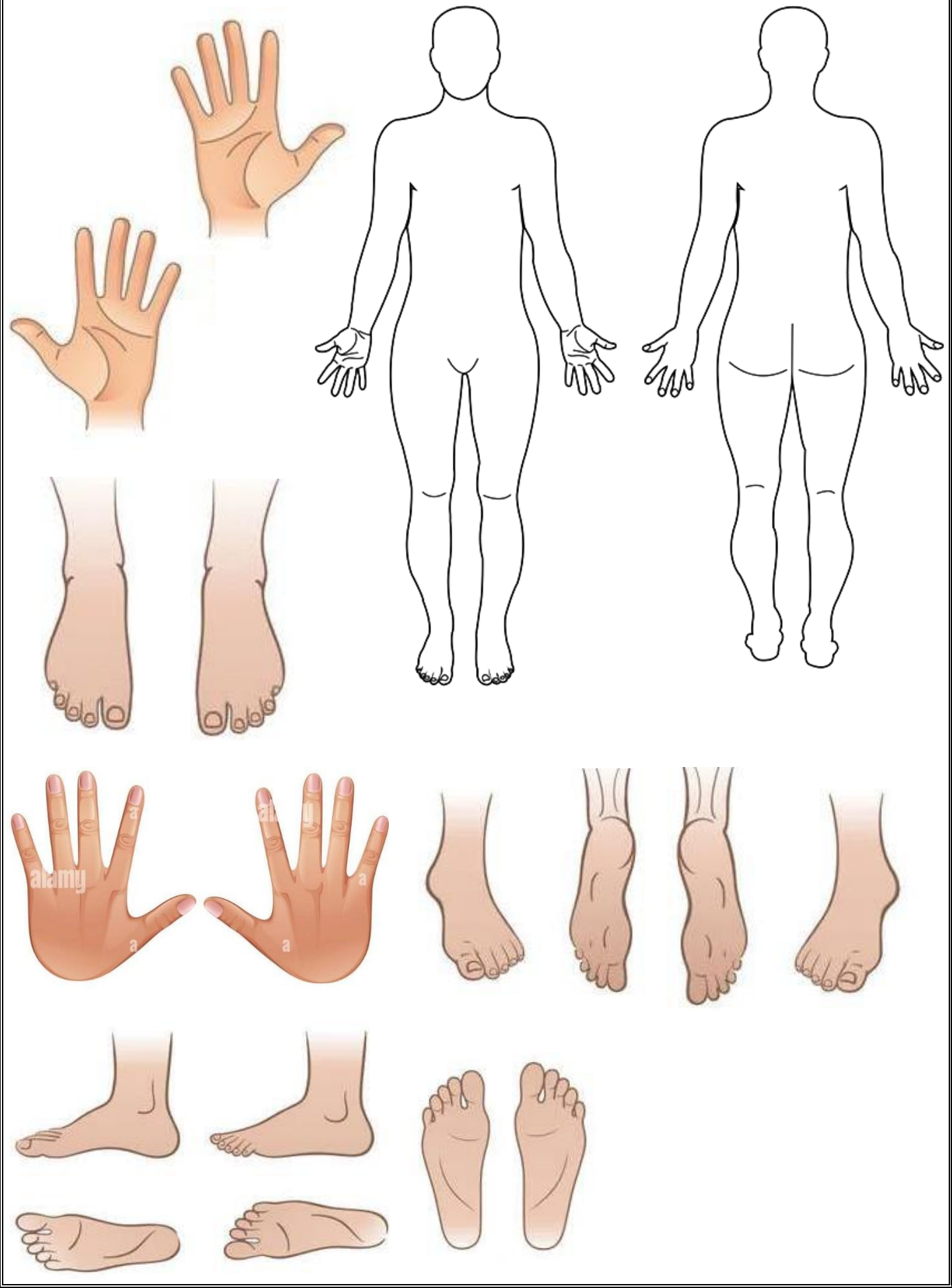
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Animal/ insect:

Type of Animal/ insect: _____

Colour of Animal/ insect: _____

_____

_____

_____

Bite marks: _____

Fang marks: _____

_____

_____

Local pain: Yes/ No _____

Local bleeding: Yes/ No _____

Bruising: Yes/ No _____

Lymphangitis: Yes/ No _____

Lymph node enlargement: Yes/ No _____

Inflammation: Swelling/ Redness/ Heat/ _____

Blistering: Yes/ No _____

Local infection: _____

Abscess formation: _____

Necrosis: Yes/ No _____

_____

_____

General condition: _____

Nausea: Yes/ No _____

Vomiting: Yes/ No _____

Malaise: Yes/ No _____

Abdominal pain: Yes/ No _____

Weakness: Yes/ No _____

Drowsiness: Yes/ No _____

Prostration: Yes/ No _____

Additional Remark: _____

_____

_____

_____

_____

SR NO.	TYPE OF SNAKE VENOM	PLACE TICK (✓) MARK IN	ACTION	PLACE TICK (✓) MARK IN	POSSIBLE SNAKE BITE	PLACE TICK (✓) MARK IN
1.	Cytotoxin		Destroys • Muscle • Cell • Tissue • Localize action on site of bite		Rattle Snake	
2.	Neurotoxin		• Fast degeneration of synaptic nerve • Respiratory Arrest • Convulsions • Nervous system including brain		Cobra	
3.	Hemotoxin		• RBC Decrease • Cardiovascular system including heart and blood			
4.	Mayotoxin		• Skeletal muscle necrosis • Paralysis			

CARDIVASCULAR CHANGES {Viperidae}:

Visual disturbance: Yes/ No _____

Dizziness: Yes/ No

_____

Faintness: Yes/ No _____

Collapse: Yes/ No _____

Shock: Yes/ No _____

Hypotension: _____

Cardiac arrhythmias: _____

Pulmonary oedema: _____

Additional Remark: _____

_____

_____

_____

_____

NEUROLOGICAL CHANGES:

Drowsiness: Yes/ No _____

Abnormalities of taste and smell: _____

Ptosis: Yes/ No _____

External ophthalmoplegia: _____

Muscle palsy's: Yes/ No _____

Aphonia: Yes/ No _____

Difficulty in swallowing: Yes/ No _____

Secretion: Yes/ No _____

Respiratory and generalised flaccid paralysis: Yes/ No _____

Additional Remark: _____

_____

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_____

_____

SKELETAL MUSCLE:

Generalisation: _____

Stiffness and tenderness of muscle: _____

Additional Remark: _____

_____

_____

_____

_____

RENAL CHANGES:

Local pain: _____

Haematuria: Yes/ No _____

Haemoglobinuria: Yes/ No _____

Myoglobinuria: Yes/ No _____

Oliguria/anuria: _____

Additional Remark: _____

_____

_____

_____

_____

ENDOCRINE CHANGES:

Acute phase: _____

Chronic phase: _____

Testicular atrophy: _____

Additional Remark: _____

_____

_____

_____

_____

Additional Remark: _____

_____

_____

_____

Oxygen Therapy:

Ventilator Support:

Mode: _____

Bi-Level: _____

BPM: _____

M.Ve: _____

PEEP: _____ **FiO_2:** _____**%**

Laboratory Investigation: _____

_____

_____

_____

_____

Surgical Intervention: _____

_____

_____

_____

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_____

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_____

Treatment: _____

_____

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Incident Report According to _____**/ Victim/ Relatives/ Witness/ Other:**

_____

_____

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_____

_____

NAME & SIGNATURES OF EXAMINER: _____

SYSTEMATIC MANAGEMENT: ANIMAL / INSECT / SNAKE BITE

Forensic Nursing – Initial Victim Examination Protocol

Bite / Sting Victim Received

IMMEDIATE SAFETY & PRIMARY SURVEY
PPE / scene-exposure safety • ABCDE • treat life-threatening conditions first

SNAKE BITE	ANIMAL BITE	INSECT / ARTHROPOD	UNKNOWN BITE
species if safely known	pet/stray/wild	sting/bite	unclear agent

ABCDE & VITALS	LOCAL EXAMINATION	SYSTEMIC SIGNS	HISTORY	DOCUMENTATION
airway/breathing/circulation GCS • pain • SpO_2	site • number • puncture/fang marks swelling • bleeding • necrosis	neurotoxicity • bleeding shock • allergy/anaphylaxis	time/place/activity • progression first aid/treatment • vaccination	body map • measurements photos when appropriate

CLINICAL ACTION	FORENSIC EVIDENCE	MEDICOLEGAL ASSESSMENT
Immobilize affected limb when indicated • wound care • monitoring antivenom/rabies/tetanus/other therapy only per treating protocol	Preserve clothing/foreign material/specimen as ordered label–seal–date/time • chain of custody	Accidental / occupational / suspected inflicted injury record circumstances and notifications objectively

CRITICAL / SYSTEMIC TOXICITY	STABLE
Resuscitation → emergency/ICU → specialist referral	Observation/treatment → education → follow-up

Clinical stabilization takes priority. Preserve dignity, document objectively, and maintain evidentiary integrity and chain of custody according to applicable law and institutional policy.

