



strangulationtraininginstitute.com
Illustration and layout of this tool by Yesenia Aceves

PEDIATRIC-ADOLESCENT FOLLOW-UP EVALUATION

Name of Examining Agency: _____

Address: _____

Date of Initial Exam: _____ Date of Today's Exam: _____ Time: _____

Case Number(s): _____

Name of Patient: _____ Date of Birth: _____

Address: _____

Accompanied By: _____

Others Present: _____

PATIENT RELEASE STATEMENT

I, _____, hereby request and authorize the staff of (agency/agencies) _____ to conduct a medical-forensic follow-up evaluation and clinical procedures, including collection and examination of specimens as are necessary for diagnosis and treatment as well as investigation. Furthermore, I hereby authorize and request the medical staff to supply all items of evidence (____ initials) and copies of medical and laboratory reports (____ initials) to the appropriate investigative agency for use in the investigation and any resulting legal proceedings.

Patient Examined: _____ Date: _____

Parent or Guardian: _____ Witness: _____

PHOTOGRAPHIC RELEASE

I, _____, hereby request and authorize the staff of (agency/agencies) _____ to capture and produce photographs of body surface or colposcope images of injury, healing injury or normal anatomy. The release of these photographs is conditioned upon the images being viewed only by those persons officially involved in the investigation or legal proceedings. De-identified photos may be used and viewed for education/teaching purposes.

Patient Examined: _____ Date: _____

Parent or Guardian: _____ Witness: _____

Patient's Name: _____

1. Review of initial exam documentation ☐ Yes ☐ No ☐ N/A
2. Reason for follow-up examination ☐ Physical Abuse ☐ Strangulation ☐ Other _____

Summary of acute strangulation evaluation: _____

Description of injury/abuse event(s) in patient's own words: _____

Name of examiner: _____ Date: _____

Signature: _____

Patient Label

Patient's Name: _____

Vital Signs: T _____ P _____ R _____ B/P _____ Pulse Ox _____

Neck Circumference _____ (Anterior) _____ (Lateral)

Mental Status/Behavior/Appearance: _____

REVIEW OF SYSTEMS

Neurological: _____

Cardiovascular: _____

Respiratory: _____

HEENT: _____

Gastrointestinal: _____

Genito-urinary: _____

OB/Gynecological: _____

Skin/Muscle/Bone: _____

Psych/Social: _____

Since the strangulation, has the patient noted any of the following symptoms:

- | | | | | | |
|---|---|--|---------------------------------------|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Coughing | <input type="checkbox"/> Drooling | <input type="checkbox"/> Dyspnea | <input type="checkbox"/> Dysphagia | <input type="checkbox"/> Odynophagia | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Lightheadedness | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Neck swelling | <input type="checkbox"/> Nose pain | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Crepitus | <input type="checkbox"/> Uncontrolled shaking | <input type="checkbox"/> Combativeness | <input type="checkbox"/> Irritability | <input type="checkbox"/> Restlessness | |
| <input type="checkbox"/> Otherwise altered mental status | Describe: _____ | | | | |
| <input type="checkbox"/> Voice changes | Describe: _____ | | | | |
| <input type="checkbox"/> Vision changes | Describe: _____ | | | | |
| <input type="checkbox"/> Bleeding | Describe: _____ | | | | |
| <input type="checkbox"/> Weakness/numbness of extremities | Describe: _____ | | | | |

Name of examiner: _____ Date: _____

Signature: _____

Patient's Name: _____

Pain score: _____ ☐ Numbered scale used ☐ Wong Baker scale used (insert score) _____

On a scale of 0-10, with 0 being no pressure and 10 being the worst pressure you can imagine, how strong was the grip during your strangulation (Circle one): 0 1 2 3 4 5 6 7 8 9 10

Is the patient **pregnant**? ☐ Yes ; How many weeks? _____ ☐ N/A

☐ **Petechiae** Locations: ☐ Conjunctivae ☐ Face ☐ Palate ☐ Ears ☐ Scalp
☐ Tympanic Membrane(s) ☐ Neck ☐ Chest

☐ **Tongue or oral cavity injury** Describe: _____

☐ **Neurological findings**
☐ Ptosis ☐ Facial droop ☐ Paralysis ☐ Unilateral weakness
☐ Loss of sensation ☐ Other: _____
☐ Absence of normal crepitus when manipulating cricoid cartilage
☐ Visible injury (describe on body maps below)
☐ Digital photography complete

Method/Manner of Strangulation:

☐ One hand Estimated length of time: _____seconds _____minutes
☐ Two hands Estimated length of time: _____seconds _____minutes
☐ "Choke-hold" Estimated length of time: _____seconds _____minutes
☐ Approached from the front
☐ Approached from behind
☐ Multiple strangulation attempts during incident How many? _____
☐ Jewelry on patient's neck during strangulation
☐ Ligature used Describe if possible: _____
☐ Smothering attempt Describe: _____
☐ Other Describe: _____

During the strangulation did the patient note any of the following:

☐ Loss of consciousness/blacking out/passing out Number of times: _____
☐ Incontinence of urine Incontinence of stool
☐ Bleeding Describe: _____
☐ Patient's feet lifted off the ground
☐ Patient's shirt was tightened around their neck

During the follow up evaluation were symptoms noted by the examiner?

