

Non-Fatal Strangulation Documentation Toolkit



INTERNATIONAL
ASSOCIATION OF
**Forensic
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PREFACE

In 1992, The International Association of Forensic Nurses (IAFN) was created by a group of nurses that recognized violence as a healthcare problem. Over the past two and a half decades much progress has been made as it relates to the care of our specialized patient population. Through this progress, knowledge has been gained and practice guidelines continue to evolve with the goal of continuous provision of safe and effective patient care.

In early 2015, the IAFN, the Board of Directors and a group of members recognized strangulation as a healthcare concern that needed practice guidance throughout the organization, and as a result, the Strangulation Task Force was created and was proven to be a group of hard working, dedicated individuals that are truly experts on strangulation. This group was tasked with establishing standards for the organization and developed what would be utilized as a toolkit for best practice provision.

The Strangulation Toolkit provides the forensic nurse with detailed guidance on assessment techniques, documentation, and evidence collection for this patient population. This toolkit also provides documents such as discharge instructions and sample policies that can be adjusted to best suit your institution and your forensic practice.

As a toolkit, it should be mentioned that the IAFN does not endorse any changes to these documents. Limitations of this toolkit include the lack of research available to guide our practice, making the need for additional research related to the management of the patient that has been strangled a high priority. Also, it should be mentioned that each clinician must refer to their own individual state practice acts when considering the implementation of any parts of this toolkit.

The Strangulation Toolkit is the first of its kind to be endorsed by the IAFN and will be a useful guide to improving and standardizing the care of patients that have been strangled. As a group, we will continue to strive to move our profession forward and improve practice internationally and this toolkit proves to keep us on this path.

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PURPOSE

The Non-Fatal Strangulation Documentation Toolkit was developed by consensus to assist clinicians in multiple settings and various disciplines with the evaluation of non-fatal strangulation.

STRANGULATION ASSESSMENT, DOCUMENTATION, AND EVIDENCE COLLECTION GUIDELINES

Equipment Needed

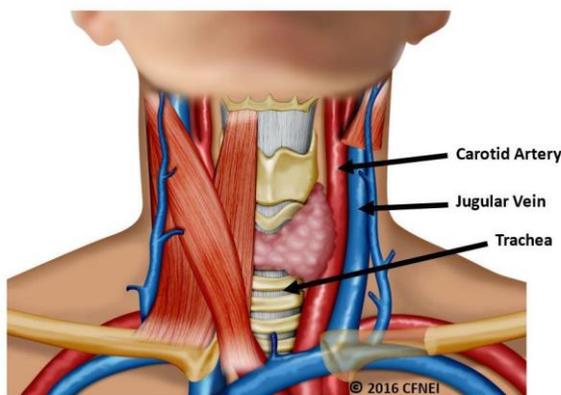
- Camera
- Measuring tape
- Evidence collection kit (swabs, sterile saline or water, envelopes, paper bags, evidence tape, etc.)
- ABFO No. 2 ruler
- Speculum
- Mannequin or Styrofoam head (optional)
- Gloves

Definition

Strangulation is a form of asphyxia produced by a constant application of pressure to the neck. The three forms of strangulation are: hanging, ligature, and manual. Hanging occurs when a person is suspended with a ligature around his or her neck, which constricts due to the gravitational pull of the person's own body weight. Ligature strangulation occurs when the pressure applied around the neck is with a ligature only. Manual strangulation occurs when pressure is applied to the neck with hands, arms, or legs. (Ernoehazy, 2016; Funk & Schuppel, 2003; Line, Stanley, & Choi, 1985; Taliaferro, Hawley, McClane, & Strack, 2009; Wilbur et al., 2001).

Anatomy/Pathophysiology

Pressure around the neck can result in the closure of blood vessels and/or air passages. Injury and death from strangulation occur from one or more mechanisms. The first mechanism is venous obstruction, whereby occlusion of the jugular veins results in congestion of the blood vessels and increased venous and intracranial pressure. The second mechanism is carotid artery obstruction, which stops blood flow and impedes oxygen delivery to the brain. The third mechanism is pressure on the carotid sinus that can cause acute bradycardia and/or cardiac arrest. Strangulation can result in injuries to the soft tissues of the neck, esophagus, larynx, trachea, cervical spine, and the laryngeal and facial nerves. (Hawley, McClane, & Strack, 2001; Shields, Corey, Weakley-Jones, & Stewart, 2010; Smith, Mills, & Taliaferro, 2001; Taliaferro, Hawley, McClane, & Strack, 2009).



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History/Patient Description of the Strangulation Event

Describe what happened, using the patient's own words. Place quotation marks around the patient's comments. Also, describe the patient's appearance, behavior, speech, eye contact, and affect/demeanor using terms such as "slumped," "weeping," "averting eye contact," "stammering," "somber," "agitated," etc. Include the assailant's name, date of birth, and his or her relationship to the patient. Attach additional pages, if needed. Below are specific questions to ask each patient who reports strangulation. (As needed, reword questions to the appropriate developmental level of the patient.)

- Describe and demonstrate on the head model how you were strangled. One hand? Two hands? Arm? Leg? Other object(s)?
- How many times were you strangled?/Over what period of time?
- Were you shaken while you were being strangled?
- Was your head pounded on the ground or wall while you were being strangled?
- Did your feet leave the ground while you were being strangled?
- How long did the strangulation(s) last?
- On a scale of 0–10, how much pressure was applied to your neck during the strangulation(s)?
- What did you think was going to happen?
- What did the assailant say to you before, during, and after you were strangled?
- What made the person stop strangling you?
- Were you suffocated (defined as smothered)? (Suffocation refers to obstruction of the airway at the nose or mouth.)
- Did you have any difficulty breathing or an inability to breathe?
- Did you or do you currently have a cough?
- Did you or do you currently have trouble swallowing?
- Did you have a hoarse, raspy, or complete loss of voice?
- Did you or do you currently have any changes in your vision? (seeing spots, tunnel vision, blurry vision, everything went black, etc.)
- Did you or do you currently have any changes in your hearing? (roaring, ringing, etc.)
- Did you become dizzy or lightheaded?
- Did you lose consciousness? (passed out, blacked out, etc.)
- Did you experience any mental status changes? (restlessness, combativeness, amnesia, psychosis, etc.)
- Did you vomit as a result of being strangled?
- Did you lose control of urine or stool while you were being strangled?
- Were you sexually assaulted?
- Were you slapped, punched, kicked, or bitten anywhere on your body?
- Have you been strangled prior to this event?/How many times?
- Did you or do you have a headache?
- Did you bite your tongue or the inside of your mouth?
- If pregnant, are you having any abdominal cramping, vaginal discharge, or bleeding?
- Were you sexually assaulted during the event?