FORENSIC NURSING ASSESSMENT

INITIAL NURSING ASSESSMENT

(CORROSIVE POISON INGESTION VICTIM)

Name: _____

Age: _____

Gender: _____

Address: _____

Date Of Birth: _____

Religion: _____

Nationality: _____

Language: _____

Mobile No: _____

Date of admission: _____

Date & time of Incident: _____

M.L.C. No.: _____

Time of Arrival: _____

Time of Assessment: _____

Loss of Consciousness:

Grade I: Drowsy/ Responds to Verbal Commands/ _____

Grade II: Unconscious/ Responds only to minimal stimuli/ Shaking/ Shouting/ _____

Grade III: Unconscious/ Responds Only to maximally Painful stimuli/ _____

Grade IV: Unconscious/ No Response Whatever/ _____

Vital Sign: _____

Temperature: _____

Blood Pressure: _____

Pulse: _____

Respiration: _____

SPO2: _____

Pupil: _____

Name of Corrosive Substance: _____

Type of Corrosive Poison: Inorganic/ Organic/ Alkaline/ _____

Rout of ingestion: _____

Time of ingestion: _____

Lips: Swollen/ Abrased/ Brown/ Black/ _____

Tongue: Swollen/ Cover with White Coating/ Darker/ Brown in Colour/ Corroded & Shapeless mass /_____

Voice: Hoarse/ Rough/ _____

Hypersalivation: Appear/ not / Present/ absent/ _____

Colour of saliva: _____

Teeth: Chalky White colour/ Rough/ Deprived of their Polish/ _____

Intense thirst: Present/ Absent

Fatal Dose: _____**ml**

Concentration: Mild/ Moderate/ Sever _____

Fatal Period: _____**hours.**

Stained Vomit: _____

Denture: Yes/ No/ _____

Nutrition: Good/ Fair/ Poor/ _____

Clubbing: No/ Yes and if yes/ its grade _____

Cyanosis: No/ Yes and if yes _____**Central/ Peripheral/ Mixed** _____

Pallor: Yes/ No/ _____

Oedema: Yes/ No/ _____**Pitting/ Non-pitting/ Varicose veins/** _____

Type Of Skin: Dry/ Moist/ Thick/ Thin/ Pinched/ _____

Skin-color: Pale/ Flushed/ Cyanosed/ Yellow/ _____

Pigmentation: Hypopigmented/ Hyperpigmented/ _____

Eruptions: Yes/ No/ _____

Nails: Pallor/ Koilonychia/ Onychia/ Discoloration/ Clubbing/ Cyanosis/ Haemorrhages/ Trophic changes/ _____

Musculoskeletal and Joints in gait: Yes/ No/ _____

Swelling: Yes/ No/ _____

Stiffness: Yes/ No/ _____

Pain: Yes/ No/ _____

Spasm: Yes/ No/ _____

Back pain: Yes/ No/ _____

Intubation: Done/ Needed/ Will be Planned/ _____

Nasogastric Tube: _____

Aspiration: _____

Suction Fluid: _____

_____

Additional Remark: _____

_____

_____

_____

Other Victim Brought by: Self/ 108/ Police/ Relative/ Others/ _____

Victim Arrival: Ambulatory/ Wheelchair/ Stretcher/ Other/ _____

Transported with: Oxygen Monitor/ IV Line /Catheter Others /_____

_____

_____

Given Treatment (first aid treatment): _____

_____

_____

General Condition of victim: _____

_____

_____

_____

_____

_____

_____

_____

Past Health History: _____

Genogram:

SUPPORTIVE THERAPY:

Tracheostomy: Done/ Needed/ Will be Planned/ _____

Oxygen Therapy:

Ventilator Support:

Mode: _____

Bi-Level: _____

BPM: _____

M.Ve: _____

PEEP: _____

FiO2: _____%

Laboratory Investigation: _____

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Perforation: _____

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Surgery: _____

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Treatment: _____

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Additional Remarks: _____

Incident Report According to _____/ Victim/ Relatives/ Witness/ Other:

NAME & SIGNATURES OF EXAMINER: _____

SYSTEMATIC MANAGEMENT: CHEMICAL / POISON INGESTION

Forensic Nursing – Victim Examination Protocol

Suspected / Known Poisoning Victim Received

IMMEDIATE SAFETY & PRIMARY SURVEY
PPE / scene-exposure safety • ABCDE • treat life-threatening conditions first

INGESTION	INHALATION	DERMAL / OCULAR	UNKNOWN
chemical/drug/food	gas/fumes	chemical exposure	substance/route unclear

A/B	C	D	E / DECONTAMINATION	TOXICOLOGY HISTORY
airway • oxygenation secretions/vomit • inhalation injury	pulse • BP • ECG • perfusion IV access as ordered	GCS • pupils • glucose seizure/delirium	remove contaminated clothing skin/eye irrigation when indicated	substance • amount • time • route container/label • intent

CLINICAL MANAGEMENT	FORENSIC EVIDENCE	INTENT / MEDICOLEGAL
Supportive care • monitoring • investigations antidote/decontamination only when clinically indicated	Container/label/tablets/material/clothing/specimens label • seal • document • chain of custody	Accidental • occupational • self-harm • suspected assault verbatim history and required notifications

CRITICAL / DETERIORATING	STABLE
Resuscitation → Toxicology/ICU → referral	Observation/treatment → psychosocial assessment → follow-up

Clinical stabilization takes priority. Preserve dignity, document objectively, and maintain evidentiary integrity and chain of custody according to applicable law and institutional policy.

FORENSIC NURSING ASSESSMENT

INITIAL NURSING ASSESSMENT

Name: _____

Age: _____

Gender: _____

Address: _____

Date Of Birth: _____

Religion: _____

Nationality: _____

Language: _____

Mobile No: _____

Date & Time of incident: _____

Date of admission: _____

M.L.C. No.: _____

Ward: _____

Time of Arrival: _____

Time of Assessment: _____

Vital Sign: _____

Temperature: _____

Blood Pressure: _____

Pulse: _____

Respiration: _____

SPO_2: _____

Pupils: _____

Loss of Consciousness:

Grade I: Drowsy/ Responds to Verbal Commands/ _____

Grade II: Unconscious/ Responds only to minimal stimuli/ Shaking/ Shouting/ _____

Grade III: Unconscious/ Responds Only to maximally Painful stimuli/ _____

Grade IV: Unconscious/ No Response Whatever/ _____

SPECIFIC ASSESSMENT (INJURIES)

Name & Nature Of Injury	Side & Site On The Body	Size Of The Injury	Severity Of Injuries	Cause Of The Injury	Age Of The Injury	Color Of Injury	Remarks (Clinical Findings)
			Simple/ Grievous/ Dangerous				

Other Victim Brought by: Self/ 108/ Police/ Relative/ Others/ _____

Victim Arrival: Ambulatory/ Wheelchair/ Stretcher/ Other/ _____

Transported with: Oxygen Monitor/ IV Line /Catheter Others /_____

_____

_____

Given Treatment (first aid treatment): _____

_____

_____

_____

General Condition of victim: _____

_____

_____

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Past Health History: _____

_____

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_____

_____

Genogram:

Built: Fair/ Poor/ _____

Nutrition: Good/ Fair/ Poor/ _____

Clubbing: No/ Yes **and if** yes/ its grade _____

Cyanosis: No/ Yes **and if** yes _____Central/ Peripheral/ Mixed _____

Pallor: Yes/ No/ _____

Oedema: Yes/ No/ _____Pitting/ Non-pitting/ Varicose veins/ _____

Type Of Skin: Dry/ Moist/ Thick/ Thin/ Pinched/ _____

Skin-color: Pale/ Flushed/ Cyanosed/ Yellow/ _____

Pigmentation: Hypopigmented/ Hyperpigmented/ _____

Eruptions: Yes/ No/ _____

Nails: Pallor/ Koilonychia/ Onychia/ Discoloration/ Clubbing/ Cyanosis/
Haemorrhages/ Trophic changes/ _____

Musculoskeletal and Joints in gait: Yes/ No/ _____

Swelling: Yes/ No/ _____

Stiffness: Yes/ No/ _____

Pain: Yes/ No/ _____

Spasm: Yes/ No/ _____

Amputation: Yes/ No/ _____

Affected Site: _____

_____

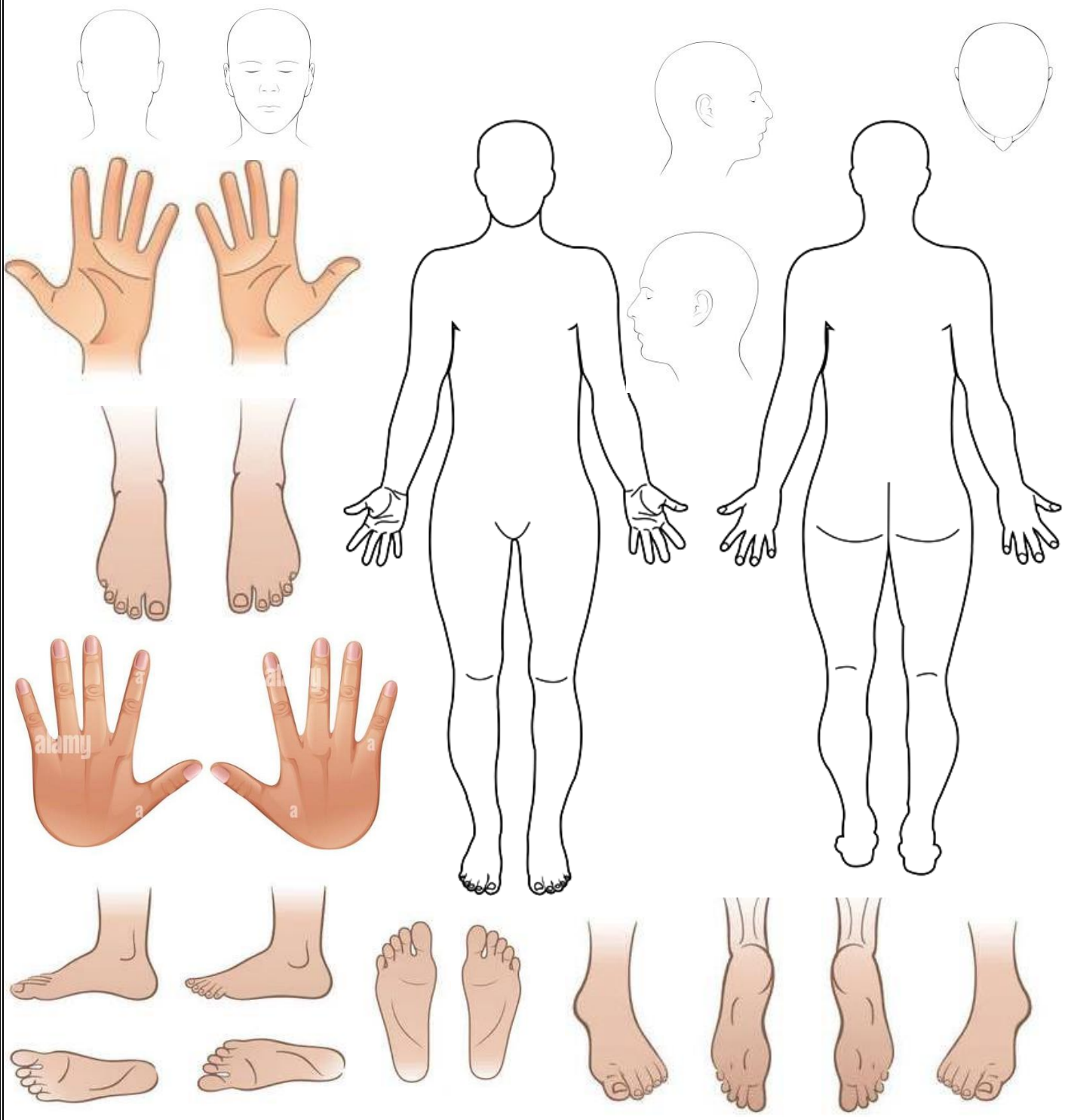
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Additional Remark: _____