☐ Yes: _____ ☐ No

Name of examiner: _____

Signature: _____ Date: _____

Patient's Name: _____

BEST EYE RESPONSE (E)	Spontaneous--open with blinking at baseline	4
	Opens to verbal command, speech, or shout	3
	Opens to pain, not applied to face	2
	None	1
BEST VERBAL RESPONSE (V)	Oriented	5
	Confused conversation, but able to answer questions	4
	In appropriate responses, words discernible	3
	Incomprehensible speech	2
	None	1
BEST MOTOR RESPONSE (M)	Obeys commands for movement	6
	Purposeful movement to painful stimulus	5
	Withdraws from pain	4
	Abnormal (spastic) flexion, decorticate posture	3
	Extensor (rigid) response, decerebrate posture	2
	None	1

Patient's Name: _____

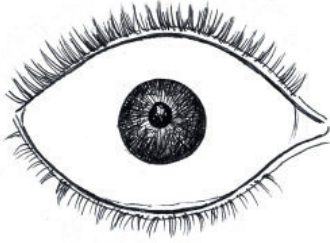
NERVE	ASSESSMENT		NOTES
CN I Olfactory	Identifies a familiar scent with eyes closed (coffee)	<input type="checkbox"/> WLN	<input type="checkbox"/> Unable to assess
CN II Optic	Read one eye at a time, visual fields tested by having patient cover one eye and identifying number of fingers in each visual field	<input type="checkbox"/> WLN	<input type="checkbox"/> Unable to assess
CN III Oculomotor	Check pupillary response with light, check accommodation by moving your finger towards the patient's nose, check for EOMs	<input type="checkbox"/> WLN	<input type="checkbox"/> Unable to assess
CN IV Trochlear	Have patient look down and in	<input type="checkbox"/> WLN	<input type="checkbox"/> Unable to assess
CN V Trigeminal	Ask patient to open mouth while you attempt to close it, have them attempt to move jaw laterally. Have patient close their eyes, touch their face with cotton and have patient identify where they were touched	<input type="checkbox"/> WLN	<input type="checkbox"/> Unable to assess
CN VI Abducens	Have patient move their eyes from side to side	<input type="checkbox"/> WLN	<input type="checkbox"/> Unable to assess
CN VII Facial	Ask patient to smile and raise eyebrows, ask them to keep eyes and lips closed while you try to open them	<input type="checkbox"/> WLN	<input type="checkbox"/> Unable to assess
CN VIII Acoustic/Vestibular	Test hearing with rubbing fingers or whispering	<input type="checkbox"/> WLN	<input type="checkbox"/> Unable to assess
CN IX Glossopharyngeal	Observe patient swallow and check gag reflex	<input type="checkbox"/> WLN	<input type="checkbox"/> Unable to assess
CN X Vagus	Assess gag and swallowing with IX, assess patient's voice characteristics	<input type="checkbox"/> WLN	<input type="checkbox"/> Unable to assess
CN XI Spinal Accessory	Have patient shrug shoulders with resistance, have patient move head from side to side	<input type="checkbox"/> WLN	<input type="checkbox"/> Unable to assess
CN XII Hypoglossal	Have patient stick out tongue and move it internally from right to left, assess articulation	<input type="checkbox"/> WLN	<input type="checkbox"/> Unable to assess