(Funk & Schuppel, 2003; Gwinn & Strack, 2013; Strack & McClane, 1999).

Documentation of Physical Findings/Description of Injuries

Examine the head, face, neck, and chest completely, using 360 degrees. Closely examine the sclera, conjunctiva, lips, oral cavity, palate, ears, and scalp. Observe for areas of erythema, abrasion, contusion, swelling, laceration, incised wound(s), fracture, bite mark(s), burn(s), or tenderness. Record each injury, including patient statements about the injury (e.g. "he grabbed my neck; that wasn't there before he did that") by drawing a diagram. Label each injury drawn on the diagram by using the consecutive alphabetical or numerical systems (A, B, C or 1, 2, 3, etc.) to describe each injury separately. Attach additional pages if needed. Document the location, shape, color, and size of all injuries, using centimeters as the unit of measure. Note length, width, and depth for each injury (if possible). Also, measure the neck with a measuring tape to establish a baseline for follow-up measurements (to determine whether neck swelling is present). Include the following in the patient's assessment:

- Voice changes: Dysphonia (defined as hoarseness) or aphonia (defined as severe or complete loss of voice)

- Swallowing changes and tongue swelling: Dysphagia (defined as difficulty swallowing) or odynophagia (defined as painful swallowing)
- Breathing changes: Dyspnea (defined as difficulty breathing)
- Visible injuries on the neck and mastoid: Ligature marks/edema/abrasions (scratches and scrapes)/erythema/contusions
- Petechiae: Eyelids/peri-orbital region/face/scalp/neck/ears/soft palate/under tongue
- Subconjunctival/Scleral hemorrhage/Scleral edema (eyes)
- Neurological findings: Ptosis/facial droop/unilateral weakness/loss of sensation/paralysis/seizure
- Neck swelling: Measurement (in centimeters) for size (mark neck with a Sharpie pen for accurate follow-up measurement)
- Miscarriage/Pregnancy - FHT/LMP
- Lung injuries: Aspiration pneumonia/pulmonary edema
- Other symptoms: Acid reflux, etc.
- Pain, swelling, erythema, contusion, abrasion, petechiae, bite marks, knife wounds, or gunshot wounds on any other area of the body (i.e., chest, back, upper extremities, lower extremities)

(Christe et al., 2009; Faugno, Waszak, Strack, Brooks, & Gwinn, 2013; Funk & Schuppel, 2003; Gwinn & Strack, 2013; Hawley, McClane, & Strack, 2001; Strack & McClane, 1999; Taliaferro, Hawley, McClane, & Strack, 2009).

Photographs

Use your facility/community protocol. If no protocol is available, use the guidelines listed below.

- Take full-body distant and mid-distance photographs. Take multiple photographs of the front, sides, and back of the face, neck, upper chest, and shoulders.
- Carefully assess and photograph the eyes and mouth. Take multiple photographs of both eyes of the patient looking up, down, to the left, to the right, and straight ahead. To visualize and photograph the conjunctival sac, gently pull down on the lower lid with a gloved hand. If no ocular trauma is present and if the patient is able to tolerate, flip the upper eyelids up on each eye to visualize and photograph.
- With the patient's mouth open, depress the tongue with appropriate assistive devices to light the internal structures. Take photographs of the upper and lower lips, frenula, under the tongue, the soft palate, uvula, and oropharynx. To completely visualize and photograph the oral structures, rotate the camera so the flash is in various positions, including the upright position, left, right, and upside down.
- Perform a complete head-to-toe assessment of the patient, and photograph and document all injuries. Take close-up photographs of all injuries with and without a measurement ruler in place. Ensure that the plane of the object being photographed is at 90 degrees.
- (Optional) Photograph the patient's demonstration on the strangulation model of how he or she was strangled.
- Take follow-up photographs of all visible injuries within 72 hours post-assault (based upon patient needs, availability, etc.).

(Funk & Schuppel, 2003; Paluch, 2013; Strack & McClane, 1999).

Collection of Evidence

Use your facility/community protocol. Consult your local forensic laboratory for recommendations. If no protocol is available, use the guidelines listed below.

- Collect dried and moist secretions (i.e., blood stains, saliva, etc.) from the face, head, neck, and mouth. Use two or four (as indicated by protocol/recommendation) sterile cotton swabs for each specimen. Swab moist secretions with dry swabs. Swab dry secretions with swabs moistened with sterile saline or sterile water. Air dry the swabs before packaging in an envelope or a swab box.
- Make control swabs by moistening swabs with the sterile saline or sterile water used (as indicated by protocol/recommendation). If collecting control swabs, label, air dry, and package separately from the evidence samples.
- Collect fingernail swabs, if indicated per history. Place swabs from each hand into a separate, labeled envelope.
- Label each envelope or swab box with the contents, patient name, collector name, the date, and time of collection. Seal the envelope with tape, and then initial. Document location and the potential biological specimen identified.

(Gwinn & Strack, 2013; Hawley, McClane, & Strack, 2001).

EXAMPLE POLICY AND PROCEDURE

Policy Name: Standard of Practice in Non-Fatal Strangulation Cases

1. Purpose

To have a policy that identifies and communicates evidenced-based best practice/standard of practice based upon the assessment of the patient, the caregiver/guardian/patient's consent, and medical status in non-fatal strangulation cases.

2. Policy

Each patient will be assessed for the purpose of medical diagnoses and treatment. This will include the physical assessment, collection of potential biological and trace evidence to identify any forensic findings, and documentation of objective findings and subjective complaints (Faugno, Waszak, Strack, Brooks, & Gwinn, 2013).

Any procedure that is completed by another professional (i.e., social work, advocate) should be documented as such.

Follow institutional/local guidelines, policies, laws for the incapacitated patient or minor.

3. Procedure

- a) Thorough head-to-toe physical assessment (genital examination to be conducted as indicated)
- b) Completion of danger assessment/lethality assessment (Campbell, 2004; Campbell, Webster, & Glass, 2009)
- c) Completion of strangulation documentation to include:
 - a. Written documentation form
 - b. Body mapping of injuries
 - c. Photo-documentation
 - d. Mannequin demonstration (optional)
- d) Neck circumference measurement
- e) Use of alternate light source (ALS)/ultraviolet (UV) light (as indicated or available) for identification of potential biological fluids and/or for enhancement of visual bruises (not to be used to identify bruises that cannot be seen) (Eldredge, Huggins, & Pugh, 2012)
- f) Potential evidence collection (as applicable or if indicated)
- g) Assist patient with acquiring the necessary resources to file for victim of violent crime fund/compensation per local jurisdiction (if available)
- h) Assess for safety planning/resources disposition
Follow individual, local, mandated reporter for adult/pediatric population with referrals as needed to adult protection services (APS) and/or child protective services (CPS).
- i) If evaluation results indicate need, discuss possibility of observation or overnight admission.
- j) Discuss follow-up plan of care

4. Follow-Up Care

Follow up examinations within 72 hours post assault. In case of holidays/weekends: follow up with a phone call within 72 hours, with a scheduled appointment as soon as possible (Taliaferro, Hawley, McClane, & Strack, 2009).

