

Course Content

PHASE II

Subject: **Forensic Medicine & Toxicology**

Second Professional

Theory / Practical

(Based on **National Medical Commission, India**, Competency based Undergraduate curriculum for the Indian Medical Graduate, 2018. **Vol. 1; page nos. 228 -251**)

FORENSIC MEDICINE AND TOXICOLOGY

1. Goals

The broad goal of the teaching of undergraduate students in Forensic Medicine is to produce a physician who is well informed about medicolegal responsibilities in practice of medicine. He /She will also be capable of making observations and inferring conclusions by logical deductions to set enquiries on the right track in criminal matters and connected medicolegal problems. He /She acquires knowledge of law in relation to medical practice, medical negligence and respect for codes of medical ethics

2. Objectives

2. (a) KNOWLEDGE:

At the end of the course, the student should be able to:

1. Identify the basic medicolegal aspects of hospital and general practice.
2. Define the medicolegal responsibilities of a general physician while rendering community service either in a rural primary health center or an urban health center.
3. Appreciate the physician's responsibilities in criminal matters and respect for the codes of medical ethics.
4. Diagnose, manage and identify also legal aspects of common acute and chronic poisonings.
5. Describe the medicolegal aspects and findings of post-mortem examination in case of death due to common unnatural conditions & poisonings.
6. Detect occupational and environmental poisoning, prevention and epidemiology of common poisoning and their legal aspects particularly pertaining to Workmen's Compensation Act.
7. Describe the general principles of analytical toxicology.
8. Medical jurisprudence in view of the Consumer Protection Act – wherein doctors have been covered under its ambit. They have both rights as well as responsibilities. Under medical insurance acts of negligence covered as well as rights for effective service delivery.

2. (b) SKILLS

At the end of the course, the student should be able to: -

1. Make observations and logical inferences in order to initiate enquiries in Criminal matters and medicolegal problems.
2. Diagnose and treat common emergencies in poisoning and manage chronic toxicity.
3. Make observations and interpret findings at postmortem examination.
4. Observe the principles of medical ethics in the practice of his profession.

2. (c) INTEGRATION

Department shall provide an integrated approach towards allied disciplines like Pathology, Radiology, Forensic Sciences, Hospital Administration etc. to impart training regarding medicolegal responsibilities of physicians at all levels of health care. Integration with relevant disciplines will provide scientific basis of clinical toxicology e.g., medicine, pharmacology etc.

Competency Nos.	Topics & Subtopics-	TL Methods
FM 1.5, 1.6, 1.7, 1.8, 1.9	Topic: General Information FM1.5 Describe Court procedures including issue of Summons, conduct money, types of witnesses, recording of evidence oath, affirmation, examination in chief, cross examination, re-examination and court questions, recording of evidence & conduct of doctor in witness box FM1.6 Describe Offenses in Court including Perjury; Court strictures vis-a- vis Medical Officer FM1.7 Describe Dying Declaration & Dying Deposition	Lecture-02
FM 1.8, 1.9	Topic: General Information FM1.8 Describe the latest decisions/notifications/resolutions/ circulars/standing orders related to medico-legal practice issued by Courts/Government authorities etc. F.M1.9 Describe the importance of documentation in medical practice in regard to medicolegal examinations, Medical Certificates and medicolegal reports	Lecture-03
FM 14.20	Skills in Forensic Medicine & Toxicology FM14.20 To record and certify dying declaration in a simulated/ supervised environment	Small group- 1 teachings/tutorials/ Integrated teaching/Practical's
FM 2.29, 14.22	Topic: General Information FM 2.29 Demonstrate respect to the directions of courts, while appearing as witness for recording of evidence under oath or affirmation, examination in chief, cross examination, re-examination and court questions, recording of evidence Skills in Forensic Medicine & Toxicology FM14.22 To give expert medical/ medico-legal evidence in Court of law	Small group-2 teachings/tutorials/ Integrated teaching/Practical's
FM 3.1	Clinical Forensic Medicine IDENTIFICATION FM 3.1 Define and describe Corpus Delicti, establishment of identity of living persons including race, Sex, religion, complexion, stature, age determination using morphology, teeth-eruption, decay, bite marks, bones-ossification centres, medico-legal aspects of age- Part 1	Lecture-04
	IDENTIFICATION FM 3.1 Define and describe Corpus Delicti, establishment of identity of living persons including race, Sex, religion, complexion, stature, age determination using morphology, teeth-eruption, decay, bite marks, bones-ossification centres, medico-legal aspects of age- Part 2	Lecture-05
FM 3.1	IDENTIFICATION FM 3.1 age determination using morphology, teeth-eruption, bones-ossification centres, medico-legal aspects of age	Small group- 3 teachings/tutorials/ Integrated teaching

Competency Nos.	Topics & Subtopics-	TL Methods
		/Practical's
FM 3.2	IDENTIFICATION FM 3.2 Describe and discuss identification of criminals, unknown persons, dead bodies from the remains-hairs, fibers, teeth, anthropometry, dactylography, foot prints, scars, tattoos, poroscopy and superimposition	Lecture-06
FM 3.2	IDENTIFICATION FM 3.2 Dactylography, foot prints, scars, tattoos, poroscopy and superimposition	Small group- 4 teachings/tutorials/ Integrated teaching /Practical's
FM 2.1,2.2,2.3	Forensic Pathology FM2.1 Define, describe and discuss death and its types including somatic/clinical/cellular, molecular and brain-death, Cortical Death and Brainstem Death FM2.2 Describe and discuss natural and unnatural deaths FM2.3 Describe and discuss issues related to sudden natural deaths	Lecture-07
FM 2.5, 2.6, 2.7 2.8	Forensic Pathology FM2.5 Discuss moment of death, modes of death - coma, asphyxia and syncope FM2.6 Discuss presumption of death and survivorship FM2.7 Describe and discuss suspended animation FM 2.8 Describe and discuss postmortem changes including signs of death, cooling of body, post-mortem lividity, rigor mortis, cadaveric spasm, cold stiffening and heat stiffening	Lecture-08
FM 2.9	Forensic Pathology FM2.9 Describe putrefaction, mummification, adipocere and maceration	Lecture-09
FM 2.10	Forensic Pathology FM2.10 Discuss estimation of time since death	Lecture-10
FM 2.11, 2.12, 2.13, 2.14	Forensic Pathology FM2.11 Describe and discuss autopsy procedures including post-mortem examination, different types of autopsies, aims and objectives of post-mortem examination FM2.12 Describe the legal requirements to conduct post-mortem examination and procedures to conduct medico-legal post-mortem examination FM2.13 Describe and discuss obscure autopsy FM2.14 Describe and discuss examination of clothing, preservation of viscera on post-mortem examination for chemical analysis and other medico-legal purposes, post-mortem artefacts	Small group- 5 teachings/tutorials/ Integrated teaching/Practical's
FM 2.15, 2.16,	Forensic Pathology FM 2.15 Describe special protocols for conduction of medico-legal	Small group- 6 teachings/tutorials/