Describe abnormalities here: _____

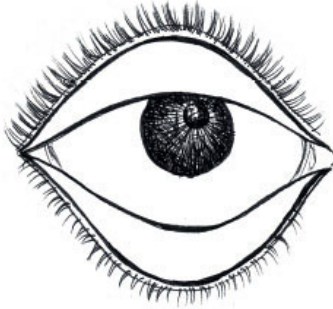
☐ Cranial nerve assessment normal

Patient's Name: _____

RIGHT CONJUNCTIVA



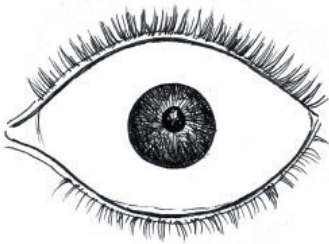
RIGHT INNER EYE LID



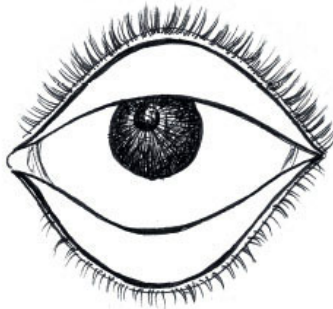
RIGHT OUTER EYE LID



LEFT CONJUNCTIVA



LEFT INNER EYE LID



LEFT OUTER EYE LID

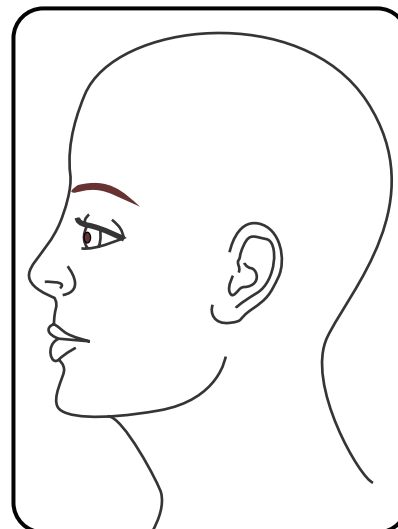
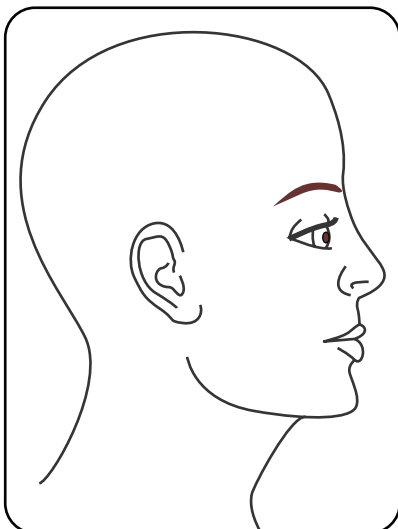
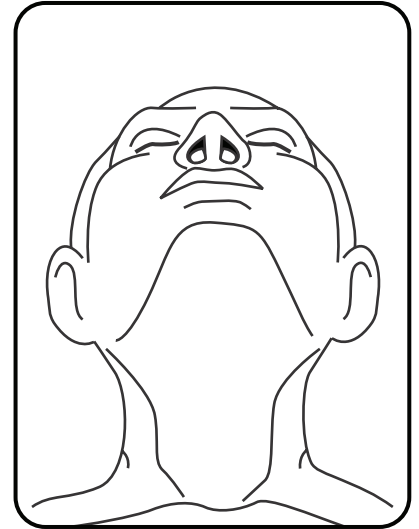
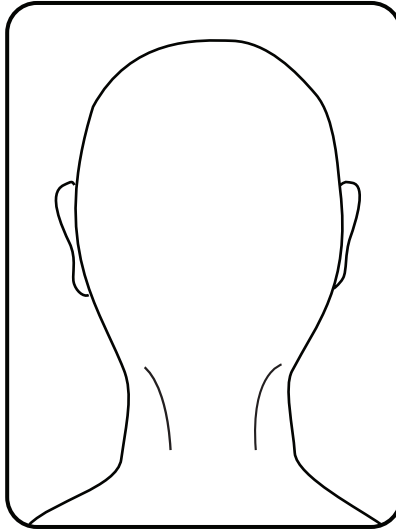
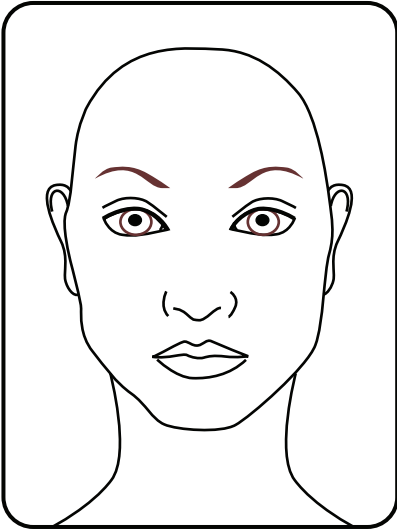
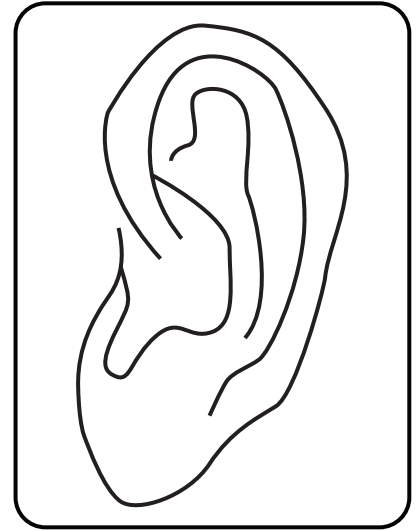
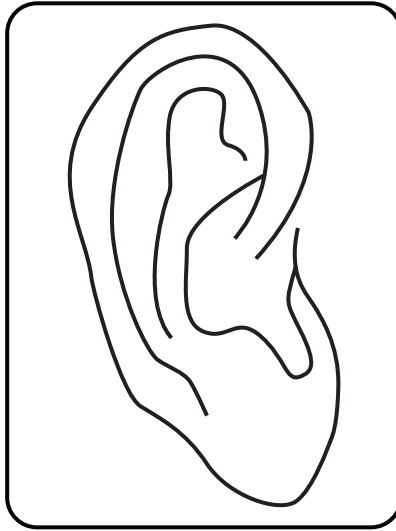
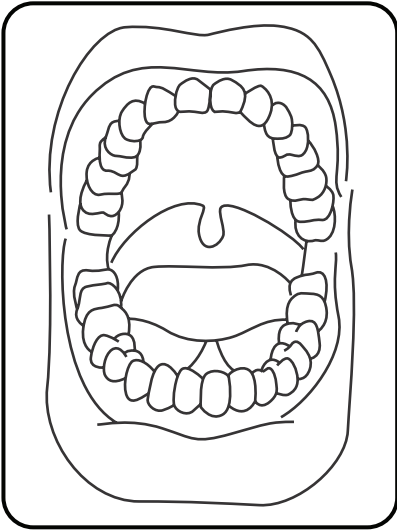