Surgical management:

_____

Treatment: _____

_____

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_____

_____

_____

Oxygen Therapy:

Ventilator Support:

Mode: _____

Bi-Level: _____

BPM: _____

M.Ve: _____

PEEP: _____ **FiO_2:** _____ **%**

Laboratory Investigation: _____

_____

_____

_____

_____

_____

_____

_____

_____

Incident Report According to _____/ Victim/ Relatives/ Witness/ Other:

NAME & SIGNATURES OF EXAMINER: _____

SYSTEMATIC MANAGEMENT: INJURY ASSAULT VICTIM

Forensic Nursing – Initial Examination & Evidence Documentation

Victim of Physical Injury / Assault Received

IMMEDIATE SAFETY & PRIMARY SURVEY
PPE / scene-exposure safety • ABCDE • treat life-threatening conditions first

BLUNT FORCE	SHARP FORCE	DEFENSIVE / RESTRAINT	MULTIPLE / UNKNOWN
impact injury	incised/stab injury	patterned injury	mechanism unclear

PRIMARY SURVEY	HEAD-TO-TOE EXAM	INJURY MAPPING	FORENSIC PHOTOGRAPHY	HISTORY
ABCDE • hemorrhage control pain • neurological status	site • type • size • shape colour • tenderness • swelling	anatomical body map number each injury consistently	overall • mid-range • close-up scale/ID per protocol	who/what/when/where/how victim's own words

TREATMENT	EVIDENCE	SAFETY & MEDICOLEGAL
Urgent wound/trauma care • investigations specialist referral as indicated	Clothing • trace/foreign material • swabs/specimens if ordered pack appropriately • seal • chain of custody	Assess ongoing danger • safeguarding needs MLC/police notification according to applicable procedure

SERIOUS / UNSTABLE INJURY	STABLE
Resuscitation → trauma/surgery → admission/referral	Treatment → safety planning/counselling → follow-up

Clinical stabilization takes priority. Preserve dignity, document objectively, and maintain evidentiary integrity and chain of custody according to applicable law and institutional policy.

FORENSIC NURSE ASSESSMENT

POST-MORTUM EXAMINATION

Name of Deceased: _____

MRD No.: _____

Postmortem No.: _____

M.L.C. No.: _____

Dead body brought by: _____

Place from Dead body found: _____

Place from Dead body send: _____

Person who identified body: _____

Date of postmortem examination: _____

Time of post mortem examination: ___: ___ a.m. / p.m. TO ___: ___a.m. / p.m.

Name of PM examiner /doctor: _____

Name of police officer: _____

_____

_____

_____

_____

_____

Condition of the body: Muscular / Emaciated /Rigor Mortis/ Decomposed / _____

Cloths of Deceased: _____

Sex of Deceased: _____

Mark of identification: _____

_____

_____

Condition of skin:

_____

_____

_____

_____

State of naturel openings:

Eyes: _____

Ears: _____

Mouth: _____

Nostrils: _____

Anus: _____

Urethra: _____

Vagina: _____

Fracture:

_____

_____

_____

_____

Injuries:

Nature of injuries: _____

Site of injuries: _____

Side of injuries: _____

Size of injuries: _____

Direction of the injuries: _____

Dimension of the injuries: _____

Distance of injuries: _____

State of limbs:

_____

_____

_____

Contents of hands:

_____

_____

_____

Contents of bones of joints:

_____

_____

Genitalia: _____

Breasts: _____

Additional remarks:

External examination:

Head and neck:

Scalps: _____

Skull bones: _____

Membranes: _____

Brain: _____

Base of skull: _____

Vertebrae. _____

Spinal cord of injuries; _____

Strychnine poisoning: _____

Neck structures: _____

Additional remark: _____

Thorax:

Walls: _____

Ribs: _____

Cartilages: _____

Pleura: _____

Diaphragm: _____

Larynx: _____

Trachea: _____

Bronchi: _____

Right lungs{weight}: _____

Left lung {weight}: _____

Pericardium: _____

Heart {weight, cavities, valves, coronaries}: _____

_____

Larges vessels: _____

_____

Additional mark: _____

_____

_____

_____

Abdomen:

Walls: _____

_____

Peritoneum: _____

_____

Peritoneum cavity: _____

_____

Buccal cavity: _____

_____

Teeth: _____

_____

Tongue: _____

_____

Pharynx: _____

_____

Oesophagus: _____

_____

Stomach: _____

_____

Stomach contents: _____

_____

Small intestine: _____

Small intestine contents: _____

Large intestine: _____

Large intestine contents: _____

Liver{weight}: _____

Gall bladder: _____

Pancreas: _____

Spleen{weight}: _____

Kidneys{weight}: _____

Urinary bladder: _____

Organ of generation: _____

Additional remarks: _____

Viscera:

_____

Other samples:

_____

_____

_____

Opinion of examiner:

Cause of death: _____

Time since death: _____

Duration of injuries {time between causation of injuries and death}: _____

Injuries: ante mortem/postmortem: _____

Weapon used: _____

Additional Remarks: _____

Incident report according to Police / Relatives / _____

SYSTEMATIC POSTMORTEM EXAMINATION MANAGEMENT

Forensic Nursing – Dead Body / Medicolegal Protocol

Dead Body Received / Death Occurs in Hospital

IMMEDIATE SAFETY & PRIMARY SURVEY
PPE / scene-exposure safety • ABCDE • treat life-threatening conditions first

KNOWN HISTORY
apparent natural death

SUDDEN DEATH
unexpected

UNNATURAL / SUSPICIOUS
medicolegal

UNKNOWN BODY / HISTORY
identity/circumstances unclear

IDENTIFICATION
ID tag • case/MLC number
unknown-body identifiers

PRESERVE BODY CONDITION
avoid unnecessary cleaning
retain devices in MLC per protocol

EXTERNAL OBSERVATION
clothing • injuries • marks
medical devices • belongings

PHOTOGRAPHY / RECORD
condition • identifying features
injury documentation as authorized

EVIDENCE SECURITY
clothing/trace/materials
label • seal • chain of custody

LEGAL COMMUNICATION
Authorized clinician/police/investigating authority
complete required records and time of communication

MORTUARY TRANSFER
Dignified handling • secure valuables • body tag/bag
record transfer and receiving person

POSTMORTEM COORDINATION
Verify requisition/identity documents
secure evidence/specimens and documented handover

POSTMORTEM REQUIRED
Authorized transfer → forensic examination → evidence handover

RELEASE AUTHORIZED
Complete records → verify identity → lawful handover

Clinical stabilization takes priority. Preserve dignity, document objectively, and maintain evidentiary integrity and chain of custody according to applicable law and institutional policy.