Competency Nos.	Topics & Subtopics-	TL Methods
2.17, 2.18	autopsies in cases of death in custody or following violation of human rights as per National Human Rights Commission Guidelines FM2.16 Describe and discuss examination of mutilated bodies or fragments, charred bones and bundle of bones. FM2.17 Describe and discuss exhumation. FM2.18 Crime Scene Investigation:- Describe and discuss the objectives of crime scene visit, the duties & responsibilities of doctors on crime scene and the reconstruction of sequence of events after crime scene investigation	Integrated teaching/Practical's
FM 1.10 1.11	Forensic Pathology FM1.10 Select appropriate cause of death in a particular scenario by referring ICD 10 code FM1.11 Write a correct cause of death certificate as per ICD 10 document	Small group- 7 teachings/tutorials/ Integrated teaching/Practical's
FM 2.19	Forensic Pathology FM 2.19 Investigation of anaesthetic, operative deaths: Describe and discuss special protocols for conduction of autopsy and for collection, preservation and dispatch of related material evidences	Lecture-11
FM 2.30	Forensic Pathology FM 2.30 Have knowledge/awareness of latest decisions/notifications/ resolutions/circulars/standing orders related to medico-legal practice issued by Courts/Government authorities etc	SDL-2
FM 2.33, 2.34, 2.35	Forensic Pathology FM 2.33 Demonstrate ability to use local resources whenever required like in mass disaster situations FM 2.34 Demonstrate ability to use local resources whenever required like in mass disaster situations FM 2.35 Demonstrate professionalism while conducting autopsy in medicolegal situations, interpretation of findings and making inference/opinion, collection preservation and dispatch of biological or trace evidences	Small group- 8 teachings/tutorials/ Integrated teaching/Practical's
FM 14.9	Skills in Forensic Medicine & Toxicology FM14.9 Demonstrate examination of & present an opinion after examination of skeletal remains in a simulated/ supervised environment	Small group- 9 teachings/tutorials/ Integrated teaching/Practical's
FM 14.4	Skills in Forensic Medicine & Toxicology FM14.4 Conduct and prepare report of estimation of age of a person for medico-legal and other purposes & prepare medico-legal report in a simulated/ supervised environment	Small group- 10 teachings/tutorials/ Integrated teaching/Practical's

Competency Nos.	Topics & Subtopics-	TL Methods
FM 14.21	Skills in Forensic Medicine & Toxicology FM14.21 To collect, preserve, seal and dispatch exhibits for DNA-Finger printing using various formats of different laboratories.	Small group- 11 teachings/tutorials/ Integrated teaching/Practical's
FM 8.1	Toxicology: General Toxicology FM8.1 Describe the history of Toxicology	SDL-3
FM 8.2, 8.3, 8.6, 8.7, 8.8	Toxicology: General Toxicology FM8.2 Define the terms Toxicology, Forensic Toxicology, Clinical Toxicology and poison FM8.3 Describe the various types of poisons, Toxicokinetics, and Toxicodynamics and diagnosis of poisoning in living and dead FM 8.6 Describe the general symptoms, principles of diagnosis and management of common poisons encountered in India FM 8.7 Describe simple Bedside clinic tests to detect poison/drug in a patient's body fluids FM 8.8 Describe basic methodologies in treatment of poisoning: decontamination, supportive therapy, antidote therapy, procedures of enhanced elimination	Lecture-12
FM 8.4	Toxicology: General Toxicology FM8.4 Describe the Laws in relations to poisons including NDPS Act, Medico-legal aspects of poisons	SDL-4
FM 8.9	Toxicology: General Toxicology FM 8.9 Describe the procedure of intimation of suspicious cases or actual cases of foul play to the police, maintenance of records, preservation and dispatch of relevant samples for laboratory analysis.	Small group-12 teachings/tutorials/ Integrated teaching/Practical's
FM 8.10	Toxicology: General Toxicology FM8.10 Describe the general principles of Analytical Toxicology and give a brief description of analytical methods available for toxicological analysis: Chromatography – Thin Layer Chromatography, Gas Chromatography, Liquid Chromatography and Atomic Absorption Spectroscopy	Small group-13 teachings/tutorials/ Integrated teaching/Practical's
FM 9.1	Toxicology : Chemical Toxicology FM9.1 Describe General Principles and basic methodologies in treatment of poisoning: decontamination, supportive therapy, antidote therapy, procedures of enhanced elimination with regard to: Caustics Inorganic – sulphuric, nitric, and hydrochloric acids; Organic- Carbolic Acid (phenol), Oxalic and acetylsalicylic acids	Small group-14 teachings/tutorials/ Integrated teaching/Practical's
FM 9.2	Toxicology : Chemical Toxicology FM9.2 Describe General Principles and basic methodologies in treatment of poisoning: decontamination, supportive therapy, antidote therapy, procedures of enhanced elimination with regard	Small group-15 teachings/tutorials/ Integrated teaching/Practical's