Name of examiner: _____

Signature: _____

Date: _____

Patient's Name: _____



Name of examiner: _____

Signature: _____

Date: _____

Patient's Name: _____

SUMMARY ASSESSMENT

PLAN OF CARE & RECOMMENDATIONS

☐ Pediatric Strangulation Discharge Instructions

Name of examiner: _____ Date: _____

Signature: _____

Patient's Name: _____

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
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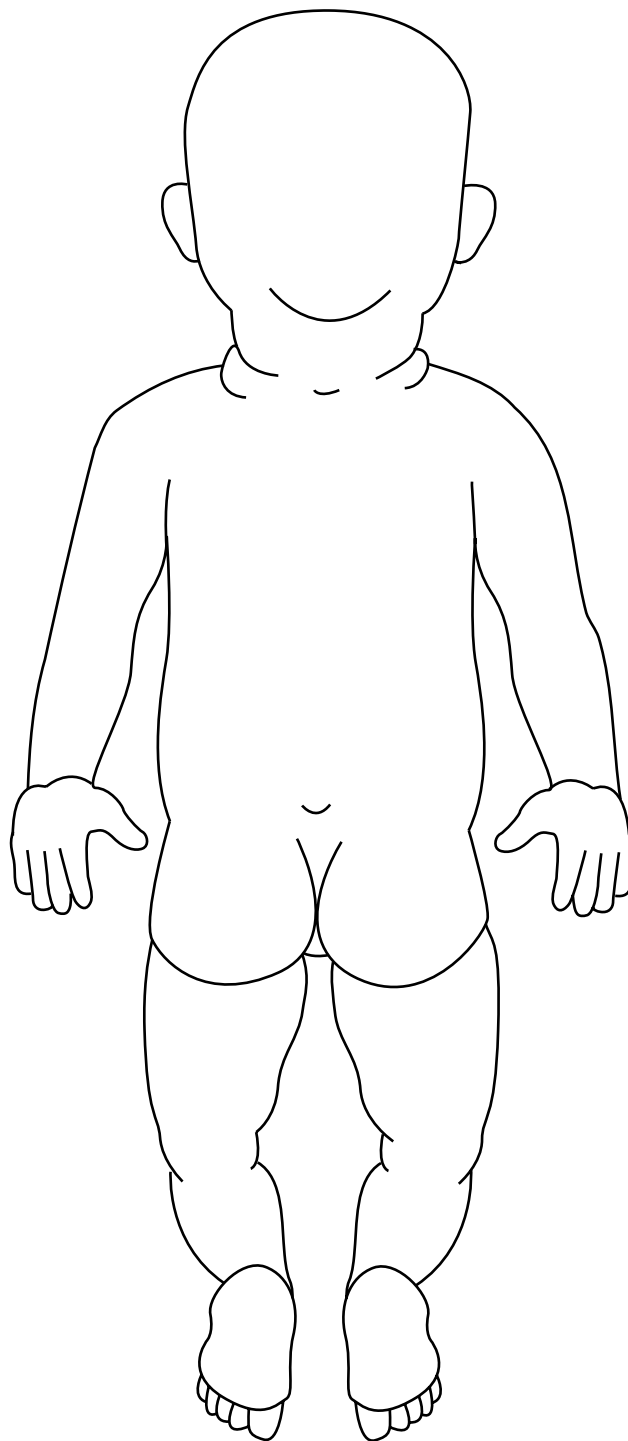
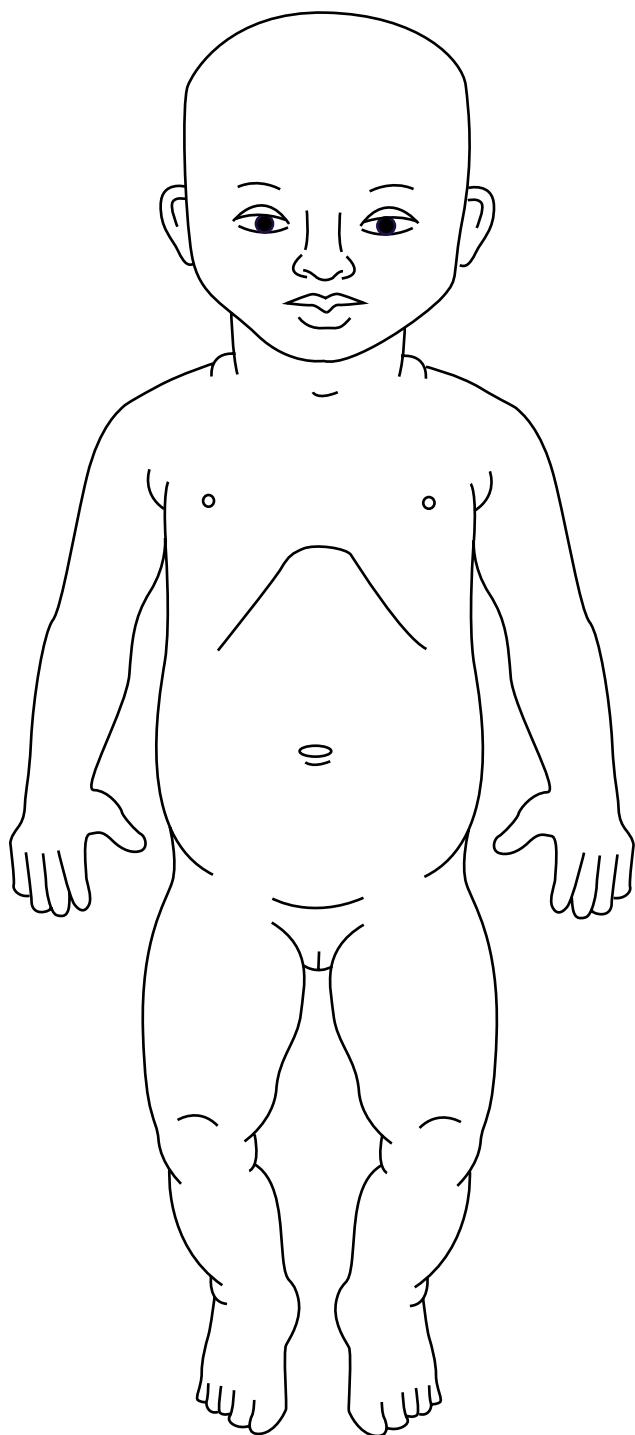
If more space is required, please use a progress note and check the box below.