FORENSIC NURSING ASSESSMENT

INITIAL NURSING ASSESSMENT

Name: _____

Age: _____

Gender: _____

Address: _____

Date Of Birth: _____

Religion: _____

Nationality: _____

Language: _____

Mobile No: _____

Date of admission: _____

M.L.C. No.: _____

Allergy: _____

Ward: _____

Time of Arrival: _____

Time of Assessment: _____

Vital Sign: _____

Temperature: _____

Blood Pressure: _____

Pulse: _____

Respiration: _____

SPO_2: _____

Pupils: _____

Loss of Consciousness:

Grade I: Drowsy/ Responds to Verbal Commands/ _____

Grade II: Unconscious/ Responds only to minimal stimuli/ Shaking/ Shouting/_____

Grade III: Unconscious/ Responds Only to maximally Painful stimuli/ _____

Grade IV: Unconscious/ No Response Whatever/ _____

Built: Fair/ Poor/ _____

Nutrition: Good/ Fair/ Poor/ _____

Clubbing: No/ Yes **and if** yes/ its grade _____

Cyanosis: No/ Yes **and if** yes _____Central/ Peripheral/ Mixed _____

Pallor: Yes/ No/ _____

Oedema: Yes/ No/ _____Pitting/ Non-pitting/ Varicose veins/ _____

Type Of Skin: Dry/ Moist/ Thick/ Thin/ Pinched/ _____

Skin-color: Pale/ Flushed/ Cyanosed/ Yellow/ _____

Pigmentation: Hypopigmented/ Hyperpigmented/ _____

Eruptions: Yes/ No/ _____

Nails: Pallor/ Koilonychia/ Onychia/ Discoloration/ Clubbing/ Cyanosis/ Haemorrhages/ Trophic changes/ _____

Musculoskeletal and Joints in gait: Yes/ No/ _____

Swelling: Yes/ No/ _____

Stiffness: Yes/ No/ _____

Pain: Yes/ No/ _____

Spasm: Yes/ No/ _____

Affected Site: _____

_____

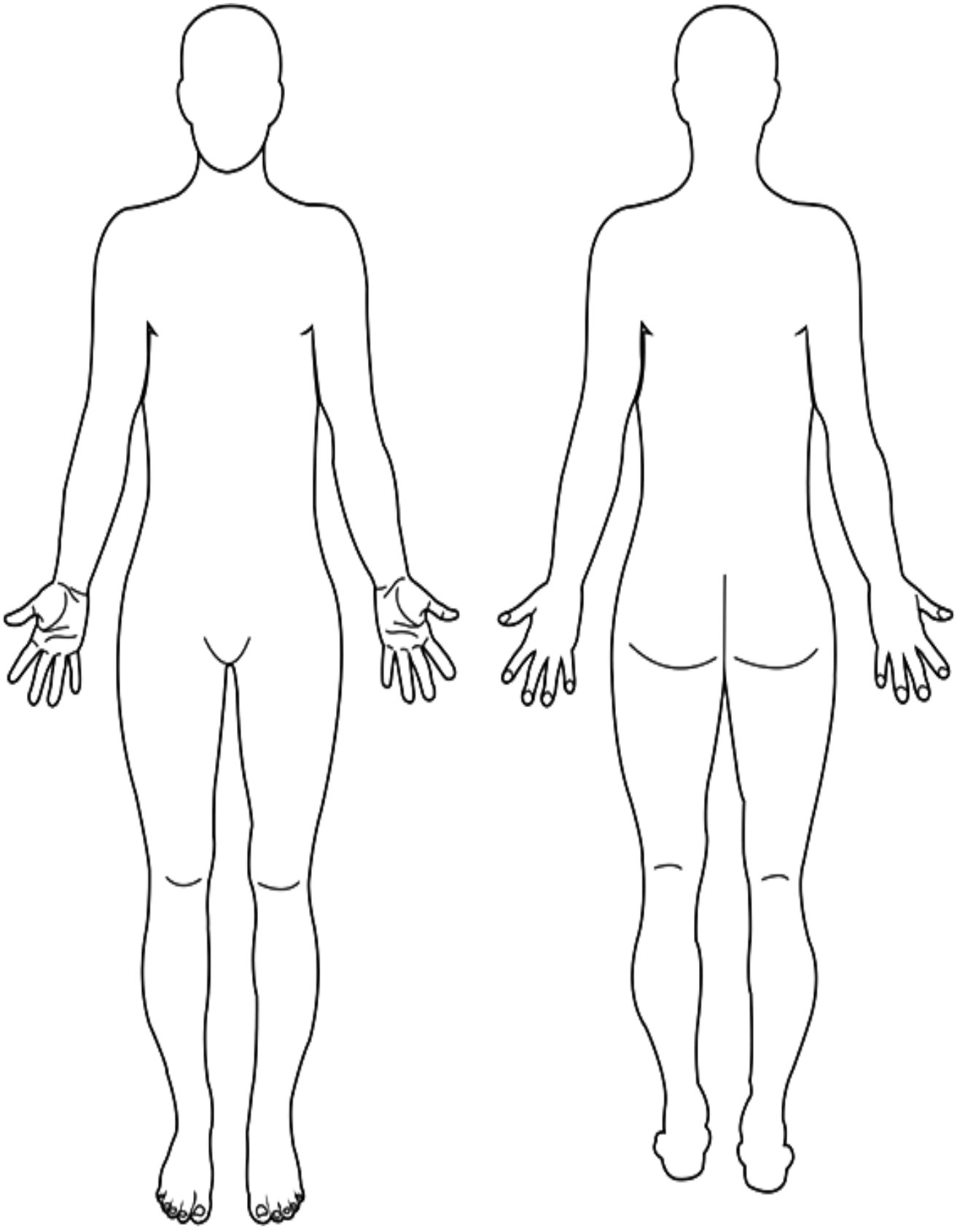
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_____

_____

_____

_____



Child
• Arm (each) - 9% • Head & Neck - 18% • Leg (each) - 14% • Anterior Trunk - 18% • Posterior Trunk - 18%

Adult
• Arm (each) - 9% • Head & Neck - 9% • Leg (each) - 18% • Anterior Trunk - 18% • Posterior Trunk - 18%

Cause Of Burns:

1. **Flame, Hot Solids:** _____
2. **Liquids At Boiling Point:** _____
3. **Friction:** _____
4. **Lightning:** _____
5. **Electricity:** _____

Classification Burns:

(1) Epidermal: _____

_____

_____

_____

_____

(2) Dermo-Epidermal: _____

_____

_____

_____

_____

(3) Deep Burn: _____

_____

_____

_____

_____

Date of burn: _____

type of burn: _____

place of burn: _____

Causative agent: _____

history of burn injury: _____

Time to hospital referral: _____

Immunization status (Tetanus vaccine): _____

SR NO.	DEGREE OF BURNS	PLACE TICK (✓) MARK IN
1.	**FIRST DEGREE BURN/ SUPERFICIAL** **These burns are not included in the percentage of the total body surface.** • Only the epidermis is involved. **Skin:** • Pink • Dry with no blistering • Heals in 3-5 days, usually does not scar. • Minimal risk of infection • Capillary refill present	
2.	**SECOND DEGREE BURN/ PARTIAL THICKNESS** • **Epidermis and dermis involved.** **Skin:** • Bright red • Pearl-pink • Painful • Moist • May have small to large blisters. • Rapid fluid loss may occur with large burns. • Heals in 10 days -2 weeks. • Capillary refill present	
3.	**THIRD-DEGREE BURN/FULL THICKNESS** • Epidermis and dermis destroyed. • Fascia and muscle may be involved**.** **Skin:** • Tan • Leathery • Charred • White • May be depressed below the level of surrounding tissue. • Painful at the edge of the burn, otherwise insensate • Capillary refill absent	

NUTRITIONAL ASSESSMENT

Food Diet: Vegetarian/ Non-Vegetarian/ Others/ _____

Type of Diet:

DD: _____

LD: _____

SRD: _____

FD: _____

CFD: _____

Other Patient Brought by: Self/ 108/ Police/ Relative/ Others/ _____

Patient Arrival: Ambulatory/ Wheelchair/ Stretcher/ Other/ _____

Transported with: Oxygen Monitor/ IV Line /Catheter Others /_____

_____

_____

Given Treatment (first aid treatment):

_____

_____

_____

General Condition of victim: _____

_____

_____

_____

_____

_____

_____

Past Health History: _____

_____

_____

_____

_____

_____

_____

Genogram:

Incident Report According to _____/ Victim/ Relatives/ Witness/ Other:

Name & Signature of Examiner: _____

SYSTEMATIC MANAGEMENT: INITIAL EXAMINATION OF BURNS

Forensic Nursing – Burn Victim Assessment Protocol

Burn Victim Received

IMMEDIATE SAFETY & PRIMARY SURVEY
PPE / scene-exposure safety • ABCDE • treat life-threatening conditions first

THERMAL	CHEMICAL	ELECTRICAL	INHALATION / MIXED
flame/scald/contact	acid/alkali/other	current/lightning	smoke/multiple mechanisms

A – AIRWAY	B – BREATHING	C/D	E – BURN EXAM	EXTENT / HISTORY
facial/neck burns • soot hoarseness/stridor	RR • SpO_2 • chest movement inhalation injury	pulse • BP • perfusion GCS • pain • glucose	expose/prevent hypothermia site • depth • circumferential burn	TBSA estimate • time/place mechanism • clothing • first aid

CLINICAL CARE
Stop burning process • clean dry covering
fluids/analgesia/airway/burn care per clinical protocol

FORENSIC DOCUMENTATION
Burn pattern/distribution • body map • photos
preserve clothing/debris/accelerant-related material when relevant

MEDICOLEGAL CONTEXT
Accidental • occupational • self-inflicted • suspected assault
record statements and circumstances objectively

MAJOR / CRITICAL BURN
Resuscitation → Burn/ICU team → transfer as indicated

MINOR / STABLE BURN
Wound care → counselling → discharge/follow-up

Clinical stabilization takes priority. Preserve dignity, document objectively, and maintain evidentiary integrity and chain of custody according to applicable law and institutional policy.