Competency Nos.	Topics & Subtopics-	TL Methods
	to Phosphorus, Iodine, Barium	
FM 9.3	Toxicology : Chemical Toxicology FM9.3 Describe General Principles and basic methodologies in treatment of poisoning: decontamination, supportive therapy, antidote therapy, procedures of enhanced elimination with regard to Arsenic, lead, mercury, copper, iron, cadmium and thallium	Small group-16 teachings/tutorials/ Integrated teaching/Practical's
FM 9.4	Toxicology : Chemical Toxicology FM9.4 Describe General Principles and basic methodologies in treatment of poisoning: decontamination, supportive therapy, antidote therapy, procedures of enhanced elimination with regard to Ethanol, methanol, ethylene glycol	Lecture-13
FM 9.4	Toxicology : Chemical Toxicology FM9.4 Describe General Principles and basic methodologies in treatment of poisoning: decontamination, supportive therapy, antidote therapy, procedures of enhanced elimination with regard to Ethanol, methanol, ethylene glycol	Small group-17 teachings/tutorials/ Integrated teaching/Practical's
FM 9.5	Toxicology : Chemical Toxicology FM9.5 Describe General Principles and basic methodologies in treatment of poisoning: decontamination, supportive therapy, antidote therapy, procedures of enhanced elimination with regard to Organophosphates, Carbamates, Organochlorines, Pyrethroids, Paraquat, Aluminium and Zinc phosphide	Small group-18 teachings/tutorials/ Integrated teaching/Practical's
FM 9.6	Toxicology : Chemical Toxicology FM9.6 Describe General Principles and basic methodologies in treatment of poisoning: decontamination, supportive therapy, antidote therapy, procedures of enhanced elimination with regard to Ammonia, carbon monoxide, hydrogen cyanide & derivatives, methyl isocyanate, tear (riot control) gases	Small group-19 teachings/tutorials/ Integrated teaching/Practical's
FM 10.1	Pharmaceutical Toxicology FM10.1 Describe General Principles and basic methodologies in treatment of poisoning: decontamination, supportive therapy, antidote therapy, procedures of enhanced elimination with regard to: i. Antipyretics – Paracetamol, Salicylates ii. Anti-Infectives (Common antibiotics – an overview) iii. Neuropsychotoxicology Barbiturates, benzodiazepins phenytoin, lithium, haloperidol, neuroleptics, tricyclics	Lecture-14
FM 10.1	Pharmaceutical Toxicology FM10.1 Describe General Principles and basic methodologies in treatment of poisoning: decontamination, supportive therapy, antidote therapy, procedures of enhanced elimination with regard to:	Small group-20 teachings/tutorials/ Integrated teaching/Practical's

Competency Nos.	Topics & Subtopics-	TL Methods
	iv .Narcotic Analgesics, Anaesthetics, and Muscle Relaxants v. Cardiovascular Toxicology Cardiotoxic plants – oleander, odollam, aconite, digitalis vi.Gastro- Intestinal and Endocrinal Drugs – Insulin	
FM 11.1	Toxicology : Biotoxicology FM11.1 Describe features and management of Snake bite, scorpion sting, bee and wasp sting and spider bite	Lecture-15
FM 12.1	Toxicology : Sociomedical Toxicology FM12.1 Describe features and management of abuse/poisoning with following chemicals: Tobacco, cannabis, amphetamines, cocaine, hallucinogens, designer drugs & solvent	Small group-21 teachings/tutorials/ Integrated teaching/Practical's
FM 13.1	Topic: Toxicology : Environmental Toxicology FM13.1 Describe toxic pollution of environment, its medico-legal aspects & toxic hazards of occupation and industry	SDL-5
FM 13.2	Topic: Toxicology : Environmental Toxicology FM13.2 Describe medico-legal aspects of poisoning in Workman's Compensation Act	Small group-22 teachings/tutorials/ Integrated teaching/Practical's
FM 14.2	Skills in Forensic Medicine & Toxicology FM 14.2 Demonstrate the correct technique of clinical examination in a suspected case of poisoning & prepare medico-legal report in a simulated/ supervised environment	Small group-23 teachings/tutorials/ Integrated teaching/Practical's
FM 14.3	Skills in Forensic Medicine & Toxicology FM14.3 Assist and demonstrate the proper technique in collecting, preserving and dispatch of the exhibits in a suspected case of poisoning, along with clinical examination	Small group-24 teachings/tutorials/ Integrated teaching/Practical's
FM 14.6	Skills in Forensic Medicine & Toxicology FM14.6 Demonstrate and interpret medico-legal aspects from examination of hair (human & animal) fibre, semen & other biological fluids	Small group-25 teachings/tutorials/ Integrated teaching/Practical's
FM 14.7, 14.8	Skills in Forensic Medicine & Toxicology FM14.7 Demonstrate & identify that a particular stain is blood and identify the species of its origin FM14.8 Demonstrate the correct technique to perform and identify ABO & RH blood group of a person	Small group-26 teachings/tutorials/ Integrated teaching/Practical's
FM 14.16	Skills in Forensic Medicine & Toxicology FM14.16 To examine & prepare medico-legal report of drunk person in a simulated/ supervised environment	Small group- 27 teachings/tutorials/ Integrated teaching/Practical's

Competency Nos.	Topics & Subtopics-	TL Methods
<p align="center">FM 14.17</p>	<p>Skills in Forensic Medicine & Toxicology FM14.17 To identify & draw medico-legal inference from common poisons e.g. dhatura, castor, cannabis, opium, aconite copper sulphate, pesticides compounds, marking nut, oleander, Nux vomica, abrus seeds, Snakes, capsicum, calotropis, lead compounds & tobacco.</p>	<p>Small group- 28 teachings/tutorials/ Integrated teaching/Practical's</p>
<p align="center">FM 14.17</p>	<p>Skills in Forensic Medicine & Toxicology FM14.17 To identify & draw medico-legal inference from common poisons e.g. dhatura, castor, cannabis, opium, aconite copper sulphate, pesticides compounds, marking nut, oleander, Nux vomica, abrus seeds, Snakes, capsicum, calotropis, lead compounds & tobacco.</p>	<p>Small group- 29 teachings/tutorials/ Integrated teaching/Practical's</p>
<p align="center">FM 14.17</p>	<p>Skills in Forensic Medicine & Toxicology FM14.17 To identify & draw medico-legal inference from common poisons e.g. dhatura, castor, cannabis, opium, aconite copper sulphate, pesticides compounds, marking nut, oleander, Nux vomica, abrus seeds, Snakes, capsicum, calotropis, lead compounds & tobacco.</p>	<p>Small group- 30 teachings/tutorials/ Integrated teaching/Practical's</p>

Course Content

Phase III-Part ONE

Subject: Forensic Medicine & Toxicology

Theory / Practical

(Based on **National Medical Commission, India** Competency based Undergraduate curriculum for the Indian Medical Graduate, 2018. Vol. 1; page nos. 228 -251)