Follow-up appointment to consist of:

- a) Head-to-toe physical assessment
- b) Strangulation documentation form
- c) Photography (of progression of bruising or identification of new bruises)
- d) Neck circumference
- e) Use of ALS/UV light (as indicated or available) as indicated above in #3e
- f) Ongoing safety assessment

- g) Referrals to ear, nose, and throat (ENT) specialist, neurology, other providers, counseling per scope of practice

5. Terms

1. Strangulation: A form of asphyxia (lack of oxygen) characterized by closure of the blood vessels and/or air passages of the neck as a result of external pressure on the neck (Iserson, 1984; Line, Stanley, & Choi, 1985).
2. Standards of Practice. Authoritative statements that “[describe a competent level of nursing care as demonstrated by the nursing process” (ANA, 2010, p. 67).
3. Danger assessment: An easy and effective method for forensic nurses and other community professionals to identify those who are at the highest potential for being seriously injured or killed (lethality) by their intimate partners so as to immediately connect these patients and clients to a domestic violence service provider in their area.
4. ALS (alternate light source): A high-intensity light using differing wavelengths that may fluoresce fluids/fibers and help enhance bruises that can be seen under white light.
5. UV (ultraviolet) light: An electromagnetic radiation with a wavelength from 100 nm to 400 nm. A portion of the light spectrum, which is not visible to the naked eye, that may help fluoresce fluids/fibers.
6. Mannequin head: An effective tool to aid the patient in demonstrating the act of strangulation.

NON-FATAL STRANGULATION CLINICAL EVALUATION

The following content is recommended as components of the clinical evaluation.

Medical History

- Primary care physician
- Allergies
- Medical/Surgical history
- Pregnancy - LMP, live births, miscarriages, abortions
- Prior hospitalizations
- Smoking/Alcohol/Drug use
- Medications, including supplements/herbs

Social History

- Employed
- Lives with
- Children (biological patient/suspect)
- Past history of sexual or physical abuse, domestic violence

Review of Systems

Physical Examination

- Appearance
- Eye contact
- Speech
- Responsiveness to clinician
- Nonverbal/Oral expression
- Facial expression
- Body posture and/or muscular tension
- Behaviors and actions
- Appearance of clothing
- Subjective complaints
- Any pain/Bleeding before, during, or after event
- Pre-existing complaints of pain, injury, or skin conditions

Forensic Medical Photography - Digital and/or colposcope (with and without ruler/scale)

- Full body
- Close-up
- Face
- Head/Scalp
- Neck
- Chest
- Mouth
- Eyes
- Mannequin demonstration
- Other injuries (i.e., defensive)

Danger Assessment

Medical Evaluation/Radiology Studies (as indicated by medical provider)

- Pulse oximetry
- Chest X-ray
- Soft tissue of the neck X-ray
- CT of the neck with and/or without contrast
- CT angiogram of carotid/vertebral arteries
- MRI of the neck

- MRA of the neck
- MRI/MRA of the brain

NON-FATAL STRANGULATION DESCRIPTORS FOR EXAMINERS

Donna A. Gaffney, DNSc, RN, FAAN

Behaviors, Mannerisms, Speech, and Eye Contact

Do not use language that could be construed as evaluative or can be interpreted as a value statement, or words that assign a subjective or emotional experience to the survivor. Instead, use words that accurately **describe outward appearance, visible behavior, speech, and eye contact**. These are words that convey the emotional state of the survivor without specifically labeling it as such.

Quantifying and Qualifying Behaviors (time, intensity, manner)

- When quantifying time, indicate the number of times a behavior was observed or the length of time it was observed (i.e., cried for 20 minutes)
- When qualifying time, name the event that coincided or preceded the behavior (i.e., sobbed as she took off her clothes)
- When qualifying intensity, describe what was sensed (i.e., soft, loud, piercing, shrill, high-pitched, sharp, etc.)
- When qualifying manner, describe what was observed (i.e., measured, haltingly, abruptly, tentatively, etc.)

Always use the patient’s statements and place in quotation marks. Do not paraphrase.

| Eye Contact or Visual Contact | Suggestions | Suggestions | Suggestions | Avoid |
|-------------------------------|--------------|-------------|---------------------------------|-------------------------------------------------------------|
| | Gape | Stare | Looks at (floor, ceiling, etc.) | Good |
| | Watch | Fixed | Only when addressed | Poor |
| | Avoid (when) | Avert | Closes eyes (when, how long) | “Good” and “poor” mean different things to different people |
| | Glance | Glare | | |

| Speech | Suggestions | Suggestions | Suggestions | Avoid |
|--------|-------------|----------------------|-------------------------------------------|-------|
| | Mumble | Stammer | Responds in one or two word answers | |
| | Murmur | Stutter | Responds only when asked questions | |
| | Shout | Slow | Whispers (differentiate from hoarseness) | |
| | Scream | Cries while speaking | Hoarse (clarify if this is normal or new) | |
| | | | Hesitates (duration in seconds, minutes) | |

| Responsive-ness to Clinician | Suggestions | Suggestions | Suggestions | Avoid |
|-------------------------------------|-------------------------|---------------------------|------------------------------------|--------------|
| | Follow directions (how) | Pause (before stating...) | Answers questions when asked | Cooperative |
| | | Unresponsive | Responds only when asked questions | |

| Nonverbal/ Oral Expression | Suggestions | Suggestions | Suggestions | Avoid |
|-----------------------------------|--------------------|--------------------|--------------------|--------------|
| | Cry | Sniffle | Wail | |
| | Moan | Sob | Whimper | |
| | Weep | Sigh | | |

| Facial Expressions | Suggestions | Suggestions | Suggestions | Avoid |
|---------------------------|--------------------|--------------------|--------------------|--------------|
| | Frown | Flinch | Pursed lips | |
| | Glower | Wince | Pucker | |
| | Scowl | Clenched jaw | Grinding teeth | |
| | Grimace | Biting lips | | |

| Body Posture and/or Muscular Tension | Suggestions | Suggestions | Suggestions | Avoid |
|---------------------------------------------|--------------------|---------------------------------|--------------------------------------------------------|--------------|
| | Slouch | Stoop | Shudders | |
| | Tremor | Slump | Clenches fists | |
| | Quiver | Restless | Crosses arms in front of body | |
| | Tremble | Shake | Wrings hands | |
| | Clutching (what) | Feet pulled up as sits in chair | Draws legs up, wraps arms around knees (how and where) | |

| Behaviors and Actions | Suggestions | Suggestions | Suggestions | Avoid |
|------------------------------|--------------------|--------------------|-----------------------------------------------|-----------------------------|
| | Pacing | Pulling at sheets | Holds front of shirt together with both hands | Afraid Fearful Scared |
| | Blew nose | Clutching clothes | Wipes at eyes with tissue | |
| | Startled | Stunned | Cowers | |
| | Cringe | Flinch | | |

| Demeanor | Suggestions | Suggestions | Suggestions | Avoid |
|----------|-------------|-------------|-------------|------------------------------------------|
| | Serious | Silent | Solemn | Depressed Sad |
| | Somber | Listless | Sluggish | In shock Cool Composed |
| | Quiet | Agitated | Irritated | Controlled Flat affect Indifferent |
| | | | | Disinterested Angry Raging |