FORENSIC NURSING ASSESSMENT

FORENSIC NURSING ASSESSMENT FOR SEXUAL ASSUALT CASES

Name: _____

Age: _____

Gender: _____

Address: _____

Date Of Birth: _____

Religion: _____

Nationality: _____

Language: _____

Mobile No: _____

Date & Time of incident: _____

Date of admission: _____

M.L.C. No.: _____

Ward: _____

Time of Arrival: _____

Time of Assessment: _____

Vital Sign: _____

Temperature: _____

Blood Pressure: _____

Pulse: _____

Respiration: _____

SPO_2: _____

Pupils: _____

Loss of Consciousness:

Grade I: Drowsy/ Responds to Verbal Commands/ _____

Grade II: Unconscious/ Responds only to minimal stimuli/ Shaking/ Shouting/ _____

Grade III: Unconscious/ Responds Only to maximally Painful stimuli/ _____

Grade IV: Unconscious/ No Response Whatever/ _____

Other Victim Brought by: Self/ 108/ Police/ Relative/ Others/ _____

Victim Arrival: Ambulatory/ Wheelchair/ Stretcher/ Other/ _____

Transported with: Oxygen Monitor/ IV Line /Catheter Others /_____

_____

_____

Given Treatment (first aid treatment): _____

_____

_____

_____

General Condition of victim: _____

_____

_____

_____

_____

Description of Assault: _____

_____

_____

_____

_____

_____

_____

_____

_____

Genogram:

Medical History: Current medicine / Allergies: _____

_____

_____

_____

Menstrual History (For Female) : _____

_____

_____

_____

History of Previous Assaults:

_____

_____

Built: Fair/ Poor/ _____

Nutrition: Good/ Fair/ Poor/ _____

Clubbing: No/ Yes **and if** yes/ its grade _____

Cyanosis: No/ Yes **and if** yes_____Central/ Peripheral/ Mixed _____

Pallor: Yes/ No/ _____

Oedema: Yes/ No/_____Pitting/ Non-pitting/ Varicose veins/ _____

Type Of Skin: Dry/ Moist/ Thick/ Thin/ Pinched/ _____

Skin-color: Pale/ Flushed/ Cyanosed/ Yellow/ _____

Pigmentation: Hypopigmented/ Hyperpigmented/ _____

Eruptions: Yes/ No/ _____

Nails: Pallor/ Koilonychia/ Onychia/ Discoloration/ Clubbing/ Cyanosis/
Haemorrhages/ Trophic changes/ _____

Musculoskeletal and Joints in gait: Yes/ No/ _____

Swelling: Yes/ No/ _____

Stiffness: Yes/ No/ _____

Pain: Yes/ No/ _____

Spasm: Yes/ No/ _____

Amputation: Yes/ No/ _____

Affected Site: _____

Appearance and Behavior;

_____

_____

Genital / Anal Injuries: _____

_____

_____

_____

Psychological Assessment:

- Assessment of mental status
- Screening for signs of emotional distress or trauma

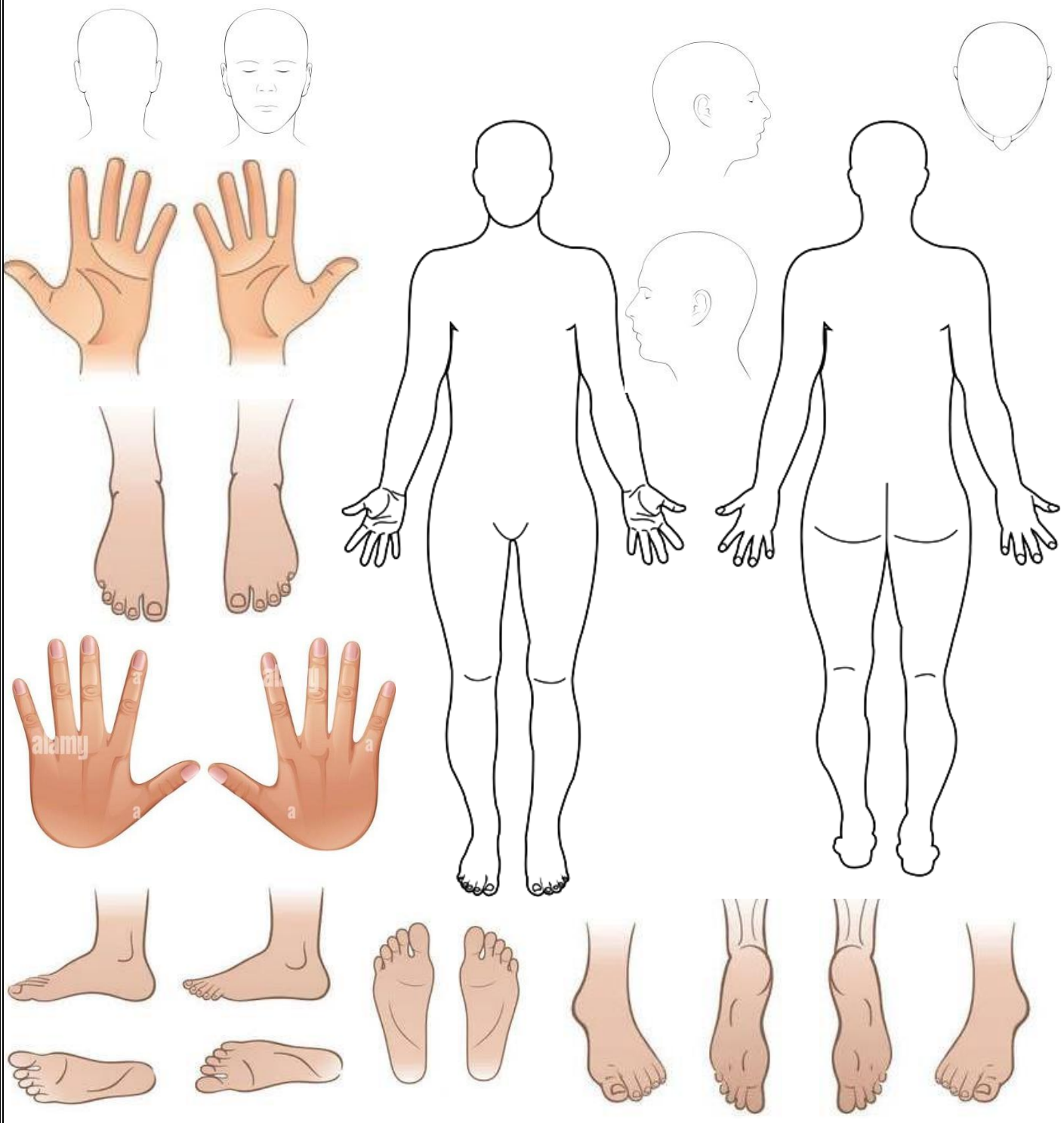
Pain and Discomfort / Psychological Distress:

Laboratory Investigation:

- STI Testing:
- Pregnancy Testing (if applicable):
- Toxicology Screening (if indicated):
- Other relevant tests as indicated:

SPECIFIC ASSESSMENT (INJURIES)

Name & Nature Of Injury	Side & Site On The Body	Size Of The Injury	Severity Of Injuries	Cause Of The Injury	Age Of The Injury	Color Of Injury	Remarks (Clinical Findings)
			Simple/ Grievous/ Dangerous				



Surgical management:

_____

_____

_____

_____

_____

Oxygen Therapy:

Ventilator Support:

Mode: _____

Bi-Level: _____

BPM: _____

M.Ve: _____

PEEP: _____ **FiO_2:** _____ **%**

Documentation of injuries or signs of trauma concerned to the genital area:

_____

_____

Collection of forensic evidence (e.g., Clothing, swabs, photographs):

_____

_____

_____

_____

_____

_____

_____

Chain of custody procedures followed:

_____

_____

_____

_____

Referral to appropriate services (e.g., counseling, support groups):

Legal reporting procedures (if applicable):

Incident Report According to_____/ Victim/ Relatives/ Witness/ Other:

NAME & SIGNATURES OF EXAMINER: _____

SYSTEMATIC MANAGEMENT: SEXUAL ASSAULT VICTIM

Forensic Nursing – Trauma-Informed Examination Protocol

Victim / Survivor Presents or Sexual Assault Is Disclosed

IMMEDIATE SAFETY & PRIMARY SURVEY
PPE / scene-exposure safety • ABCDE • treat life-threatening conditions first

RECENT ASSAULT
possible forensic evidence

DELAYED DISCLOSURE
medical/psychosocial needs

CHILD / VULNERABLE PERSON
safeguarding pathway

OTHER SPECIAL NEEDS
injury/intoxication/disability

SAFETY & URGENT CARE
ABCDE • serious injury
acute intoxication/mental status
custody

INFORMED CONSENT
explain choices • privacy
consent for each component

TRAUMA-INFORMED HISTORY
open-ended • non-leading
verbatim relevant statements

HEAD-TO-TOE EXAM
injuries • body map
anogenital exam only as
indicated/authorized

EVIDENCE & PHOTOS
kit/specimens per protocol
label/seal • chain of

HEALTHCARE
Treat injuries • pregnancy/STI assessment and prophylaxis
emergency contraception/other care as clinically indicated

SUPPORT & SAFEGUARDING
Crisis support • advocate/support person when desired
child/vulnerable-person protection requirements

MEDICOLEGAL DOCUMENTATION
Objective notes • consent/refusal • persons present
notifications/reporting according to applicable law and policy

URGENT MEDICAL / SAFETY RISK
Emergency treatment → safeguarding → admission/referral

STABLE
Complete chosen care/evidence steps → safety plan → follow-up

Clinical stabilization takes priority. Preserve dignity, document objectively, and maintain evidentiary integrity and chain of custody according to applicable law and institutional policy.