1. Total Teaching hours : **75**
2. A. Lectures(hours):**25** B. Self-directed learning (hours) :**5**
C. Clinical Postings (hours):
D. Small group teachings/tutorials/Integrated teaching/ Practicals (hours):**45**

AETCOM Modules-3.3-Foundation of Communication and 3.4-Confidentiality

Competency Nos.	Topics & Subtopics-	TL Methods
FM 4.2, 4.3, 4.4, 4.5, 4.22	Medical Jurisprudence (Medical Law and ethics) FM 4.2 Describe the Code of Medical Ethics 2002 conduct, Etiquette and Ethics in medical practice and unethical practices & the dichotomy FM 4.3 Describe the functions and role of Medical Council of India and State Medical Councils FM 4.4 Describe the Indian Medical Register FM 4.5 Rights/privileges of a medical practitioner, penal erasure, infamous conduct, disciplinary Committee, disciplinary procedures, warning notice and penal erasure 4.22 Explain Oath – Hippocrates, Charaka and Sushruta and procedure for administration of Oath.	Lecture-1
FM 4.1	Medical Jurisprudence (Medical Law and ethics) FM4.1 Describe Medical Ethics and explain its historical emergence	SDL-1
FM 4.7, 4.8, 4.9	Medical Jurisprudence (Medical Law and ethics) FM4.7 Describe and discuss the ethics related to HIV patients FM4.8 Describe the Consumer Protection Act-1986 (Medical Indemnity Insurance, Civil Litigations and Compensations), Workman's Compensation Act & ESI Act FM4.9 Describe the medico - legal issues in relation to family violence, violation of human rights, NHRC and doctors	Small group- 1 teachings/tutorials/ Integrated teaching/ Practical's
FM 4.6, 4.24, 4.28	Medical Jurisprudence (Medical Law and ethics) FM4.6 Describe the Laws in Relation to medical practice and the duties of a medical practitioner towards patients and society	Lecture-2

	<p>FM4.24 Enumerate rights, privileges and duties of a Registered Medical Practitioner. Discuss doctor- patient relationship: professional secrecy and privileged communication</p> <p>FM4.28 Demonstrate respect to laws relating to medical practice and Ethical code of conduct prescribed by Medical Council of India and rules and regulations prescribed by it from time to time</p>	
FM 4.10, 4.11	<p>Medical Jurisprudence (Medical Law and ethics)</p> <p>FM4.10 Describe communication between doctors, public and media</p> <p>FM4.11 Describe and discuss euthanasia</p>	Small group- 2 teachings/tutorials/ Integrated teaching/ Practical's
FM 4.12, 4.16, 4.17	<p>Medical Jurisprudence (Medical Law and ethics)</p> <p>FM4.12 Discuss legal and ethical issues in relation to stem cell research</p> <p>FM4.16 Describe and discuss Bioethics</p> <p>FM4.17 Describe and discuss ethical Principles: Respect for autonomy, non- malfeasance, beneficence & justice</p>	Small group-3 teachings/tutorials/ Integrated teaching/ Practical's
FM 4.18	<p>Medical Jurisprudence (Medical Law and ethics)</p> <p>FM4.18 Describe and discuss medical negligence including civil and criminal negligence, contributory negligence, corporate negligence, vicarious liability, Res Ipsa Loquitor, prevention of medical negligence and defenses in medical negligence litigations</p>	Lecture-3
FM 4.19	<p>Medical Jurisprudence (Medical Law and ethics)</p> <p>FM4.19 Define Consent. Describe different types of consent and ingredients of informed consent. Describe the rules of consent and importance of consent in relation to age, emergency situation, mental illness and alcohol intoxication</p>	Lecture-4
FM 4.20, 4.21	<p>Medical Jurisprudence (Medical Law and ethics)</p> <p>FM4.20 Describe therapeutic privilege, Malingering, Therapeutic Misadventure, Professional Secrecy, Human Experimentation</p> <p>FM4.21 Describe Products liability and Medical Indemnity Insurance</p>	Lecture-5
FM 4.23	<p>Medical Jurisprudence (Medical Law and ethics)</p> <p>FM 4.23 Describe the modified Declaration of Geneva and its relevance</p>	SDL-2
FM 4.25, 4.26, 4.27	<p>Medical Jurisprudence (Medical Law and ethics)</p> <p>FM4.25 Clinical research & Ethics Discuss human experimentation including clinical trials</p> <p>FM4.26 Discuss the constitution and functions of ethical committees</p> <p>FM4.27 Describe and discuss Ethical Guidelines for Biomedical Research on Human Subjects & Animals</p>	Small group-4 teachings/tutorials/ Integrated teaching/ Practical's

FM 2.4	Forensic Pathology FM 2.4 Describe salient features of the Organ Transplantation and The Human Organ Transplant (Amendment) Act 2011 and discuss ethical issues regarding organ donation	Lecture-6
FM 2.31	Forensic Pathology FM2.31 Demonstrate ability to work in a team for conduction of medico-legal autopsies in cases of death following alleged negligence medical dowry death, death in custody or following violation of human rights as per National Human Rights Commission Guidelines on exhumation	Small group-5 teachings/tutorials/ Integrated teaching/ Practical's
FM 4.14	Medical Jurisprudence (Medical Law and ethics) FM 4.14 Describe & discuss the challenges in managing medico-legal cases including development of skills in relationship management – Human behaviour, communication skills, conflict resolution techniques	Small group- 6 teachings/tutorials/ Integrated teaching/ Practical's
FM 4.15	Medical Jurisprudence (Medical Law and ethics) Describe the principles of handling pressure – definition, types, causes, sources and skills for managing the pressure while dealing with medico-legal cases by the doctor	Small group- 7 teachings/tutorials/ Integrated teaching/ Practical's
FM 4.29	Medical Jurisprudence (Medical Law and ethics) FM4.29 Demonstrate ability to communicate appropriately with media, public and doctors	Small group- 8 teachings/tutorials/ Integrated teaching/ Practical's
FM 4.30	Medical Jurisprudence (Medical Law and ethics) FM4.30 Demonstrate ability to conduct research in pursuance to guidelines or research ethics	Small group- 9 teachings/tutorials/ Integrated teaching/ Practical's
FM 3.4, 3.3	Mechanical injuries and wounds: FM 3.4 Define injury, assault & hurt. Describe IPC pertaining to injuries FM 3.3 Define, describe and classify different types of mechanical injuries, abrasion, bruise, laceration, stab wound, incised wound, chop wound, defense wound, self-inflicted/fabricated wounds and their medico-legal aspects	Lecture-7
FM 3.3	Mechanical injuries and wounds: FM 3.3 Define, describe and classify different types of mechanical injuries, abrasion, bruise, laceration, stab wound, incised wound, chop wound, defense wound, self-inflicted/fabricated wounds	Lecture-8
FM 3.3	Mechanical injuries and wounds: FM 3.3 Define, describe and classify different types of mechanical injuries, abrasion, bruise, laceration, stab wound, incised wound, chop wound, defense wound, self-inflicted/fabricated wounds	Lecture-9
FM 3.3	Mechanical injuries and wounds: FM 3.3 Define, describe and classify different types of mechanical injuries, abrasion, bruise, laceration, stab wound, incised wound, chop wound, defense wound, self-inflicted/fabricated wounds	Lecture-10

