

# Sexual Assault Supplemental Report Form

- It is recommended that the Sexual Assault Supplemental Report be used in the reporting, recording and investigation of *all* alleged sexual assault incidents, **for each and every incident reported**
- Supervisory review of all sexual assault cases is encouraged
- This form is not intended for use when the victim is a minor

Agency		ORI		Incident #		Case #	
Name of Person Who Contacted Police <i>(optional on information reports)</i>				Method Report Received <input type="checkbox"/> 911 Call <input type="checkbox"/> Non-emergency number <input type="checkbox"/> Online <input type="checkbox"/> Other <i>(describe)</i> _____			
Address of Person Who Contacted Police				City		State	Zip Code
Telephone: Home		Work		Cell		Email	
Relationship to Victim			Others Present with Victim During Interview				
Location of Interview <input type="checkbox"/> Hospital <input type="checkbox"/> On Scene <input type="checkbox"/> At Department <input type="checkbox"/> Other <i>(describe)</i> _____							

## Dates

Date of Report <i>(mm/dd/yyyy)</i>		Time of Report		Date(s) of Incident <i>(mm/dd/yyyy)</i>		Time of Incident From To	
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## Victim

*Victim's identifying or contact information may be exempt from disclosure under the Freedom of Information Act and Crime Victim's Rights Act or if this is a blind report.*

Last Name			First Name			Middle Name	
Any Aliases			Primary Language		Special Needs, Disability, Requests, etc.		
Race/Ethnicity		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth <i>(mm/dd/yyyy)</i>		Height		Weight
Address				City		State	Zip Code
Telephone: Home		Work		Cell		Email	
Emergency Contact			Emergency Contact Telephone		Best Way to Safely Contact Victim		

Victim Demeanor Observed at Time of Interview *(select all that apply)* Include detailed description in narrative

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Afraid/Fearful  | <input type="checkbox"/> Confused         | <input type="checkbox"/> Shaking/Trembling           | <input type="checkbox"/> Other <i>(describe)</i> _____ |
| <input type="checkbox"/> Angry           | <input type="checkbox"/> Flat Affect      | <input type="checkbox"/> Tearful/Crying              |  |
| <input type="checkbox"/> Calm/Controlled | <input type="checkbox"/> Nervous/Agitated | <input type="checkbox"/> Withdrawn/Quiet/Flat Affect |  |

Are there any injuries? <i>If yes, detail in narrative</i>		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Follow up needed		Does the victim report pain? <i>If yes, describe</i>		<input type="checkbox"/> Y <input type="checkbox"/> N	
Were weapons used to hurt/injure/threaten? <i>If yes, detail in narrative</i>		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Follow up needed		Does the victim believe she/he may have been drugged? <i>If yes or unsure, detail in narrative</i>		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unsure	
Did the victim voluntarily consume alcohol within 24 hours of incident? <i>If yes, detail in narrative</i>		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Follow up needed		Did the victim voluntarily take other controlled substance within 96 hours of incident? <i>If yes, detail in narrative</i>		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Follow up needed	
Has sexual abuse by suspect been ongoing? <i>If yes, how long?</i>		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Follow up needed		Any other known or possible victims? <i>If yes, list names and contact information</i>		<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Follow up needed	

## Victim Assistance Checklist

- |  |   |
|--|---|
| <input type="checkbox"/> Victim's Personal Safety Concerns Addressed | <input type="checkbox"/> Sexual Assault Victim Rights and Services Information Provided |
| <input type="checkbox"/> Victim Given Department Contact Information | <input type="checkbox"/> Crime Victim's Rights and Compensation Information Provided    |

## Incident Information

Location of Interaction Before Assault(s) *(detail in narrative)*

Location(s) of Assault(s) *(detail in narrative)*

Locations Suspect Took Victim After the Assault(s) *(detail in narrative)*

Type of Coercion/Force/Fear Involved *(select all that apply)*

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Disregarding the victims' stated or otherwise communicated lack of consent | <input type="checkbox"/> Victim was incapacitated (see below) | <input type="checkbox"/> Threat of death |
| <input type="checkbox"/> Verbal pressure/coercion   | <input type="checkbox"/> Presence of weapon                   | <input type="checkbox"/> Abduction       |
| <input type="checkbox"/> Position of authority (teacher, supervisor, boss, parent)                  | <input type="checkbox"/> Stalking                             | <input type="checkbox"/> Other _____     |
| <input type="checkbox"/> Threat of physical force or violence                                       | <input type="checkbox"/> Physical restraint                   |  |
|   | <input type="checkbox"/> Physical force                       |  |