FORENSIC NURSING ASSESSMENT

FORENSIC NURSING ASSESSMENT FOR GENERAL ABUSES [Women, Child, Geriatrics, Adults]

Name: _____

Age: _____

Gender: _____

Address: _____

Date Of Birth: _____

Religion: _____

Nationality: _____

Language: _____

Mobile No: _____

Date & Time of incident: _____

Date of admission: _____

M.L.C. No.: _____

Ward: _____

Time of Arrival: _____

Time of Assessment: _____

Vital Sign: _____

Temperature: _____

Blood Pressure: _____

Pulse: _____

Respiration: _____

SPO_2: _____

Pupils: _____

Loss of Consciousness:

Grade I: Drowsy/ Responds to Verbal Commands/ _____

Grade II: Unconscious/ Responds only to minimal stimuli/ Shaking/ Shouting/ _____

Grade III: Unconscious/ Responds Only to maximally Painful stimuli/ _____

Grade IV: Unconscious/ No Response Whatever/ _____

SPECIFIC ASSESSMENT (INJURIES)

Name & Nature Of Injury	Side & Site On The Body	Size Of The Injury	Severity Of Injuries	Cause Of The Injury	Age Of The Injury	Color Of Injury	Remarks (Clinical Findings)
			Simple/ Grievous/ Dangerous				

Other Victim Brought by: Self/ 108/ Police/ Relative/ Others/ _____

Victim Arrival: Ambulatory/ Wheelchair/ Stretcher/ Other/ _____

Transported with: Oxygen Monitor/ IV Line /Catheter Others /_____

_____

_____

Given Treatment (first aid treatment): _____

_____

_____

_____

General Condition of victim: _____

_____

_____

_____

_____

Past Health History: _____

_____

_____

_____

_____

_____

_____

_____

_____

Genogram:

Built: Fair/ Poor/ _____

Nutrition: Good/ Fair/ Poor/ _____

Clubbing: No/ Yes **and if** yes/ its grade _____

Cyanosis: No/ Yes **and if** yes_____Central/ Peripheral/ Mixed _____

Pallor: Yes/ No/ _____

Oedema: Yes/ No/_____Pitting/ Non-pitting/ Varicose veins/ _____

Type Of Skin: Dry/ Moist/ Thick/ Thin/ Pinched/ _____

Skin-color: Pale/ Flushed/ Cyanosed/ Yellow/ _____

Pigmentation: Hypopigmented/ Hyperpigmented/ _____

Eruptions: Yes/ No/ _____

Nails: Pallor/ Koilonychia/ Onychia/ Discoloration/ Clubbing/ Cyanosis/
Haemorrhages/ Trophic changes/ _____

Musculoskeletal and Joints in gait: Yes/ No/ _____

Swelling: Yes/ No/ _____

Stiffness: Yes/ No/ _____

Pain: Yes/ No/ _____

Spasm: Yes/ No/ _____

Amputation: Yes/ No/ _____

Affected Site: _____

_____

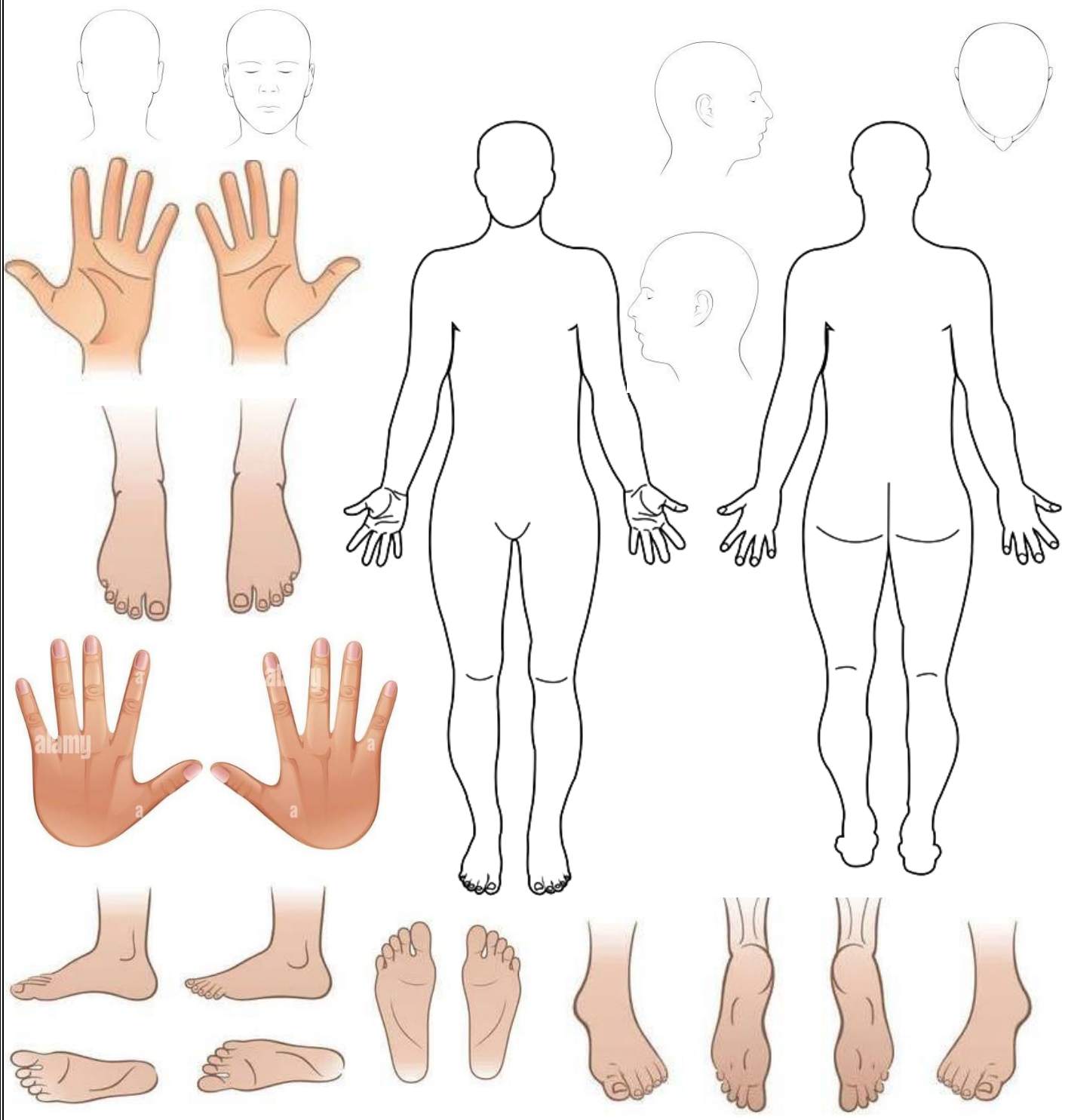
_____

_____

_____

_____

_____



Anthropometric Measurement: _____

1. **Height**
   - Measurement Technique: (e.g., Standing height using a stadiometer)
   - Measurement (cm):
   - Percentile (if available):
   - Interpretation:

2. **Weight:**
   - Measurement Technique: (e.g., Using a calibrated scale)
   - Measurement (kg):
   - Percentile (if available):
   - Interpretation:

3. **Head Circumference (Infants and Young Children):**
   - Measurement Technique: (e.g., Using a flexible tape measure)
   - Measurement (cm):
   - Percentile (if available):
   - Interpretation:

4. **Body Mass Index (BMI) (For Children Over 2 Years):**
   - Calculation: Weight (kg) / Height (m)^2
   - BMI:
   - Percentile (if available):
   - Interpretation:

Additional Remarks:

_____

_____

Surgical Marks / management:

_____

_____

_____

_____

_____

_____

HEAD-TO-TOE ASSESSMENT

Safety considerations:

1. Perform hand hygiene.
2. Check room for contact precautions.
3. Introduce yourself to patient.
4. Confirm patient ID using two patient identifiers (e.g., name and date of birth).
5. Explain process to patient.
6. Be organized and systematic in your assessment.
7. Use appropriate listening and questioning skills.
8. Listen and attend to patient cues.
9. Ensure patient's privacy and dignity.
10. Assess ABCCS (airway, breathing, circulation, consciousness, safety)/suction/oxygen/safety.
11. Apply principles of asepsis and safety.
12. Check vital signs.
13. Complete necessary focused assessments.

1. **General appearance:**
   - Affect/behavior/anxiety
   - Level of hygiene
   - Body position
   - Patient mobility
   - Speech pattern and articulation

2. **Skin, hair, and nails:**

- Inspect for lesions, bruising, and rashes.
- Palpate skin for temperature, moisture, and texture.
- Inspect for pressure areas.
- Inspect skin for oedema.
- Inspect scalp for lesions and hair and scalp for presence of lice and/or nits.
- Inspect nails for consistency, colour, and capillary refill.

3. **Head and neck:**

- Inspect eyes for drainage.
- Inspect eyes for pupillary reaction to light.
- Inspect mouth, tongue, and teeth for moisture, colour, dentures.
- Inspect for facial symmetry.

4. Chest:

- Inspect:
  - ✓ Expansion/retraction of chest wall/work of breathing and/or accessory muscle use
  - ✓ Jugular distension
- Auscultation:
  - ✓ For breath sounds interiorly and posterior
  - ✓ Apices and bases for any adventitious sounds
  - ✓ Apical heart rate
- Palpate:
  - ✓ For symmetrical lung expansion

5. Abdomen:

- Inspect:
  - ✓ Abdomen for distension, asymmetry
- Auscultation:
  - ✓ Bowel sounds (RLQ)
- Palpate:
  - ✓ Four quadrants for pain and bladder/bowel distension (light palpation only)
  - ✓ Check urine output for frequency, colour, odour.
  - ✓ Determine frequency and type of bowel movements.

6. Extremities:

- Inspect:
  - ✓ Arms and legs for pain, deformity, edema, pressure areas, bruises
  - ✓ Compare bilaterally
- Palpate:
  - ✓ Radial pulses
  - ✓ Pedal pulses: dorsalis pedis and posterior tibial
  - ✓ CWMS and capillary refill (hands and feet)
- Assess handgrip strength and equality.
- Assess dorsiflex and plantarflex feet against resistance (note strength and equality).
- Check skin integrity and pressure areas.

7. Back area (turn patient to side or ask to sit up or lean forward):

- Inspect back and spine.
- Inspect coccyx/buttocks.

8. Tubes, drains, dressings, and IVs:

- Inspect for drainage, position, and function.
- Assess wounds for unusual drainage.

9. Mobility:

- Check if full or partial weight-bearing.
- Determine gait/balance.
- Determine need for and use of assistive devices.