FM 3.5	Mechanical injuries and wounds: FM3.5 Describe accidental, suicidal and homicidal injuries. Describe simple, grievous and dangerous injuries. Describe ante-mortem and post-mortem injuries	Small group-10 teachings/tutorials/ Integrated teaching/ Practical's
FM 3.6	Mechanical injuries and wounds: FM3.6 Describe healing of injury and fracture of bones with its medico-legal importance	Small group-11 teachings/tutorials/ Integrated teaching/ Practical's
FM 3.7	Mechanical injuries and wounds: FM3.7 Describe factors influencing infliction of injuries and healing, examination and certification of wounds and wound as a cause of death: Primary and Secondary	Small group-12 teachings/tutorials/ Integrated teaching/ Practical's
FM 3.8	Mechanical injuries and wounds: FM3.8 Describe and discuss different types of weapons including dangerous weapons and their examination	Small group-13 teachings/tutorials/ Integrated teaching/ Practical's
FM 3.9	Firearm injuries: FM3.9 Describe different types of firearms including structure and components. Along with description of ammunition propellant charge and mechanism of fire-arms, different types of cartridges and bullets and various terminology in relation of firearm – caliber, range, choking	Lecture-11
FM 3.10	Firearm injuries: FM3.10 Describe and discuss wound ballistics-different types of firearm injuries, blast injuries and their interpretation, preservation and dispatch of trace evidences in cases of firearm and blast injuries, various tests related to confirmation of use of firearms	Lecture-12
FM 3.10	Firearm injuries: FM3.10 Describe and discuss wound ballistics-different types of firearm injuries, blast injuries and their interpretation, preservation and dispatch of trace evidences in cases of firearm and blast injuries, various tests related to confirmation of use of firearms	Lecture-13
FM 3.11	Regional Injuries: FM3.11 Describe and discuss regional injuries to head (Scalp wounds, fracture skull, intracranial haemorrhages, coup and contrecoup injuries), neck, chest, abdomen, limbs, genital organs, spinal cord and skeleton	Lecture-14
FM 3.12	Regional Injuries FM3.12 Describe and discuss injuries related to fall from height and vehicular injuries – Primary and Secondary impact, Secondary injuries, crush syndrome, railway spine	Small group-14 teachings/tutorials/ Integrated teaching/ Practical's
FM 2.24	Forensic Pathology	Lecture-15

	FM2.24 Thermal deaths: Describe the clinical features, post-mortem finding and medicolegal aspects of injuries due to physical agents like heat (heat-hyper-pyrexia, heat stroke, sun stroke, heat exhaustion/prostration, heat cramps [miner's cramp] or cold (systemic and localized hypothermia, frostbite, trench foot, immersion foot)	
FM 2.25	Forensic Pathology FM2.25 Describe types of injuries, clinical features, pathophysiology, post-mortem findings and medico-legal aspects in cases of burns, scalds, lightning, electrocution and radiations	Lecture-16
FM 2.26	Forensic Pathology FM 2.26 Describe and discuss clinical features, post-mortem findings and medico-legal aspects of death due to starvation and neglect	SDL-3
FM 14.1	Skills in Forensic Medicine and Toxicology FM14.1 Examine and prepare Medico-legal report of an injured person with different etiologies in a simulated/ supervised environment	Small group-15 teachings/tutorials/ Integrated teaching/ Practical's
FM 14.10	Skills in Forensic Medicine and Toxicology FM14.10 Demonstrate ability to identify & prepare medicolegal inference from specimens obtained from various types of injuries e.g. contusion, abrasion, laceration, firearm wounds, burns, head injury and fracture of bone	Small group-16 teachings/tutorials/ Integrated teaching/ Practical's
FM 14.11	Skills in Forensic Medicine and Toxicology FM14.11 To identify & describe weapons of medicolegal importance which are commonly used e.g. lathi, knife, kripa, axe, gandasa, gupta, farsha, dagger, bhalla, razor & stick. Able to prepare report of the weapons brought by police and to give opinion regarding injuries present on the person as described in injury report/ PM report so as to connect weapon with the injuries. (Prepare injury report/ PM report must be provided to connect the weapon with the injuries)	Small group-17 teachings/tutorials/ Integrated teaching/ Practical's
FM 14.12	Skills in Forensic Medicine and Toxicology FM14.12 Describe the contents and structure of bullet and cartridges used & to provide medico-legal interpretation from these	Small group-18 teachings/tutorials/ Integrated teaching/ Practical's
FM 2.20, 2.21	Mechanical asphyxia: FM2.20 Define, classify and describe asphyxia and medico-legal interpretation of post-mortem findings in asphyxial deaths Mechanical asphyxia: FM2.21 Describe and discuss different types of hanging and strangulation including clinical findings, causes of death, post-mortem findings and medico-legal aspects of death due to hanging and strangulation including examination, preservation	Lecture-17