Describe all types of coercion/force/fear involved. *(Include detailed description in narrative)*

Type of Assault *(select all that apply)*

- | Attempted                | Completed                |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Rape (penile/vaginal penetration against the will, by force, threat, or intimidation)                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Forced sodomy (penile/anal penetration against the will, by force, threat, or intimidation)             |
| <input type="checkbox"/> | <input type="checkbox"/> | Forced oral-genital contact (oral copulation)   |
| <input type="checkbox"/> | <input type="checkbox"/> | Forced sexual penetration with an object or finger  |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexual battery (forced touching of intimate parts, fondling, kissing, oral contact but not penetration) |
| <input type="checkbox"/> | <input type="checkbox"/> | Physical assault/battery  |
| <input type="checkbox"/> | <input type="checkbox"/> | Strangulation   |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____   |

Additional Crimes to be Investigated:

Victim Incapacitated or Incapable of Consenting or Communicating Unwillingness to Engage in Sexual Contact Due to: *(select all that apply)*

- |                                  |   |   |
|----------------------------------|---|---|
| <input type="checkbox"/> Age     | <input type="checkbox"/> Mental incapacity    | <input type="checkbox"/> Unconsciousness or sleep |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Physical incapacity  | <input type="checkbox"/> Other <i>(describe)</i>  |
| <input type="checkbox"/> Drugs   | <input type="checkbox"/> Subordinate position |   |

## Initial Investigation

Victim Medical Treatment *(select all that apply)*

	Where	By Whom	Date
<input type="checkbox"/> First aid rendered	_____	_____	_____
<input type="checkbox"/> Medical exam	_____	_____	_____
<input type="checkbox"/> Forensic exam/rape kit	_____	_____	_____
<input type="checkbox"/> Admitted to hospital	_____	_____	_____
<input type="checkbox"/> Will seek own	_____	_____	_____
<input type="checkbox"/> Declined	_____	_____	_____

Suspect Forensic Exam Conducted? Y  N  Follow up needed  If yes, by whom? \_\_\_\_\_ Date \_\_\_\_\_

Photos	Taken By	Date Taken	Digital	Polaroid	35 mm	Video
<input type="checkbox"/> Victim injuries	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Suspect injuries	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Crime scene(s)	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Property damage	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Evidence Collected *(select all that apply)*

- |   | By Whom | Location Stored | Analyzed  |
|---|---------|-----------------|---|
| <input type="checkbox"/> Physical evidence <i>(i.e. clothing, sheets, tissue)</i> <i>(list)</i> _____ | _____   | _____           | Y <input type="checkbox"/> N <input type="checkbox"/> |
| <input type="checkbox"/> Property damage <i>(list)</i> _____  | _____   | _____           | Y <input type="checkbox"/> N <input type="checkbox"/> |
| <input type="checkbox"/> Weapons <i>(list)</i> _____  | _____   | _____           | Y <input type="checkbox"/> N <input type="checkbox"/> |

	Victim	Attached	Suspect	Attached		Victim	Attached	Suspect	Attached
911 print out	<input type="checkbox"/>	<input type="checkbox"/>			Suspect polygraph	<input type="checkbox"/>		<input type="checkbox"/>	
Forensic exam report	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pretext phone call	<input type="checkbox"/>		<input type="checkbox"/>	
Toxicology report	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

Follow up needed, specify \_\_\_\_\_

**Suspect** Photocopy and complete the following information for each suspect on a separate page and attach to the report.