10. Report and document assessment findings and related health problems:

_____

_____

_____

11. Follow-up Plan:
Instructions for follow-up care

_____

_____

_____

Referral to appropriate services (e.g., counselling, support groups):

Legal reporting procedures (if applicable):

12. Documentation:
Detailed documentation of assessment findings, evidence collected, and treatment provided_

Signed consent forms for evidence collection and treatment:

Photographic documentation of injuries and evidence:

Treatment:

Oxygen Therapy:

Ventilator Support:

Mode:

Bi-Level:

BPM:

M.Ve:

PEEP: **FiO_2:** **%**

Laboratory Investigation:

Incident Report According to_____/ Victim/ Relatives/ Witness/ Other:

NAME & SIGNATURES OF EXAMINER: _____

SYSTEMATIC MANAGEMENT: GENERAL ASSAULT VICTIM

Forensic Nursing – Women • Children • Geriatric / Other Vulnerable Victims

Victim Presents / Abuse or Assault Suspected

IMMEDIATE SAFETY & PRIMARY SURVEY
PPE / scene-exposure safety • ABCDE • treat life-threatening conditions first

WOMAN	CHILD	GERIATRIC	OTHER VULNERABLE
physical/psychological/economic	physical/emotional/neglect	physical/financial/neglect	care-dependent/disability

IMMEDIATE SAFETY	PRIVATE INTERVIEW	HEAD-TO-TOE EXAM	DOCUMENTATION	RISK / SAFEGUARDING
ABCDE • urgent injury separate from alleged perpetrator when safe	trauma-informed • interpreter open-ended questions	injury/neglect indicators functional & pain assessment	verbatim statements • body map photos when appropriate	ongoing danger • dependents capacity/cognition where relevant

CLINICAL CARE	FORENSIC EVIDENCE	PROTECTION & LEGAL PATHWAY
Treat injuries/illness • nutrition/hygiene needs mental-health/psychosocial assessment when indicated	Clothing/materials/specimens when indicated label • seal • secure • chain of custody	Safety plan • safeguarding referral mandatory/statutory reporting where applicable

IMMEDIATE DANGER / SERIOUS INJURY	STABLE
Emergency care → protection/safeguarding → admission/referral	Treatment → psychosocial support → safe disposition → follow-up

Clinical stabilization takes priority. Preserve dignity, document objectively, and maintain evidentiary integrity and chain of custody according to applicable law and institutional policy.

Standard Protocols for Medicolegal case management in Hospital

Ways to Reporting of Medicolegal Case in Hospital

- Brought By Police
- By Self or with intention to Register a case by victim
- Referral MLC From Previous
- History Collection and examination of Victim

Medicolegal Nursing Management (Live Victim)

Victim comes to the Emergency Department in Hospital

↓

Preliminary Assessment (Vital Signs and Airway, Breathing and Circulation)

↓

Basic Documentation and Evidence Collection, Forensic Photography & Inform to Police and Register **Medicolegal Case**

↓

Clinical Assessment and Forensic Investigation

↓

- Critical Condition
  - ↓ Treatment and Intervention
    - ↓ Not Respond Positively
      - ↓ Refer to higher Clinical Center
    - ↓ Respond Positively
- Non-Critical Condition
  - ↓ Primary Survey
  - ↓ Counselling

↓

Follow up the Treatment and Care

↓

Discharge the Victim from Hospital

Medicolegal Nursing Management (Dead Body)

If proper History Available

- If patient was suffering from any chronic illnesses and treated in our hospital, Doctor can issue the death certificate
- If previous illness not supportive to death, then subjected to PM

If proper History Not Available

- Mandatory to make an MLC and inform to police
- Forensic Photography and report write with major findings
- Body should not be released from the hospital without following the protocols and should be sent to PM

FORENSIC EVIDENCE COLLECTION AND PRESERVATION IN THE RELEVENT CASES

Evidence Collected	Method of Collection	Preservation and Packaging
Blood	Collect 2–5 mL by venipuncture into vacutainer	Store it sealed, labelled and refrigerate in (2–8°C)
Buccal Swab	Rub sterile swab firmly against inner cheek for 30–60 seconds.	Air-dry, place in swab box or paper envelope
Saliva	Sterile swab from suspected area or oral cavity	Air-dry, place in swab box or paper envelope
Semen stain	Air-dry clothing or collect stain with sterile swab	Paper bag or paper envelope
Urine	Midstream sample in sterile container	Leak-proof container and refrigerate
Sweat	Sterile gauze/swab from skin	Air-dry and store in paper envelope
Tear	Sterile pipette or swab	Sterile tube
Hair (scalp, pubic, body)	Pull 20–50 hairs with roots or comb for loose hairs	Paper bindle inside paper envelope
Foreign hairs	Forceps or tape lift	Paper bindle inside paper envelope
Nail clippings	Sterile nail cutter; each hand separately	Paper envelope or
Fingernail scrapings	Sterile wooden stick/scalpel onto clean paper	Folded paper bindle in envelope
Teeth	Remove with sterile forceps	Sterile dry container
Vaginal swabs, cervical swabs, vulval swabs	Sterile swab	Air-dry; swab box
Anal swabs	Sterile swab from anal canal	Air dry and store in swab box
Oral swabs	Swab oral cavity	Air dry and store in swab box
Penile swabs	Swab shaft, foreskin	Air dry and store in swab box
Pubic hair combings	Comb over clean paper	Fold paper into bindle and store in paper envelope
Foreign material from genitalia	Sterile forceps or swab	Sterile container or paper packet
Clothing worn during assault	Air-dry and package separately	Individual paper bags

Sanitary pad/tampon	Air dry	Paper bag
Condom	Handle with gloves; tie open end if fluid present	Sterile leak-proof container
Lubricant residue	Sterile Swab	Air dry and store in swab box
Glass fragments	Collect with Forceps	Rigid plastic vial /Container
Fibres	Collect with Forceps or Tape lift	Paper Bindle
Gunshot residue (GSR) swabs	Sterile cotton swabs moistened with 2–5% dilute nitric acid	Air dry and store in swab box or paper envelope
GSR Hand Wash Method	Wash each hand separately with 5% nitric acid	Sterile Box or Glass container
Explosive residues	Swab suspected areas using sterile cotton swabs lightly moistened with distilled water, acetone, or isopropyl alcohol or tape lift	Air dry and store in paper envelope
Worn Clothes /Blood-stained clothes	Air-dry completely	Pack in individual paper bags
Undergarments	Air dry completely	Collect in Separate Paper bags
Footwear	Wrap Separately	Paper bag or cardboard box
Jewellery	Handle with gloves	Evidence boxes or envelope
Bullets, pellets, bullet fragments	Rubber tipped Forceps	Cotton lined rigid container
Glass pieces, metal fragments, splinters	Forceps	Rigid Container
Knife fragments or embedded objects	Forceps	Cardboard box with padding
gastric lavage	Collect in sterile container	Collect in Leak-proof bottle and refrigerate
vomitus	Collect representative sample	Collect in Leak-proof bottle and refrigerate
Blood alcohol sample	Sodium fluoride/potassium oxalate tube	Grey top Vacutainer
Urine for drugs of abuse	Sterile container	Store it labelled, sealed and refrigerate
Burn swabs (if indicated)	Sterile swab before dressing	Air dry and store in swab box
Soot from nostrils/mouth	Sterile swab	Swab box
Fingerprints	Ink or digital scanner	Fingerprint card or secure digital file
Photographs of injuries(with consent by	Capture the images in a high-resolutiondigital	Save the original file in RAW or

hiding the identity/ blocking the eyes)	camera Overall-Capture the entire body or the relevant body region. Midrange-Shows the injury in relation to nearby anatomical structures. Close up- Records the precise dimensions and morphology of the injurywith ABFO No.2 Forensic Scale in same plane as the injury	JPEG format

SNAKE BITE TABLE

Sr. No.	Possible Snake Bite	Venom Type	Outdoor (Pre-hospital Nursing Care)	Indoor (Hospital Nursing Care)	Clinical Features	Forensic Evidence Collection	Investigations	Treatment	Nursing Responsibilities
1	**Cobra (Naja spp.)**	Neurotoxic	Reassure patient, immobilize bitten limb with splint, remove rings/jewellery, transport immediately, avoid tourniquet/cutting/suction	ABC assessment, oxygen therapy, airway monitoring, prepare for intubation if needed	Ptosis, diplopia, dysphagia, respiratory paralysis, local swelling	Photograph bite, measure fang marks, preserve clothing, document time and place, maintain chain of custody	WBCT, CBC, RFT, LFT, ABG, ECG	Polyvalent ASV, ventilatory support, neostigmine with atropine (where indicated)	Monitor respiratory rate, SpO_2, GCS, vital signs every 15–30 min, prepare ventilator, monitor ASV reactions
2	**Common Krait (Bungarus caeruleus)**	Neurotoxic	Immobilize limb, reassure patient, immediate transport, avoid unnecessary movement	Close neurological monitoring, airway management, ICU admission if respiratory weakness develops	Minimal local swelling, abdominal pain, ptosis, generalized paralysis	Document bite site, collect clothing, maintain forensic records	CBC, ABG, Electrolytes, ECG	ASV, ventilatory support, neostigmine trial where appropriate	Frequent neurological assessment, suction airway, monitor urine output, emotional support
3	**Russell's Viper (Daboia russelii)**	Hemotoxic	Immobilize limb, reassure patient, avoid herbal treatment	Establish IV access, monitor bleeding, shock management	Pain, swelling, bleeding gums, hematuria, hypotension, AKI	Photograph swelling progression, preserve blood-stained clothes	WBCT, PT/INR, CBC, Platelets, Creatinine, Urinalysis	ASV, blood products if indicated, dialysis if AKI	Monitor bleeding, urine output (>0.5 mL/kg/hr), renal function, fluid balance

4	**Saw-scaled Viper (Echis carinatus)**	Hemotoxic	Immobilize limb, early referral	Observe coagulation profile, monitor for compartment syndrome	Local swelling, blistering, coagulopathy, bleeding	Measure circumference of limb every 2–4 hours, document progression	CBC, Coagulation profile, RFT	ASV, wound care	Neurovascular assessment, pain assessment, limb elevation after stabilization
5	**Pit Viper (Trimeresurus spp.)**	Cytotoxic/Hemotoxic	Immobilization, transport	Wound assessment, monitor coagulation	Severe pain, edema, tissue necrosis	Serial photographs, wound measurements	CBC, PT/INR, Fibrinogen	ASV (if indicated), surgical consultation	Wound care, infection prevention, documentation
6	**Sea Snake**	Myotoxic	Remove from water safely, immobilize patient	Cardiac and renal monitoring	Muscle pain, weakness, dark urine, respiratory weakness	Record exposure history	CK, Serum Potassium, Urinalysis, RFT	ASV (where indicated), aggressive hydration	Monitor rhabdomyolysis, urine output, renal function

REPORTING AND COLLABORATION WITH EXPERT

Reporting and Referral

Depending on the case, the Nurse practitioner should inform the appropriate team.