Describing Anxiety

State that the client is anxious and then support with observable behaviors: wringing hands, tapping feet, sweating profusely, dilated pupils, or the client's statement (e.g., "I feel nauseated," "I have a knot in my stomach," etc.).

2001, Donna Gaffney Associates

NON-FATAL STRANGULATION DOCUMENTATION FORM

Patient Name: _____

Date: _____

Medical Record Number: _____

Time: _____

Strangulation is a serious event that often occurs in the context of intimate partner violence (IPV). Many times strangulation presents **NO VISIBLE INJURIES**. It is important to ask about strangulation in all IPV cases, and document positive disclosure or any signs and symptoms.

Strangulation Event History

How long did the strangulation last? _____ seconds _____ minutes _____ cannot recall

How many times did strangulation occur? _____

Why/how did the strangulation stop? _____

What type of strangulation occurred? (Check all that apply)

Hanging Ligature Manual Other

What was used to strangle the patient?

Right hand Left hand Both hands Unknown Chokehold maneuver

Other (describe) _____

Was the patient smothered?

No Yes (describe) _____

Was the patient shaken during the incident?

No Yes (describe) _____

Was the patient's head pounded against any object during the incident?

No Yes (describe) _____

Was the patient slapped, kicked, or bitten anywhere?

No Yes (describe) _____

Was the assailant wearing any jewelry on hands or wrists?

Unknown No Yes (describe) _____

Describe the neck pressure during strangulation on a 0-10 scale (0=no pressure and 10=crushing pressure):

What is the measurement of the patient's neck circumference? _____

Was the patient sexually assaulted?

No Yes

What was the patient thinking during the strangulation?

What did the assailant say before, during, or after the strangulation?

Describe mannequin demonstration (where applicable)

Signs/Symptoms of Strangulation

The following signs/symptoms should be asked about, assessed for and documented in writing, with body mapping, and by photo-imaging (if applicable). **Check ALL that apply.**

| Signs | Prior to Strangulation | During Strangulation | After Strangulation | At time of Assessment |
|-------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Face | <input type="checkbox"/> Red, flushed <input type="checkbox"/> Petechiae <input type="checkbox"/> Abrasions <input type="checkbox"/> Cuts <input type="checkbox"/> Lacerations <input type="checkbox"/> Discoloration <input type="checkbox"/> Swelling <input type="checkbox"/> Other _____ | <input type="checkbox"/> Red, flushed <input type="checkbox"/> Petechiae <input type="checkbox"/> Abrasions <input type="checkbox"/> Cuts <input type="checkbox"/> Lacerations <input type="checkbox"/> Discoloration <input type="checkbox"/> Swelling <input type="checkbox"/> Other _____ | <input type="checkbox"/> Red, flushed <input type="checkbox"/> Petechiae <input type="checkbox"/> Abrasions <input type="checkbox"/> Cuts <input type="checkbox"/> Lacerations <input type="checkbox"/> Discoloration <input type="checkbox"/> Swelling <input type="checkbox"/> Other _____ | <input type="checkbox"/> Red, flushed <input type="checkbox"/> Petechiae <input type="checkbox"/> Abrasions <input type="checkbox"/> Cuts <input type="checkbox"/> Lacerations <input type="checkbox"/> Discoloration <input type="checkbox"/> Swelling <input type="checkbox"/> Other _____ |
| Eyes | <input type="checkbox"/> Discoloration <input type="checkbox"/> Swelling <input type="checkbox"/> Abrasions <input type="checkbox"/> Petechiae: Conjunctiva <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> Eyelids <input type="checkbox"/> <i>Upper right</i> <input type="checkbox"/> <i>Lower right</i> <input type="checkbox"/> <i>Upper left</i> <input type="checkbox"/> <i>Lower left</i> <input type="checkbox"/> Subconjunctival hemorrhage <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Ptosis <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Vascular congestion <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Other _____ | <input type="checkbox"/> Discoloration <input type="checkbox"/> Swelling <input type="checkbox"/> Abrasions <input type="checkbox"/> Petechiae: Conjunctiva <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> Eyelids <input type="checkbox"/> <i>Upper right</i> <input type="checkbox"/> <i>Lower right</i> <input type="checkbox"/> <i>Upper left</i> <input type="checkbox"/> <i>Lower left</i> <input type="checkbox"/> Subconjunctival hemorrhage <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Ptosis <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Vascular congestion <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Other _____ | <input type="checkbox"/> Discoloration <input type="checkbox"/> Swelling <input type="checkbox"/> Abrasions <input type="checkbox"/> Petechiae: Conjunctiva <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> Eyelids <input type="checkbox"/> <i>Upper right</i> <input type="checkbox"/> <i>Lower right</i> <input type="checkbox"/> <i>Upper left</i> <input type="checkbox"/> <i>Lower left</i> <input type="checkbox"/> Subconjunctival hemorrhage <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Ptosis <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Vascular congestion <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Other _____ | <input type="checkbox"/> Discoloration <input type="checkbox"/> Swelling <input type="checkbox"/> Abrasions <input type="checkbox"/> Petechiae: Conjunctiva <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> Eyelids <input type="checkbox"/> <i>Upper right</i> <input type="checkbox"/> <i>Lower right</i> <input type="checkbox"/> <i>Upper left</i> <input type="checkbox"/> <i>Lower left</i> <input type="checkbox"/> Subconjunctival hemorrhage <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Ptosis <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Vascular congestion <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Other _____ |
| Nose | <input type="checkbox"/> Bleeding <input type="checkbox"/> Swelling <input type="checkbox"/> Petechiae <input type="checkbox"/> Discoloration <input type="checkbox"/> Other _____ | <input type="checkbox"/> Bleeding <input type="checkbox"/> Swelling <input type="checkbox"/> Petechiae <input type="checkbox"/> Discoloration <input type="checkbox"/> Other _____ | <input type="checkbox"/> Bleeding <input type="checkbox"/> Swelling <input type="checkbox"/> Petechiae <input type="checkbox"/> Discoloration <input type="checkbox"/> Other _____ | <input type="checkbox"/> Bleeding <input type="checkbox"/> Swelling <input type="checkbox"/> Petechiae <input type="checkbox"/> Discoloration <input type="checkbox"/> Other _____ |