☐ Please see progress note for additional findings.

☐ Please see age appropriate diagrams (appendices) for additional findings

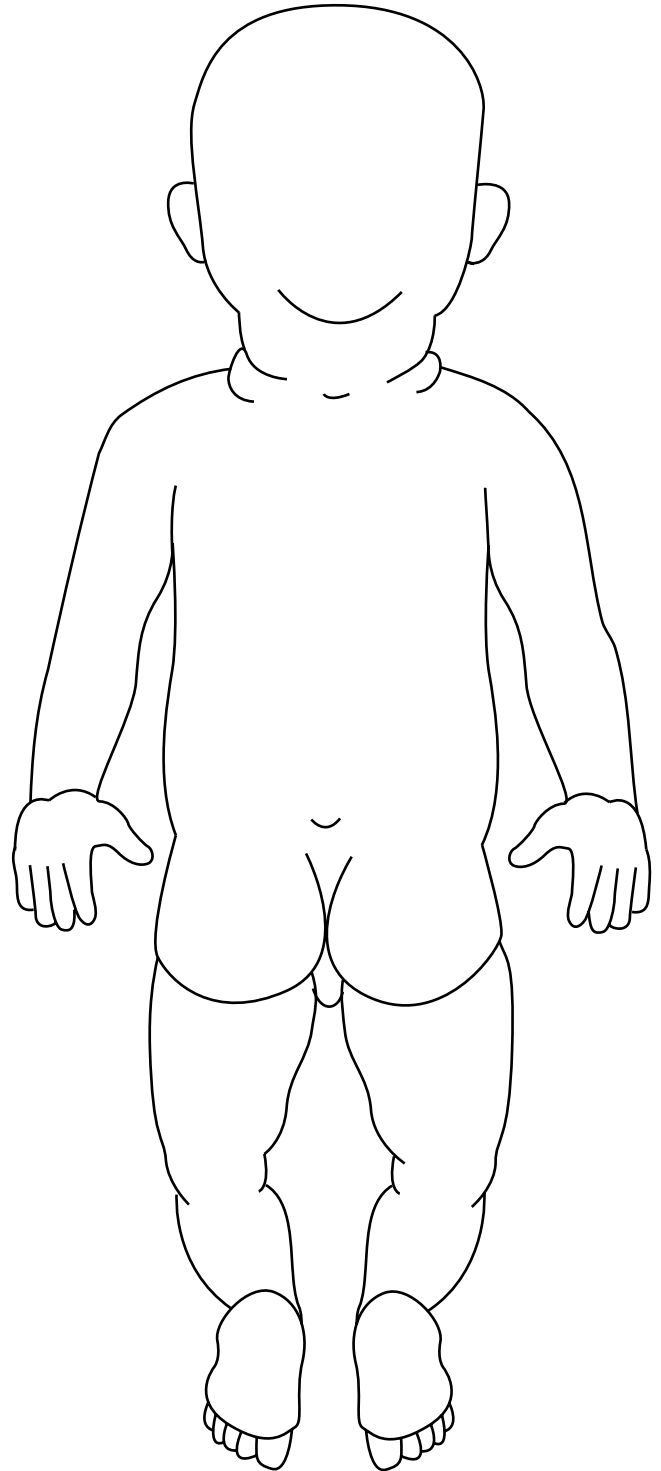
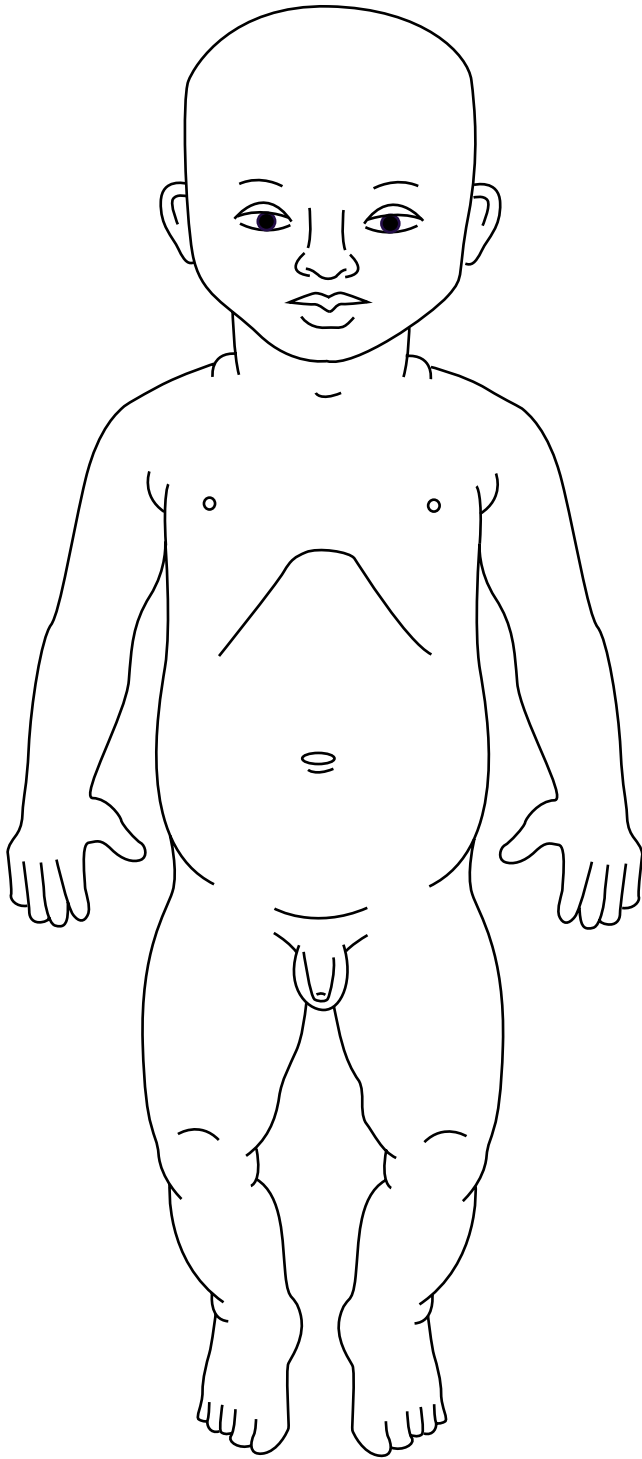
Patient's Name: _____