Sr. No.	Expert	Role
1	Police	FIR, seizure, investigation
2	Medical Officer	MLC certification
3	Forensic Nurse	Assessment, documentation, evidence collection
4	Forensic Medicine Specialist	Opinion and expert evidence
5	Forensic Science Laboratory	DNA, toxicology, trace evidence
6	Magistrate	Judicial procedures
7	Child Welfare Committee	Child abuse cases
8	Protection Officer	Domestic violence cases
9	One Stop Centre	Survivor support
10	Social Worker	Rehabilitation
11	Psychologist	Mental health assessment

NURSING INCIDENT REPORT

Hospital Name: _____

Hospital Registration No.: _____

Medico-Legal Case (MLC) No.: _____

Date of Examination://_____

Time of Examination: _____

PART A. PATIENT IDENTIFICATION

Item	Details
Patient Name	
Hospital ID	
Age	
Sex	
Date of Birth	
Address	
Mobile Number	
Occupation	
Nationality	
Identification Marks	
Guardian/Attendant	
Relationship	

PART B. INCIDENT INFORMATION

Date of Incident: _____

Time of Incident: _____

Place of Incident (Exact Location):

GPS/Nearest Landmark (if available):

Type of Incident (✓)

- Snake Bite
- Animal Bite
- Assault
- Sexual Assault
- Burns
  Poisoning
- Road Traffic Accident
- Fall
- Occupational Injury
  Other _____

PART C. SOURCE OF HISTORY

History provided by

- Patient
- Relative
- Witness
- Police Officer
- Ambulance Staff
- Other _____

Patient conscious during history?

- Yes
- No

Interpreter required?

- Yes
- No

Language Used _____

PART D. HISTORY OF PRESENT INCIDENT

- **Events leading to injury:**
- **Mechanism of injury:**
- **Object/weapon/animal involved:**
- **Time elapsed before hospital arrival:**
- **First aid received:**
- **Transport details:**
- **Narrative:**_____
  _____
  _____
  _____
  _____
  _____
  _____
  _____
  _____

PART E. PRE-HOSPITAL CARE

First aid given

- None
- Pressure Bandage
- Limb Immobilization
- CPR
- Oxygen
- IV Fluids
- Wound Dressing
- Tourniquet Applied
- Unknown

Given by

- Self
- Relative
- Ambulance
- Primary Health Centre
- Private Hospital
- Other _____

PART F. INITIAL NURSING ASSESSMENT

- Time of Arrival _____

- Triage Category
  Red
  Yellow
  Green
  Black
- Vital Signs
  Temperature _____
  Pulse _____
  Respiratory Rate _____
  Blood Pressure _____
  SpO_2 _____
  GCS _____
  Pain Score _____ /10

General Appearance

Stable
Critical
Unconscious
Distressed

PART G. PHYSICAL EXAMINATION

Head-to-Toe Examination

Head _____
Neck _____
Chest _____
Abdomen _____
Upper Limbs _____
Lower Limbs _____
Back _____
Genitalia (when applicable)

Body Map Attached

Yes No

Photographs Taken

Yes No

Photo Identification Number(s)

PART H. FORENSIC EVIDENCE COLLECTION

Evidence Collected	Yes	No	Quantity	Label No.
Blood Sample				
Urine Sample				
Saliva Swab				
Hair Sample				
Nail Scrapings				
Clothing				
Foreign Material				
Weapon/Object				
Bite Swab				
Other				

PART I. EVIDENCE PRESERVATION

- **Packaging Method**
  - Paper Bag
  - Plastic Container
  - Evidence Envelope
  - Sterile Tube
  - Glass Container
  - Other _____
- **Seal Number** _____
- **Evidence Stored At**_____

PART J. CHAIN OF CUSTODY

Date & Time	Evidence ID	Collected By	Handed To	Signature

PART K. INVESTIGATIONS

Laboratory Tests Ordered

- CBC
- Blood Group
- Coagulation Profile
- Toxicology
- DNA Sample
- Urinalysi
- Pregnancy Test
- ECG
- X-ray
- CT Scan
- MRI
- Other _____

PART L. TREATMENT PROVIDED

EmergencyTreatment_____

_____

_____

_____

_____

_____

MedicationsAdministered_____

_____

_____

_____

_____

_____

ProceduresPerformed_____

_____

_____

_____

Surgery: Yes / No
Details

PART M. CONSULTATIONS

Department	Name	Time
Emergency Medicine		
Surgery		
Orthopedics		
Forensic Medicine		
Psychiatry		
Obstetrics &Gynecology		
Pediatrics		
Toxicology		
Others		

PART N. REPORTING TO AUTHORITIES

Police Informed: Yes/ No
Police Station
Officer Name
Buckle/ID Number
GD/DD/FIR Number
Date & Time
Magistrate Informed (if applicable): Yes/ No
Child Welfare Committee (if applicable): Yes/ No
Protection Officer (Domestic Violence): Yes/ No

PART O. NURSING OPINION

The injuries documented are consistent with the history provided at the time of examination. This report is limited to observations recorded during nursing assessment and does not constitute a medico-legal opinion regarding the cause, manner, or legal determination of injuries.

Additional Remarks:

PART P. DISPOSITION

- Discharged
- Admitted
- ICU
- Referred
- Surgery
- Died
- Left Against Medical Advice (LAMA)
- Follow-up Advice

PART Q. DECLARATION

I certify that the above information has been recorded accurately based on the patient's history, clinical findings, and forensic nursing assessment. All evidence collected has been handled according to the standard chain of custody procedures.

_____

_____

Examiner Details

Forensic Nurse Specialist

Name: _____

Registration Number: _____

Designation: _____

Signature: _____

Date: _____

Time: _____

Medical Officer Verification

Name: _____

Designation: _____

Registration Number: _____

Signature: _____

Date: _____

Time: _____

NURSING EVIDENCE CHECKLIST

Sr. No.	Aspects to check	Yes / No
A. Legal and Ethical Requirements		
	Patient identity confirmed (using at least two identifiers)	
	Medico-Legal Case (MLC) registered	
	Informed written consent obtained for examination	
	Separate consent obtained for photography	
	Separate consent obtained for forensic evidence collection	
	Assent obtained (for minors, where applicable) and guardian consent documented	
	Privacy and dignity maintained throughout examination	
B. Personal Safety		
	Hand hygiene performed	
	Appropriate PPE worn (gloves, mask, gown, eye protection as required)	
	Sterile evidence collection kit used	
	Equipment checked before use	
C. Documentation		
	Incident history documented verbatim (patient's own words where possible)	
	Date and time of examination recorded	
	Body map completed	
	Injury measurements recorded (size, shape, location, colour, orientation)	
	Clinical photographs taken with scale and patient ID (where consented)	
	All entries dated, timed, and signed	
D. Biological Evidence Collection (As Applicable)		
	Blood sample collected	
	Urine sample collected	
	Saliva/Buccal swab collected	
	Vaginal swabs collected	
	Cervical swabs collected	
	Anal/Rectal swabs collected	
	Penile swabs collected	
	Oral swabs collected	
	Skin swabs collected	
	Bite-mark swab collected	
	Nail scrapings/clippings collected	
	Head hair sample collected	
	Pubic hair sample collected	
	Foreign material collected (soil, glass, paint, fibres, etc.)	
E. Physical Evidence Collection		
	Clothing collected separately in paper bags	
	Undergarments collected (if applicable)	
	Footwear collected (if applicable)	
	Weapon/object preserved (if applicable)	
	Ligature material preserved (if applicable)	
	Personal belongings documented and secured	
	Wet evidence air-dried before packaging	
	Paper bags/envelopes used where appropriate	
	Each item individually packaged	
	Evidence labelled with patient ID, MLC number, date, time, collector's	

	name and signature	
	Tamper-evident seals applied	
	Evidence storage conditions documented	
G. Chain of Custody		
	Evidence inventory completed	
	Chain of Custody form completed	
	Every transfer documented with date and time	
	Receiving officer's name, designation and signature obtained	
	Seal numbers verified and documented	
H. Reporting and Communication		
	Medical Officer informed	
	Police informed (where legally required)	
	Forensic Medicine Department informed (if applicable)	
	Child Welfare Committee informed (child abuse cases)	
	Protection Officer informed (domestic violence cases)	
	Social Worker/Psychologist referral completed (where indicated)	
I. Completion		
	Laboratory request forms completed	
	Evidence transferred to authorized authority/FSL	
	Patient received treatment and discharge/admission instructions	
	Follow-up appointment arranged	
	Final nursing documentation completed	
	Examiner's name, registration number, signature, date and time recorded	

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