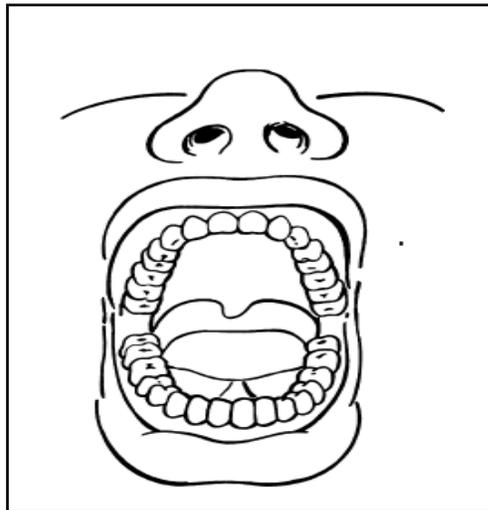
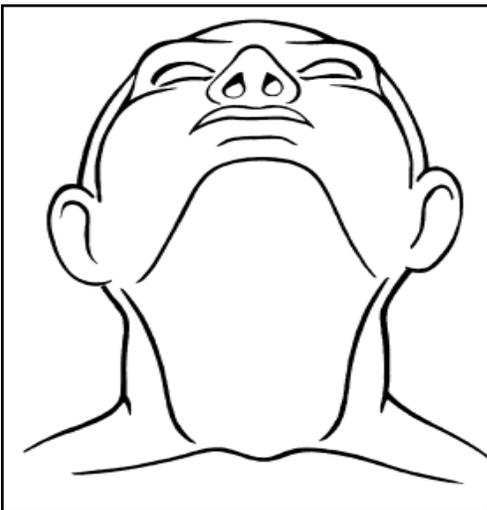
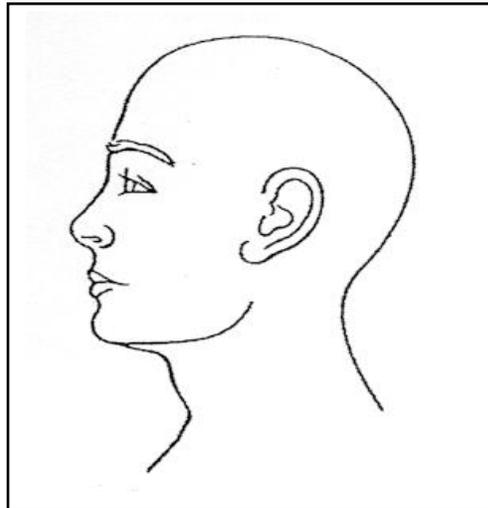
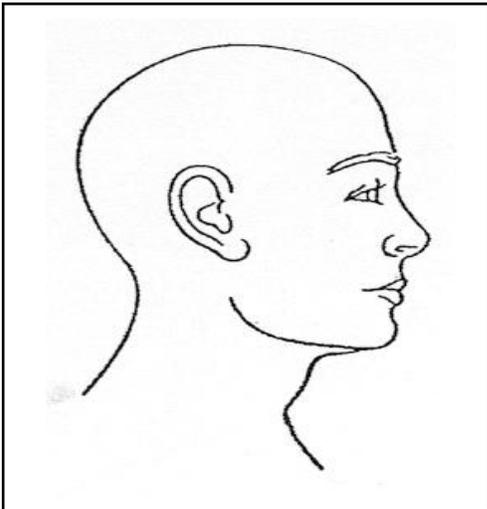
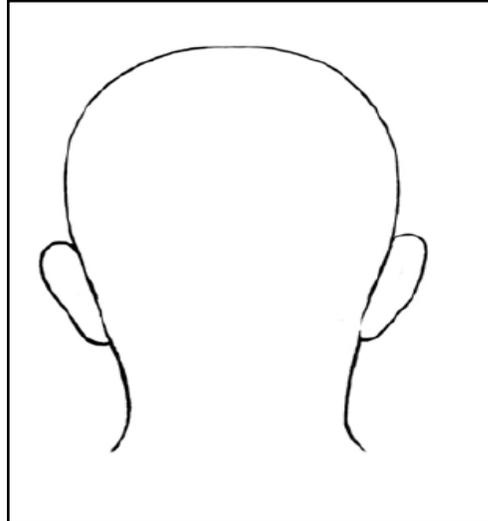
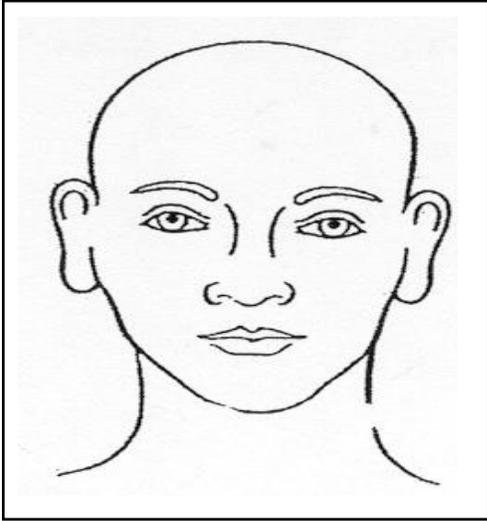
| Signs | Prior to Strangulation | During Strangulation | After Strangulation | At time of Assessment |
|------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Mouth | <input type="checkbox"/> Discoloration <input type="checkbox"/> Swollen tongue <input type="checkbox"/> Swollen lips <input type="checkbox"/> Cut <input type="checkbox"/> Lacerations <input type="checkbox"/> Abrasions <input type="checkbox"/> Petechiae <input type="checkbox"/> Other | <input type="checkbox"/> Discoloration <input type="checkbox"/> Swollen tongue <input type="checkbox"/> Swollen lips <input type="checkbox"/> Cut <input type="checkbox"/> Lacerations <input type="checkbox"/> Abrasions <input type="checkbox"/> Petechiae <input type="checkbox"/> Other | <input type="checkbox"/> Discoloration <input type="checkbox"/> Swollen tongue <input type="checkbox"/> Swollen lips <input type="checkbox"/> Cut <input type="checkbox"/> Lacerations <input type="checkbox"/> Abrasions <input type="checkbox"/> Petechiae <input type="checkbox"/> Other | <input type="checkbox"/> Discoloration <input type="checkbox"/> Swollen tongue <input type="checkbox"/> Swollen lips <input type="checkbox"/> Cut <input type="checkbox"/> Lacerations <input type="checkbox"/> Abrasions <input type="checkbox"/> Petechiae <input type="checkbox"/> Other |
| Ears | <input type="checkbox"/> Petechiae <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Bleeding from ear canal <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Discoloration <input type="checkbox"/> Auditory changes <input type="checkbox"/> Other | <input type="checkbox"/> Petechiae <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Bleeding from ear canal <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Discoloration <input type="checkbox"/> Auditory changes <input type="checkbox"/> Other | <input type="checkbox"/> Petechiae <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Bleeding from ear canal <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Discoloration <input type="checkbox"/> Auditory changes <input type="checkbox"/> Other | <input type="checkbox"/> Petechiae <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Bleeding from ear canal <input type="checkbox"/> <i>Right</i> <input type="checkbox"/> <i>Left</i> <input type="checkbox"/> Discoloration <input type="checkbox"/> Auditory changes <input type="checkbox"/> Other |
| Head/scalp | <input type="checkbox"/> Petechiae on scalp <input type="checkbox"/> Pulled hair <input type="checkbox"/> Contusions <input type="checkbox"/> Other | <input type="checkbox"/> Petechiae on scalp <input type="checkbox"/> Pulled hair <input type="checkbox"/> Contusions <input type="checkbox"/> Other | <input type="checkbox"/> Petechiae on scalp <input type="checkbox"/> Pulled hair <input type="checkbox"/> Contusions <input type="checkbox"/> Other | <input type="checkbox"/> Petechiae on scalp <input type="checkbox"/> Pulled hair <input type="checkbox"/> Contusions <input type="checkbox"/> Other |
| Neck/under Chin | <input type="checkbox"/> Redness <input type="checkbox"/> Scratch marks/abrasions <input type="checkbox"/> Bruises <input type="checkbox"/> Neck pain _____ (Pain scale 0-10) <input type="checkbox"/> Bruises <input type="checkbox"/> Swelling <input type="checkbox"/> Ligature marks <input type="checkbox"/> Subcutaneous emphysema <input type="checkbox"/> Other | <input type="checkbox"/> Redness <input type="checkbox"/> Scratch marks/abrasions <input type="checkbox"/> Bruises <input type="checkbox"/> Neck pain _____ (Pain scale 0-10) <input type="checkbox"/> Bruises <input type="checkbox"/> Swelling <input type="checkbox"/> Ligature marks <input type="checkbox"/> Subcutaneous emphysema <input type="checkbox"/> Other | <input type="checkbox"/> Redness <input type="checkbox"/> Scratch marks/abrasions <input type="checkbox"/> Bruises <input type="checkbox"/> Neck pain _____ (Pain scale 0-10) <input type="checkbox"/> Bruises <input type="checkbox"/> Swelling <input type="checkbox"/> Ligature marks <input type="checkbox"/> Subcutaneous emphysema <input type="checkbox"/> Other | <input type="checkbox"/> Redness <input type="checkbox"/> Scratch marks/abrasions <input type="checkbox"/> Bruises <input type="checkbox"/> Neck pain _____ (Pain scale 0-10) <input type="checkbox"/> Bruises <input type="checkbox"/> Swelling <input type="checkbox"/> Ligature marks <input type="checkbox"/> Subcutaneous emphysema <input type="checkbox"/> Other |
| Shoulders | <input type="checkbox"/> Redness <input type="checkbox"/> Scratch marks/abrasions <input type="checkbox"/> Bruises <input type="checkbox"/> Neck pain _____ (Pain scale 0-10) <input type="checkbox"/> Bruises <input type="checkbox"/> Other | <input type="checkbox"/> Redness <input type="checkbox"/> Scratch marks/abrasions <input type="checkbox"/> Bruises <input type="checkbox"/> Neck pain _____ (Pain scale 0-10) <input type="checkbox"/> Bruises <input type="checkbox"/> Other | <input type="checkbox"/> Redness <input type="checkbox"/> Scratch marks/abrasions <input type="checkbox"/> Bruises <input type="checkbox"/> Neck pain _____ (Pain scale 0-10) <input type="checkbox"/> Bruises <input type="checkbox"/> Other | <input type="checkbox"/> Redness <input type="checkbox"/> Scratch marks/abrasions <input type="checkbox"/> Bruises <input type="checkbox"/> Neck pain _____ (Pain scale 0-10) <input type="checkbox"/> Bruises <input type="checkbox"/> Other |