Numerically mark each finding (1, 2, 3...) and provide a detailed description.



Patient's Name: _____

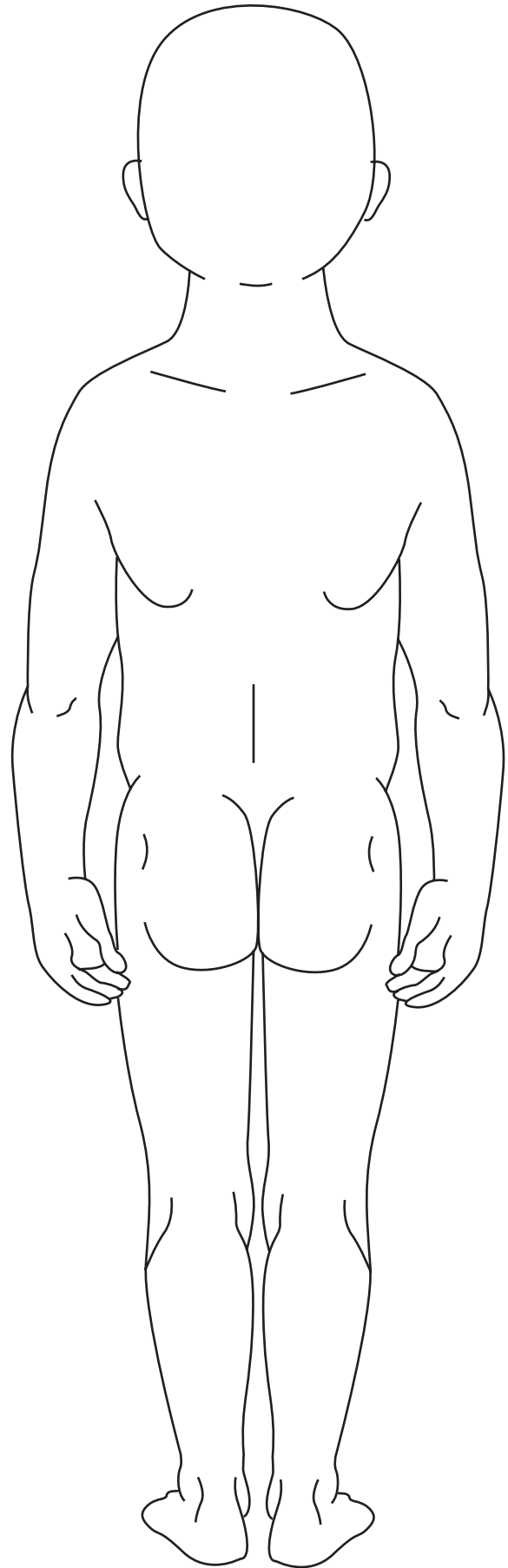
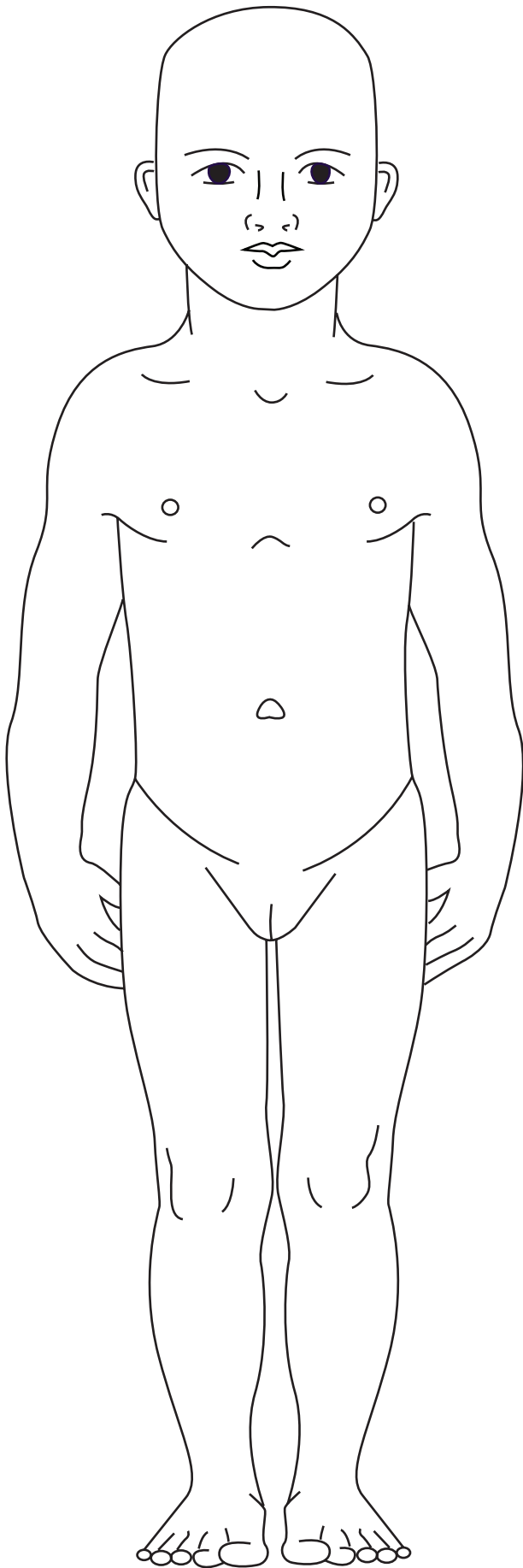
Numerically mark each finding (1, 2, 3...) and provide a detailed description.