No. of Suspects	Last Name (Suspect # _____)		First Name		Middle Name	
Aliases			Height	Weight	Hair Color	Eye Color
Race/Ethnicity	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth (mm/dd/yyyy)	Social Security No.		Driver's License No./State	
Address			City		State	Zip Code
Telephone: Home		Work	Cell		Email	
Primary Language (if not English)		Suspect's Defining Characteristics (i.e. tattoos, scars, physical disabilities, etc.)				
Suspect on Scene Y <input type="checkbox"/> N <input type="checkbox"/>		Suspect Arrested Y <input type="checkbox"/> N <input type="checkbox"/> If Yes, Arrest Number				
Suspect Conduct Prior to Incident (select all that apply) Include detailed description as gathered from interviews of suspect, victim, and associated persons in narrative						
<input type="checkbox"/> Grooming (i.e. targeting vulnerability, testing boundaries, building trust)		<input type="checkbox"/> Monitoring victim (tracking patterns of conduct)				
<input type="checkbox"/> Electronic contact (i.e. internet, text messaging)		<input type="checkbox"/> Providing alcohol/controlled substances				
<input type="checkbox"/> Isolating victim		<input type="checkbox"/> Other (describe) _____				
Relationship to Victim (select all that apply)			Suspect Demeanor as Observed at Time of Interview (select all that apply) Include detailed description in narrative			
<input type="checkbox"/> Recent acquaintance		<input type="checkbox"/> Domestic partner		<input type="checkbox"/> Parent of victim		
<input type="checkbox"/> Casual acquaintance of victim		<input type="checkbox"/> Married		<input type="checkbox"/> Relative of victim		
<input type="checkbox"/> Friend (non-romantic)		<input type="checkbox"/> Legally separated		<input type="checkbox"/> Position of authority		
<input type="checkbox"/> Internet relationship		<input type="checkbox"/> Divorced		<input type="checkbox"/> Co-worker		
<input type="checkbox"/> Planned first meeting/date		<input type="checkbox"/> Father of children		<input type="checkbox"/> Stranger		
<input type="checkbox"/> Intimate partner/dating		<input type="checkbox"/> Cohabiting		<input type="checkbox"/> Other (describe) _____		
<input type="checkbox"/> Former intimate partner/dating		<input type="checkbox"/> Neighbor				
Did the Suspect Consume Alcohol Within 24 Hours Prior to Incident? Y <input type="checkbox"/> N <input type="checkbox"/> If yes, detail in narrative Follow up needed <input type="checkbox"/>		Did the Suspect Take Controlled Substances Within 96 Hours Prior to Incident? Y <input type="checkbox"/> N <input type="checkbox"/> If yes, detail in narrative Follow up needed <input type="checkbox"/>		Visible Suspect Injuries? Y <input type="checkbox"/> N <input type="checkbox"/> If yes, detail in narrative		

**Suspect History**

	Y <input type="checkbox"/> N <input type="checkbox"/>	Date(s)	Type(s)
Arrest record	Y <input type="checkbox"/> N <input type="checkbox"/>	_____	_____
Prior sexual assault offenses	Y <input type="checkbox"/> N <input type="checkbox"/>	_____	_____
Prior use of weapons in a sex related offense	Y <input type="checkbox"/> N <input type="checkbox"/>	_____	_____
Currently on probation	Y <input type="checkbox"/> N <input type="checkbox"/>	_____	_____
Currently on parole	Y <input type="checkbox"/> N <input type="checkbox"/>	_____	_____
Subject of protection order(s)	Y <input type="checkbox"/> N <input type="checkbox"/>	_____	_____

**Associated Persons** Photocopy and complete the following information for each witness on a separate page and attach to the report.

Last Name (Witness # _____)		First Name		Middle Name		
Aliases			Height	Weight	Hair Color	Eye Color
Race/Ethnicity	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Date of Birth (mm/dd/yyyy)	Social Security No.		Driver's License No./State	
Address			City		State	Zip Code
Telephone: Home		Work	Cell		Email	
Relationship to Victim (see above categories)			Relationship to Suspect (see above categories)			
Aware of Incident Y <input type="checkbox"/> N <input type="checkbox"/>		Contact with Victim Prior to Incident Y <input type="checkbox"/> N <input type="checkbox"/> If yes, detail in narrative		Contact with Suspect Prior to Incident Y <input type="checkbox"/> N <input type="checkbox"/> If yes, detail in narrative		
Present During Incident Y <input type="checkbox"/> N <input type="checkbox"/> If yes, detail in narrative			Contact with Victim After the Incident Y <input type="checkbox"/> N <input type="checkbox"/> If yes, detail in narrative			
Did Victim Disclose Y <input type="checkbox"/> N <input type="checkbox"/> If yes, detail in narrative		Contact with Suspect After the Incident Y <input type="checkbox"/> N <input type="checkbox"/> If yes, detail in narrative			Did Suspect Disclose Y <input type="checkbox"/> N <input type="checkbox"/> If yes, detail in narrative	