| Signs | Prior to Strangulation | During Strangulation | After Strangulation | At time of Assessment |
|--------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Chest | <input type="checkbox"/> Redness <input type="checkbox"/> Scratch marks/abrasions <input type="checkbox"/> Bruises <input type="checkbox"/> Neck pain _____ <small>(Pain scale 0-10)</small> <input type="checkbox"/> Bruises <input type="checkbox"/> Swelling <input type="checkbox"/> Subcutaneous emphysema <input type="checkbox"/> Other _____ | <input type="checkbox"/> Redness <input type="checkbox"/> Scratch marks/abrasions <input type="checkbox"/> Bruises <input type="checkbox"/> Neck pain _____ <small>(Pain scale 0-10)</small> <input type="checkbox"/> Bruises <input type="checkbox"/> Swelling <input type="checkbox"/> Subcutaneous emphysema <input type="checkbox"/> Other _____ | <input type="checkbox"/> Redness <input type="checkbox"/> Scratch marks/abrasions <input type="checkbox"/> Bruises <input type="checkbox"/> Neck pain _____ <small>(Pain scale 0-10)</small> <input type="checkbox"/> Bruises <input type="checkbox"/> Swelling <input type="checkbox"/> Subcutaneous emphysema <input type="checkbox"/> Other _____ | <input type="checkbox"/> Redness <input type="checkbox"/> Scratch marks/abrasions <input type="checkbox"/> Bruises <input type="checkbox"/> Neck pain _____ <small>(Pain scale 0-10)</small> <input type="checkbox"/> Bruises <input type="checkbox"/> Swelling <input type="checkbox"/> Subcutaneous emphysema <input type="checkbox"/> Other _____ |