Patient's Name: _____

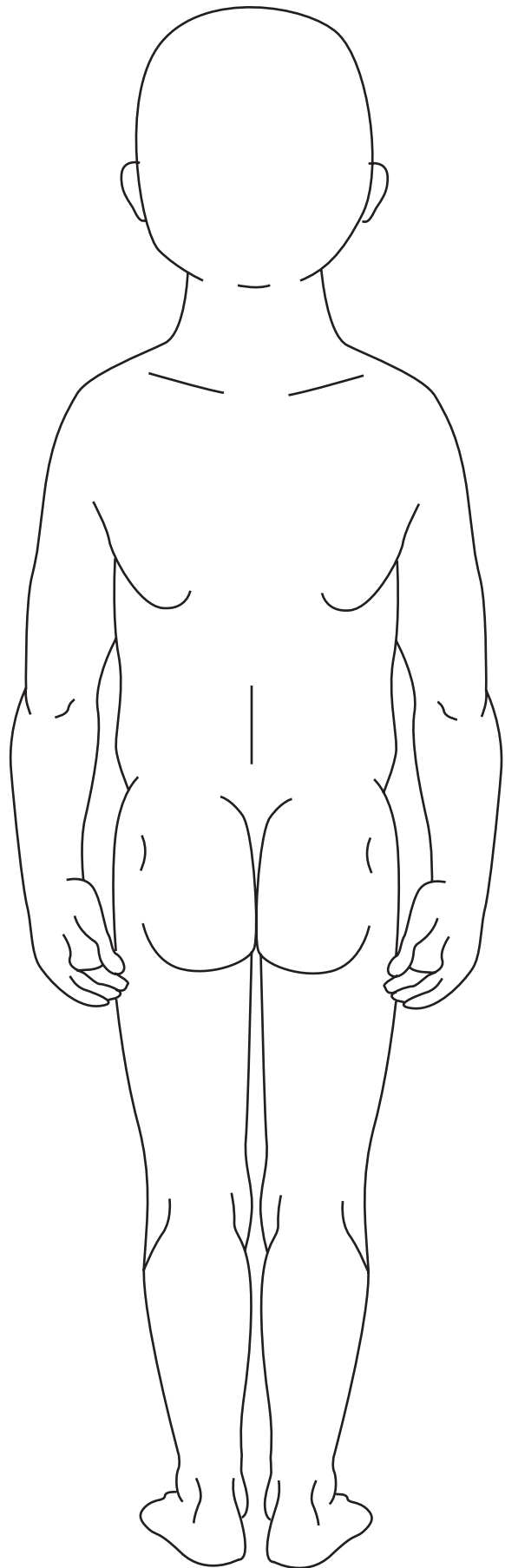
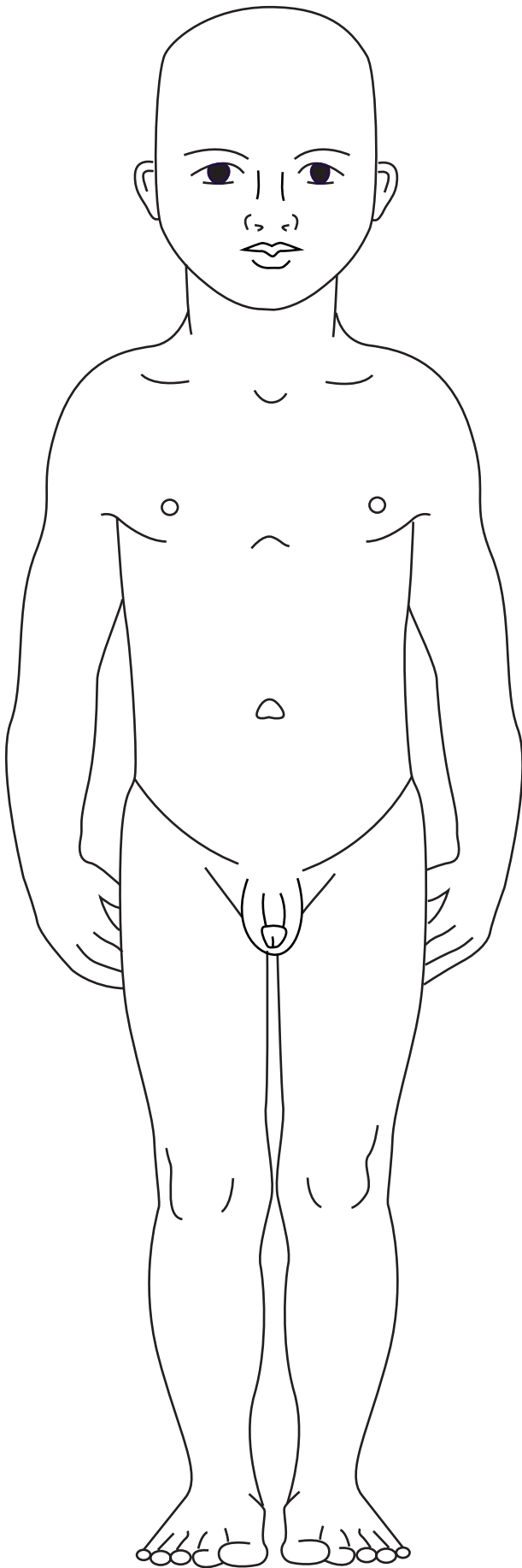
Patient's Name: _____