	and dispatch of ligature material	
FM 2.21	Mechanical asphyxia: FM2.21 Describe and discuss different types of hanging and strangulation including clinical findings, causes of death, post-mortem findings and medico-legal aspects of death due to hanging and strangulation including examination, preservation and dispatch of ligature material	Lecture-18
FM 2.22	Mechanical asphyxia: FM 2.22 Describe and discuss patho-physiology, clinical features, post-mortem findings and medico-legal aspects of traumatic asphyxia, obstruction of nose & mouth, suffocation and sexual asphyxia	Lecture-19
FM 2.23	Mechanical asphyxia: FM2.23 Describe and discuss types, patho-physiology, clinical features, post mortem findings and medico-legal aspects of drowning, diatom test and, gettler test.	Lecture-20
FM 3.18, 3.13	SEXUAL OFFENCES FM3.18 Describe anatomy of male and female genitalia, hymen and its types. Discuss the medico-legal importance of hymen. Define virginity, defloration, legitimacy and its medicolegal importance FM3.13 Describe different types of sexual offences. Describe various sections of IPC regarding rape including definition of rape (Section 375 IPC), Punishment for Rape (Section 376 IPC) and recent amendments notified till date	Lecture-21
FM 3.14	SEXUAL OFFENCES FM3.14 Describe and discuss the examination of the victim of an alleged case of rape, and the preparation of report, framing the opinion and preservation and dispatch of trace evidences in such cases	Small group-19 teachings/tutorials/ Integrated teaching/ Practical's
FM 3.15	SEXUAL OFFENCES FM3.15 Describe and discuss examination of accused and victim of sodomy, preparation of report, framing of opinion, preservation and dispatch of trace evidences in such cases	Small group-20 teachings/tutorials/ Integrated teaching/ Practical's
FM 4.13	Medical Jurisprudence (Medical Law and ethics) FM 4.13 Describe social aspects of Medico-legal cases with respect to victims of assault, rape, attempted suicide, homicide, domestic violence, dowry- related cases	Small group-21 teachings/tutorials/ Integrated teaching/ Practical's
FM 14.14	Skills in Forensic Medicine and Toxicology FM14.14 To examine & prepare report of an alleged accused in rape/unnatural sexual offence in a simulated/ supervised environment	Small group-22 teachings/tutorials/ Integrated teaching/ Practical's
FM 14.15	Skills in Forensic Medicine and Toxicology FM14.15 To examine & prepare medico-legal report of a victim of	Small group-23 teachings/tutorials/

	sexual offence/unnatural sexual offence in a simulated/supervised environment	Integrated teaching/ Practical's
FM 3.16	SEXUAL OFFENCES FM3.16 Describe and discuss adultery and unnatural sexual offences- sodomy, incest, lesbianism, buccal coitus, bestiality, indecent assault and preparation of report, framing the opinion and preservation and dispatch of trace evidences in such cases	Small group-24 teachings/tutorials/ Integrated teaching/ Practical's
FM 3.17	SEXUAL OFFENCES FM3.17 Describe and discuss the sexual perversions fetishism, transvestism, voyeurism, sadism, necrophagia, masochism, exhibitionism, frotteurism, Necrophilia	SDL-4
FM 3.19	SEXUAL OFFENCES FM3.19 Discuss the medicolegal aspects of pregnancy and delivery, signs of pregnancy, precipitate labour superfoetation, superfecundation and signs of recent and remote delivery in living and dead	Lecture-22
FM 14.13	SEXUAL OFFENCES FM14.13 To estimate the age of foetus by post-mortem examination	Small group-25 teachings/tutorials/ Integrated teaching/ Practical's
FM 3.20	SEXUAL OFFENCES FM 3.20 Discuss disputed paternity and maternity	Small group-26 teachings/tutorials/ Integrated teaching/ Practical's
FM 3.21	FM 3.21 Discuss Pre-conception and Pre Natal Diagnostic Techniques (PC&PNDT) - Prohibition of Sex Selection Act 2003 and Domestic Violence Act 2005	Small group-27 teachings/tutorials/ Integrated teaching/ Practical's
FM 3.22, 3.23	SEXUAL OFFENCES FM 3.22 Define and discuss impotence, sterility, frigidity, sexual dysfunction, premature ejaculation. Discuss the causes of impotence and sterility in male and female FM 3.23 Discuss Sterilization of male and female, artificial insemination, Test Tube Baby, surrogate mother, hormonal replacement therapy with respect to appropriate national and state laws	Small group-28 teachings/tutorials/ Integrated teaching/ Practical's
FM 3.24, 3.25, 3.26	SEXUAL OFFENCES FM 3.24 Discuss the relative importance of surgical methods of contraception (vasectomy and tubectomy) as methods of contraception in the National Family Planning Programme FM 3.25 Discuss the major results of the National Family Health Survey FM 3.26 Discuss the national Guidelines for accreditation,	Small group-29 teachings/tutorials/ Integrated teaching/ Practical's

	supervision & regulation of ART Clinics in India	
FM 3.27, 3.28	FM 3.27 Define, classify and discuss abortion, methods of procuring MTP and criminal abortion and complication of abortion. MTP Act 1971 FM 3.28 Describe evidences of abortion - living and dead, duties of doctor in cases of abortion, investigations of death due to criminal abortion	Lecture-23
FM 3.29	Torture and Human rights FM3.29 Describe and discuss child abuse and battered baby syndrome	Small group-30 teachings/tutorials/ Integrated teaching/ Practical's
FM 3.30	Torture and Human rights FM3.30 Describe and discuss issues relating to torture, identification of injuries caused by torture and its sequelae, management of torture survivors	Small group-31 teachings/tutorials/ Integrated teaching/ Practical's
FM 3.31	Torture and Human rights FM3.31 Describe and discuss guidelines and Protocols of National Human Rights Commission regarding torture	Small group-32 teachings/tutorials/ Integrated teaching/ Practical's
FM 3.32	FM3.32 Demonstrate the professionalism while preparing reports in medicolegal situations, interpretation of findings and making inference/opinion, collection preservation and dispatch of biological or trace evidences	Small group-33 teachings/tutorials/ Integrated teaching/ Practical's
FM 3.33	SEXUAL OFFENCES FM3.33 Should be able to demonstrate the professionalism while dealing with victims of torture and human right violations, sexual assaults- psychological consultation, rehabilitation	Small group-34 teachings/tutorials/ Integrated teaching/ Practical's
FM 5.1, 5.2	Forensic Psychiatry FM5.1 Classify common mental illnesses including post-traumatic stress disorder (PTSD) FM5.2 Define, classify and describe delusions, hallucinations, illusion, lucid interval and obsessions with exemplification	Lecture-24
FM 5.3, 5.4	Forensic Psychiatry FM 5.3 Describe Civil and criminal responsibilities of a mentally ill person FM 5.4 Differentiate between true insanity from feigned insanity	Lecture-25
FM 5.5, 5.6	Forensic Psychiatry FM5.5 Describe & discuss Delirium tremens FM5.6 Describe the Indian Mental Health Act, 1987 with special	Small group-35 teachings/tutorials/ Integrated teaching/