| Symptoms | Prior to Strangulation | During Strangulation | After Strangulation | At time of Assessment |
|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Behavioral | <input type="checkbox"/> Agitation <input type="checkbox"/> Combative <input type="checkbox"/> Anxiety <input type="checkbox"/> Memory disruption <input type="checkbox"/> Confusion <input type="checkbox"/> Other _____ | <input type="checkbox"/> Agitation <input type="checkbox"/> Combative <input type="checkbox"/> Anxiety <input type="checkbox"/> Memory disruption <input type="checkbox"/> Confusion <input type="checkbox"/> Other _____ | <input type="checkbox"/> Agitation <input type="checkbox"/> Combative <input type="checkbox"/> Anxiety <input type="checkbox"/> Memory disruption <input type="checkbox"/> Confusion <input type="checkbox"/> Other _____ | <input type="checkbox"/> Agitation <input type="checkbox"/> Combative <input type="checkbox"/> Anxiety <input type="checkbox"/> Memory disruption <input type="checkbox"/> Confusion <input type="checkbox"/> Other _____ |
| Neurological | <input type="checkbox"/> LOC <input type="checkbox"/> Uncertain if LOC <input type="checkbox"/> Incontinence of urine <input type="checkbox"/> Incontinence of feces <input type="checkbox"/> Seizures <input type="checkbox"/> Headache _____ <small>(Pain scale 0-10)</small> <input type="checkbox"/> Dizzy <input type="checkbox"/> Fainting <input type="checkbox"/> Tinnitus <input type="checkbox"/> Visual changes <input type="checkbox"/> Other _____ | <input type="checkbox"/> LOC <input type="checkbox"/> Uncertain if LOC <input type="checkbox"/> Incontinence of urine <input type="checkbox"/> Incontinence of feces <input type="checkbox"/> Seizures <input type="checkbox"/> Headache _____ <small>(Pain scale 0-10)</small> <input type="checkbox"/> Dizzy <input type="checkbox"/> Fainting <input type="checkbox"/> Tinnitus <input type="checkbox"/> Visual changes <input type="checkbox"/> Other _____ | <input type="checkbox"/> LOC <input type="checkbox"/> Uncertain if LOC <input type="checkbox"/> Incontinence of urine <input type="checkbox"/> Incontinence of feces <input type="checkbox"/> Seizures <input type="checkbox"/> Headache _____ <small>(Pain scale 0-10)</small> <input type="checkbox"/> Dizzy <input type="checkbox"/> Fainting <input type="checkbox"/> Tinnitus <input type="checkbox"/> Visual changes <input type="checkbox"/> Other _____ | <input type="checkbox"/> LOC <input type="checkbox"/> Uncertain if LOC <input type="checkbox"/> Incontinence of urine <input type="checkbox"/> Incontinence of feces <input type="checkbox"/> Seizures <input type="checkbox"/> Headache _____ <small>(Pain scale 0-10)</small> <input type="checkbox"/> Dizzy <input type="checkbox"/> Fainting <input type="checkbox"/> Tinnitus <input type="checkbox"/> Visual changes <input type="checkbox"/> Other _____ |
| Throat/Voice | <input type="checkbox"/> Dysphagia <input type="checkbox"/> Odynophagia (pain) <input type="checkbox"/> Dysphasia <input type="checkbox"/> Aphasia <input type="checkbox"/> Drooling or Inability to swallow <input type="checkbox"/> Throat pain _____ <small>(Pain scale 0-10)</small> <input type="checkbox"/> Hoarse/Raspy <input type="checkbox"/> Other _____ | <input type="checkbox"/> Dysphagia <input type="checkbox"/> Odynophagia (pain) <input type="checkbox"/> Dysphasia <input type="checkbox"/> Aphasia <input type="checkbox"/> Drooling or Inability to swallow <input type="checkbox"/> Throat pain _____ <small>(Pain scale 0-10)</small> <input type="checkbox"/> Hoarse/Raspy <input type="checkbox"/> Other _____ | <input type="checkbox"/> Dysphagia <input type="checkbox"/> Odynophagia (pain) <input type="checkbox"/> Dysphasia <input type="checkbox"/> Aphasia <input type="checkbox"/> Drooling or Inability to swallow <input type="checkbox"/> Throat pain _____ <small>(Pain scale 0-10)</small> <input type="checkbox"/> Hoarse/Raspy <input type="checkbox"/> Other _____ | <input type="checkbox"/> Dysphagia <input type="checkbox"/> Odynophagia (pain) <input type="checkbox"/> Dysphasia <input type="checkbox"/> Aphasia <input type="checkbox"/> Drooling or Inability to swallow <input type="checkbox"/> Throat pain _____ <small>(Pain scale 0-10)</small> <input type="checkbox"/> Hoarse/Raspy <input type="checkbox"/> Other _____ |

| Symptoms | Prior to Strangulation | During Strangulation | After Strangulation | At time of Assessment |
|-------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Respiratory | <input type="checkbox"/> Stridor <input type="checkbox"/> Coughing <input type="checkbox"/> Hyper-ventilation <input type="checkbox"/> Respiratory distress <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Inability to tolerate supine position <input type="checkbox"/> Other _____ _____ | <input type="checkbox"/> Stridor <input type="checkbox"/> Hoarseness <input type="checkbox"/> Hyper-ventilation <input type="checkbox"/> Respiratory distress <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Inability to tolerate supine position <input type="checkbox"/> Other _____ _____ | <input type="checkbox"/> Stridor <input type="checkbox"/> Hoarseness <input type="checkbox"/> Hyper-ventilation <input type="checkbox"/> Respiratory distress <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Inability to tolerate supine position <input type="checkbox"/> Other _____ _____ | <input type="checkbox"/> Stridor <input type="checkbox"/> Hoarseness <input type="checkbox"/> Hyper-ventilation <input type="checkbox"/> Respiratory distress <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Inability to tolerate supine position <input type="checkbox"/> Other _____ _____ |
| Gynecological | <input type="checkbox"/> Vaginal bleeding <input type="checkbox"/> Pregnant <input type="checkbox"/> Contractions <input type="checkbox"/> FHR _____ <input type="checkbox"/> Other _____ _____ | <input type="checkbox"/> Vaginal bleeding <input type="checkbox"/> Pregnant <input type="checkbox"/> Contractions <input type="checkbox"/> FHR _____ <input type="checkbox"/> Other _____ _____ | <input type="checkbox"/> Vaginal bleeding <input type="checkbox"/> Pregnant <input type="checkbox"/> Contractions <input type="checkbox"/> FHR _____ <input type="checkbox"/> Other _____ _____ | <input type="checkbox"/> Vaginal bleeding <input type="checkbox"/> Pregnant <input type="checkbox"/> Contractions <input type="checkbox"/> FHR _____ <input type="checkbox"/> Other _____ _____ <input type="checkbox"/> EDC _____ |
| Genitourinary | <input type="checkbox"/> Dysuria <input type="checkbox"/> Other _____ | <input type="checkbox"/> Dysuria <input type="checkbox"/> Other _____ | <input type="checkbox"/> Dysuria <input type="checkbox"/> Other _____ | <input type="checkbox"/> Dysuria <input type="checkbox"/> Other _____ |
| Gastrointestinal | <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Anal/rectal bleeding <input type="checkbox"/> Abdominal pain _____ <small>(scale 0-10)</small> | <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Anal/rectal bleeding <input type="checkbox"/> Abdominal pain _____ <small>(scale 0-10)</small> | <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Anal/rectal bleeding <input type="checkbox"/> Abdominal pain _____ <small>(scale 0-10)</small> | <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Anal/rectal bleeding <input type="checkbox"/> Abdominal pain _____ <small>(scale 0-10)</small> |

Please indicate all injuries checked above on the body maps below.