Numerically mark each finding (1, 2, 3...) and provide a detailed description.



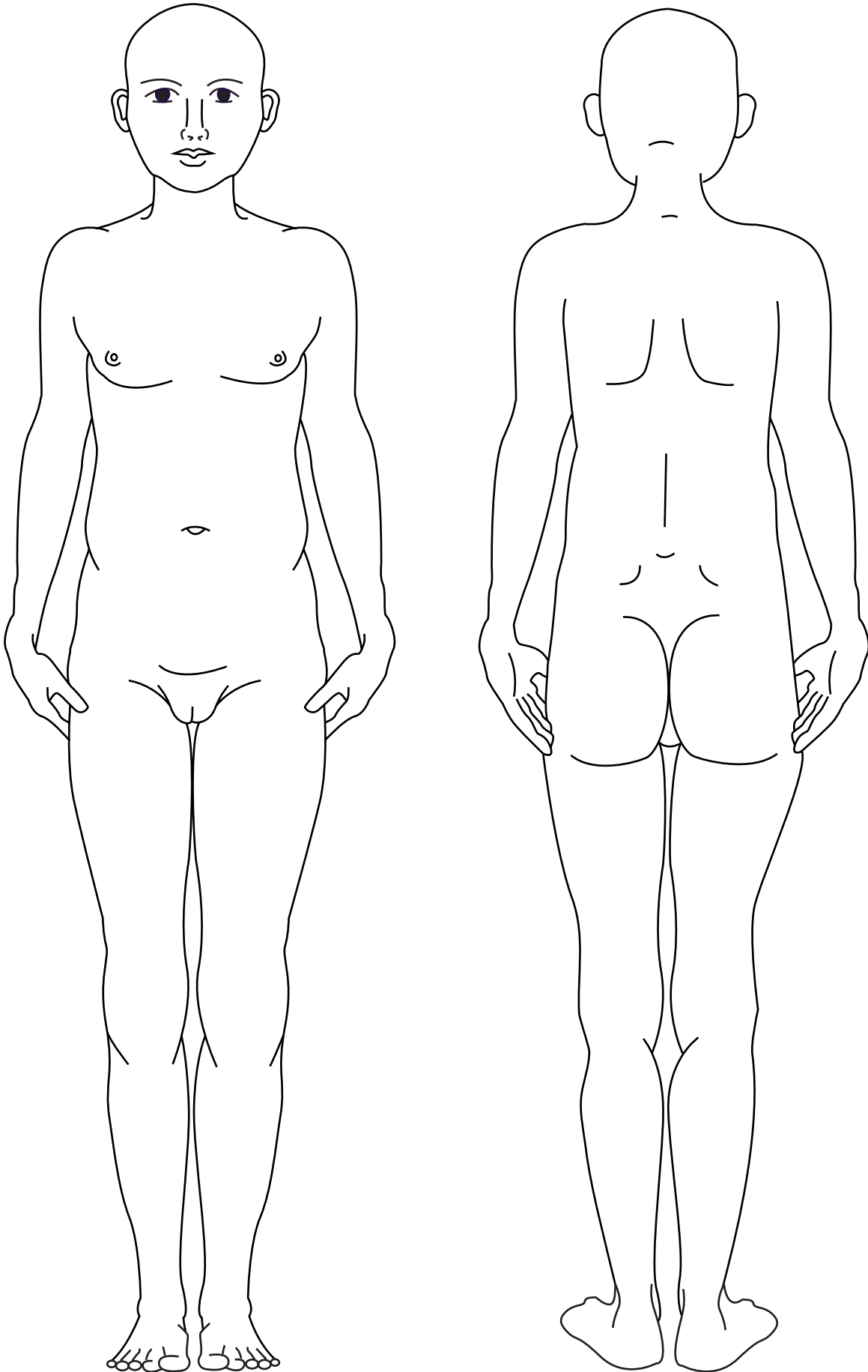
Patient's Name: _____

Numerically mark each finding (1, 2, 3...) and provide a detailed description.



Patient's Name: _____

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