	reference to admission, care and discharge of a mentally ill person	Practical's
FM 6.1	Forensic Laboratory investigation in medical legal practice FM 6.1 Describe different types of specimen and tissues to be collected both in the living and dead: Body fluids (blood, urine, semen, faeces saliva), Skin, Nails, tooth pulp, vaginal smear, viscera, skull, specimen for histo-pathological examination, blood grouping, HLA Typing and DNA Fingerprinting.	Small group-36 teachings/tutorials/ Integrated teaching/ Practical's
FM 6.1	Forensic Laboratory investigation in medical legal practice Describe Locard's Exchange Principle	SDL-5
FM 6.1	Forensic Laboratory investigation in medical legal practice FM 6.1 Describe different types of specimen and tissues to be collected both in the living and dead: Body fluids (blood, urine, semen, faeces saliva), Skin, Nails, tooth pulp, vaginal smear, viscera, skull, specimen for histo-pathological examination, blood grouping, HLA Typing and DNA Fingerprinting.	Small group-37 teachings/tutorials/ Integrated teaching/ Practical's
FM 6.2	Forensic Laboratory investigation in medical legal practice FM6.2 Describe the methods of sample collection, preservation, labelling, dispatch, and interpretation of reports	Small group-38 teachings/tutorials/ Integrated teaching/ Practical's
FM 6.3	Forensic Laboratory investigation in medical legal practice FM6.3 Demonstrate professionalism while sending the biological or trace evidences to Forensic Science laboratory, specifying the required tests to be carried out, objectives of preservation of evidences sent for examination, personal discussions on interpretation of findings	Small group-39 teachings/tutorials/ Integrated teaching/ Practical's
FM 7.1	Emerging technologies in Forensic Medicine FM7.1 Enumerate the indications and describe the principles and appropriate use for: - DNA profiling Facial reconstruction - Polygraph (Lie Detector) - Narcoanalysis, - Brain Mapping, - Digital autopsy, - Virtual Autopsy, - Imaging technologies	Small group-40 teachings/tutorials/ Integrated teaching/ Practical's
FM 7.1	Emerging technologies in Forensic Medicine FM7.1 Enumerate the indications and describe the principles and appropriate use for: - DNA profiling Facial reconstruction - Polygraph (Lie Detector)	Small group-41 teachings/tutorials/ Integrated teaching/ Practical's

	<ul style="list-style-type: none"> - Narcoanalysis, - Brain Mapping, - Digital autopsy, - Virtual Autopsy, - Imaging technologies 	
FM 14.21	<p>Skills in Forensic Medicine & Toxicology</p> <p>FM14.21 To collect, preserve, seal and dispatch exhibits for DNA-Finger printing using various formats of different laboratories.</p>	Small group-42 teachings/tutorials/ Integrated teaching/ Practical's
FM 14.18	<p>Skills in Forensic Medicine & Toxicology</p> <p>FM14.18 To examine & prepare medico-legal report of a person in police, judicial custody or referred by Court of Law and violation of human rights as requirement of NHRC, who has been brought for medical examination</p>	Small group-43 teachings/tutorials/ Integrated teaching/ Practical's
FM 14.19	<p>Skills in Forensic Medicine & Toxicology</p> <p>FM14.19 To identify & prepare medico-legal inference from histo-pathological slides of Myocardial Infarction, pneumonitis, tuberculosis, brain infarct, liver cirrhosis, brain haemorrhage, bone fracture, Pulmonary oedema, brain oedema, soot particles, diatoms & wound healing</p>	Small group-44 teachings/tutorials/ Integrated teaching/ Practical's
FM 14.5	<p>Skills in Forensic Medicine & Toxicology</p> <p>FM14.5 Conduct & prepare post-mortem examination report of varied etiologies (at least 15) in a simulated/ supervised environment</p> <p>Journal and logbook checking-</p>	Small group-45 teachings/tutorials/ Integrated teaching/ Practical's It can be scheduled at any small groups as per availability of Post Mortem examination.

MBBS**PHASE II& PHASE III Part -I****Internal Assessment****Subject: Forensic Medicine & Toxicology**

Phase	I-Exam (After 3 months from start of II Phase-Jan in case phase II started in Oct.)			II-Exam (After three months of I Interna assessment Examination- Apr.)		
	Theory	Practical (Including 10 Marks for Journal & Log Book)	Total Marks	Theory	Practical Including 10 Marks for Journal & Log Book	Total Marks
II MBBS	50	40+10=50	100	50	40+10=50	100

Phase	I-Exam (After 3 months from start of III Phase- Jan/Feb in case phase III started in Oct.)			II-Exam (June/July-Preliminary)		
	Theory	Practical (Including 10 Marks for Journal & Log Book)	Total Marks	Theory	Practical	Total Marks
III/PART-I MBBS	50	40+10=50	100	100	100	200

- There will be 4 internal assessment examinations in Forensic medicine. The structure of the Preliminary internal assessment theory examinations should be similar to the structure of University examination.
- It is mandatory for the students to appear for all the internal assessment Examinations in the respective phases. A student who has not taken minimum required number of tests for Internal Assessment each in theory and practical will not be eligible for University examinations.

3. There will be only one additional examination for absent students (due to genuine reason) after approval by the Institutional Grievances Committee. It should be taken after preliminary examination and before submission of internal assessment marks to the University.

4. Internal assessment marks for theory will be out of 250 and practical will be out of 250.

5. Reduce total theory internal assessment to 40 marks and total practical internal assessment to 40 marks. Students must secure at least 50% marks of the total marks (combined in theory and practical; not less than 40 % marks in theory and practical separately) to be eligible for appearing University examination

6. Conversion Formula for calculation of marks in internal assessment examinations

	First IA II Phase	Second IA II Phase	Third IA III Phase Part -I	(Prelim) III Phase Part -I	Total	Internal assessment marks: Conversion formula (out of 40)	Eligibility to appear for final University examination (after conversion out of 40) (40% separately in Theory & Practical, 50% Combined)
Theory	50	50	50	100	250	Total marks obtained 6.25	16 (Minimum) Total of Theory + Practical Must be 40.
Practical	50	50	50	100	250	Total marks obtained 6.25	

7. While preparing Final Marks of Internal Assessment, the rounding-off marks shall done as illustrated in following table

Internal Assessment Marks	Final rounded marks
15.01 to 15.49	15
15.50 to 15.99	16

8. Students must secure at least 50% marks of the total marks (combined in theory and practical / clinical; not less than 40 % marks in theory and practical Separately) assigned for internal assessment in order to be eligible for appearing at the final University examination of that subject. Internal assessment marks will reflect as separate head of passing at the summative examination.