## Interview History

	Date(s)	Time	Location	Officer Initials
Victim	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
Suspect(s)	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
Associated Person(s)	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

## Case Review Checklist *Select all that apply*

<input type="checkbox"/> Follow-up photos taken of the victim's injuries <i>(mm/dd/yyyy)</i> _____ <input type="checkbox"/> Available witness(es) interviewed <input type="checkbox"/> Witness(es) provided a written statement <input type="checkbox"/> Unable to contact or interview the following person(s) _____ _____ <input type="checkbox"/> Case referred to the prosecutor's office <i>(mm/dd/yyyy)</i> _____	<b>Contacts Initiated by Police</b> <i>(select all that apply)</i> <input type="checkbox"/> Community-based advocate <input type="checkbox"/> Dept./Victim/Witness advocate <input type="checkbox"/> Language translation <input type="checkbox"/> Medical <input type="checkbox"/> Mental health <input type="checkbox"/> Probation/Parole <input type="checkbox"/> Prosecutor <input type="checkbox"/> Other agency _____	<b>Contacts Initiated by Victim</b> <i>(select all that apply)</i> <input type="checkbox"/> Community-based advocate <input type="checkbox"/> Medical <input type="checkbox"/> Mental health <input type="checkbox"/> Other _____																													
<b>Evidence Follow-Up <i>(select all that apply)</i></b>																															
<table border="0"> <tr> <td></td> <td style="text-align: center;">Victim</td> <td style="text-align: center;">Attached</td> <td style="text-align: center;">Suspect</td> <td style="text-align: center;">Attached</td> </tr> <tr> <td>Forensic exam results</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>DNA results</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		Victim	Attached	Suspect	Attached	Forensic exam results	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DNA results	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<table border="0"> <tr> <td></td> <td style="text-align: center;">Victim</td> <td style="text-align: center;">Attached</td> <td style="text-align: center;">Suspect</td> <td style="text-align: center;">Attached</td> </tr> <tr> <td>Toxicology results</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Other _____</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		Victim	Attached	Suspect	Attached	Toxicology results	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																											

Officer Printed Name \_\_\_\_\_ Rank \_\_\_\_\_ Badge Number \_\_\_\_\_

Officer Signature \_\_\_\_\_ Date (mm/dd/yyyy) \_\_\_\_\_

Investigator Printed Name \_\_\_\_\_ Rank \_\_\_\_\_ Badge Number \_\_\_\_\_

Investigator Signature \_\_\_\_\_ Date (mm/dd/yyyy) \_\_\_\_\_

Supervisor Printed Name \_\_\_\_\_ Rank \_\_\_\_\_ Badge Number \_\_\_\_\_

Supervisor Signature \_\_\_\_\_ Date (mm/dd/yyyy) \_\_\_\_\_

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## Officer Narrative *(See next page)*

### Narrative Report Checklist

#### Describe and Document:

- How case was received
- Observations on approach—document what you saw, heard, etc.
- Spontaneous statements and demeanor at time of statement
  - Victim
  - Victim during transport
  - Suspect
  - Suspect during transport and booking
- Injuries of all parties
  - Type and extent
  - How the injuries occurred
- Interview and provide detailed account of incident
  - Victim
  - Suspect
  - Witness(es), esp. first disclosure
  - Medical personnel
- Drugs/alcohol used/involved
- Weapons used/involved
- Coercion, force, fear
- Crime scene and physical evidence
- Actions taken (i.e. evidence collected, arrest decision, exams, follow up photographs and interviews)
- Documents included with report (search/arrest warrants, affidavits, subpoenas, 911 print-out, pretext phone call synopsis, transcripts, crime lab reports, victim/suspect forensic exam reports, photos, etc.)

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*Officer Printed Name*

*Rank*

*Badge Number*

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*Officer Signature*

*Date (mm/dd/yyyy)*