Please indicate all injuries checked above on the body maps below.

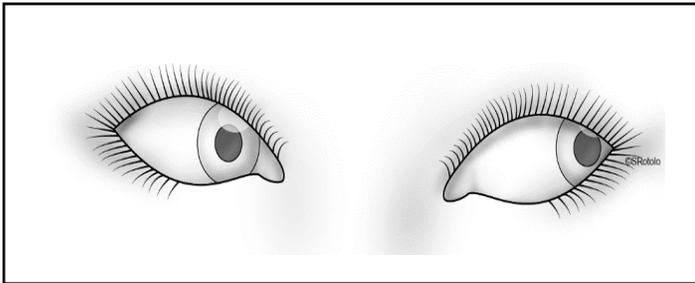
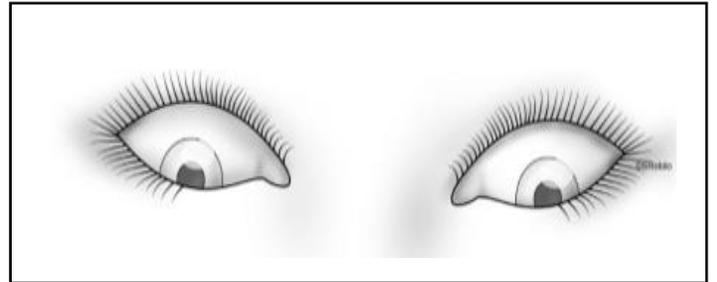
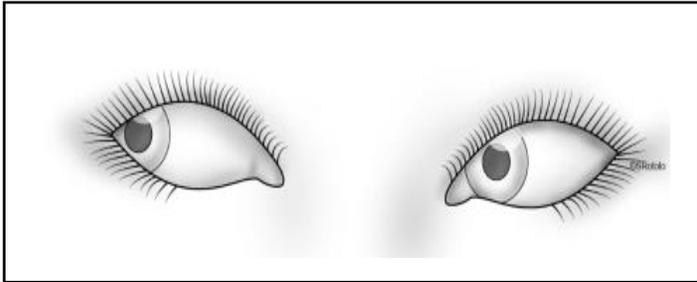
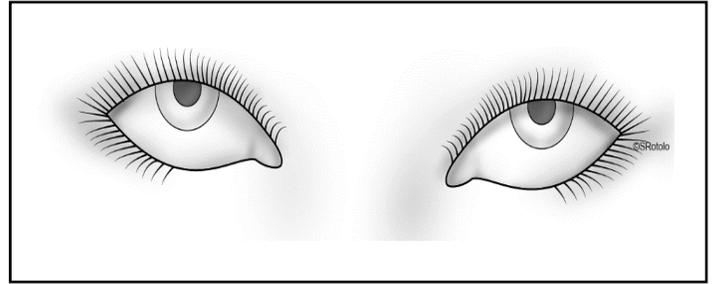
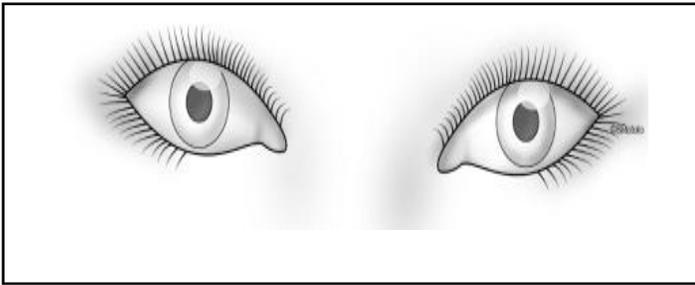


Photo-documentation of findings: Yes No

Notes _____

EXAMPLE STRANGULATION DISCHARGE INSTRUCTIONS

Because you have reported being “choked” or strangled, we are providing you with the following instructions:

Make sure someone stays with you for the next 24–72 hours after this event.

Health complications can appear immediately or may develop a few days after a strangulation event. Please call 911 or report immediately to the nearest emergency department if you notice any of the following:

- Problems breathing, difficulty breathing while lying down, shortness of breath, persistent cough, or coughing up blood
- Loss of consciousness or “passing out”
- Changes in your voice or difficulty speaking
- Difficulty swallowing, a lump in your throat, or muscle spasms in your throat or neck
- Swelling to your throat, neck, or tongue
- Increasing neck pain
- Left- or right-sided weakness, numbness, or tingling
- Drooping eyelid
- Difficulty speaking or understanding speech
- Difficulty walking
- Headache not relieved by pain medication
- Dizziness, lightheadedness or changes in your vision
- Pinpoint red or purple dots on your face or neck, or burst blood vessels in your eye
- Seizures
- Behavioral changes, memory loss, or confusion
- Thoughts of harming yourself or others

If you are pregnant, report the strangulation and any of the following symptoms to your doctor immediately:

- Decreased movement of the baby
- Vaginal spotting or bleeding
- Abdominal pain
- Contractions

You may notice some bruising or mild discomfort. Apply ice to the sore areas for 20 minutes at a time, 4 times per day, for the first 2 days. If you notice new bruising or injury, follow up for additional photo-documentation.

After your initial evaluation, keep a list of any changes in symptoms to share with your healthcare provider and your law enforcement contact.

- It is important to have a follow-up medical screening in 1–2 weeks with your healthcare provider.
- A follow-up forensic examination is needed within 72 hours.

Please follow up with the crisis/advocacy center at _____ to clarify your options and discuss safety planning. If you have questions or concerns regarding your legal case, please contact the police department, officer involved, prosecutor, or victim advocate by calling _____.

Forensic Nurse: _____ Phone: _____

ADDITIONAL RESOURCES

General Resources

International Association of Forensic Nurses Position Statement [The Evaluation and Treatment of Non-Fatal Strangulation in the Health Care Setting](#) (October 2016)

Strangulation Training Institute [Recommendations for the Medical/Radiographic Evaluation of Acute Adult Non-Fatal Strangulation](#) (September 2016)

Sample Documents from the Strangulation Toolkit

Non-Fatal Strangulation Clinical Evaluation ([Word](#)) ([PDF](#))

Non-Fatal Strangulation Descriptors for Examiners ([Word](#)) ([PDF](#))

Non-Fatal Strangulation Documentation Form ([Word](#)) ([PDF](#))

Example Strangulation Discharge Instructions ([Word](#)) ([PDF](#))

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