9. Internal assessment marks will not to be added to marks of the University examinations and will be shown separately in mark list.

Second & Third part I MBBS Practical Mark's Structure

Internal Assessment Examinations

INTERNAL ASSESSMENT EXAMINATION-AS PER THE SYLABUS OF THEORY AND PRACTICAL COVERED IN THAT SPECIFIC DURATION OF PHASE-AUTONOMY AT INSTITUTE LEVEL.

Theory Internal Assessment Pattern

Total marks-50

Section A-MCQ's-10 Marks

Section-B- Short Answer Questions-30 Marks (6 out Of 7)-5 Marks Each

Section-C-Long Answer Questions-10 Marks (1 out of 2)-10 Marks each.

Practical Internal Assessment Pattern

Total Marks-50.

Exercises taught in that particular term-30 Marks

(Each Exercise marks should be as per University Exam pattern)

Viva-10 Marks

Journal and Log book-10 marks

PHASE III PART I-MBBS Practical Mark's Structure MUHS

Subject: Forensic Medicine & Toxicology													
Practical										Oral/ Viva			Total
Seat No.	Medical Certificate of Cause of Death (MCCD)	Injury report	Survivor/ Accused of Sexual Assault report	Alcohol Intoxication Drunkenness report	Sickness/ Fitness certificate	Age/ Potency/ Foetus Report	Weapon Report	Spots- • Bone-1 • Specimen-1 • Poison-2 • X-ray/ Photograph/ Instrument/ Document-1	Total	Forensic Pathology, Clinical Forensic Medicine	Medical Jurisprudence and Toxicology	Total	Practical & Oral (I + L)
	A	B	C	D	E	F	G	H	I	J	K	L	M
Max. Marks	10	10	10	10	10	10	5	3 X 5= 15	80	10	10	20	100

Suggestions:

1. It is suggested that 2 exercises can be kept as actual case or in simulated environment.
2. In the spots -2 spots can be kept as **OSPE stations.**

Phase III Part I MBBS Practical Mark's Structure Preliminary Examination

Subject: Forensic Medicine & Toxicology													
Practical										Oral/ Viva			Total
Seat No.	Medical Certificate of Cause of Death (MCCD)	Injury report	Survivor/ Accused of Sexual Assault report	Alcohol Intoxication Drunkenness report	Sickness/ Fitness certificate	Age/ Potency/ Foetus Report	Weapon Report	Spots- • Bone-1 • Specimen-1 • Poison-2 • X-ray/ Photograph/ Instrument/ Document-1	Total	Forensic Pathology, Clinical Forensic Medicine	Medical Jurisprudence and Toxicology	Total	Practical & Oral (I + L)
	A	B	C	D	E	F	G	H	I	J	K	L	M
Max. Marks	10	10	10	10	10	10	5	3 X 5= 15	80	10	10	20	100

Suggestions:

1. It is suggested that 2 exercises can be kept as actual case or in simulated environment.
2. In the spots - 2 spots can be kept as **-OSPE stations.**

MAHARASHTRA UNIVERSITY OF HEALTH SCIENCES, NASHIK
FORMAT / SKELETON OF QUESTION PAPER

1. Course and Year : MBBS –PHASE III Part -I (applicable w.e.f. OCT 2022 & onwards examinations)	2. Subject Code :		
3. Subject (PSP) : Forensic Medicine & Toxicology (TT) :			
4. Paper : --	5. Total Marks : 100	6. Total Time : 3 Hrs.	7. Remu. (Rs) : Rs. 300/-
			8. Remu. (Rs) : Rs. 350/-
9. Web Pattern : []	10. Web Skeleton : []	11. Web Syllabus : []	12. Web Old QP : []

Instructions:

SECTION “A” MCQ

- 1) Put in the appropriate box below the question number once only.
- 2) Use blue ball point pen only.
- 3) Each question carries **One mark**.
- 4) Students will not be allotted mark if he/she overwrites strikes or put white ink on the cross once marked.

SECTION “A” MCQ (20 Marks)

1. Multiple Choice Questions (Total 20 MCQ of One mark each) (20 x 1=20)
- a) b) c) d) e) f) g) h) i) j)
k) l) m) n) o) p) q) r) s) t)

SECTION “B” & “C”

- Instructions:**
- 1) Use **blue/black** ball point pen only.
 - 2) **Do not** write anything on the **blank portion of the question paper**. If written anything, such type of act will be considered as an attempt to resort to unfair means.
 - 3) **All** questions are **compulsory**.
 - 4) The number to the **right** indicates **full** marks.
 - 5) Draw diagrams **wherever** necessary.
 - 6) Distribution of syllabus in Question Paper is only meant to cover entire syllabus within the stipulated frame. The Question paper pattern is a mere guideline. Questions can be asked from any paper's syllabus into any question paper. Students cannot claim that the Question is out of syllabus. As It is only for the placement sake, the distribution has been done.
 - 7) Use a common answer book for all sections.

SECTION “B” (40 Marks)

- 2 Short Answer Questions (Any 6 out of 7) (6x5=30)

a) b) c) d) e) f) g)

- Long Answer Questions (Any 1 out of 2) (1x10=10)

3 a) b)

SECTION “C” (40Marks)

- 4 Short answer questions (One short note should be from **AETCOM 3.3 and 3.4** is compulsory) (Any 6 out of 7) (6x5=30)

a) b) c) d) e) f) g)

5. Long Answer Questions (Any 1 out of 2) (1x10=10)

a) b)

Maharashtra University of Health Sciences, Nashik



FORENSIC MEDICINE AND TOXICOLOGY LOGBOOK for PHASE II and PHASE III (Part 1) MBBS STUDENTS AS PER COMPETENCY BASED CURRICULUM

First Edition: 2021

Preface

The National Medical Commission has revised the undergraduate medical education curriculum so that the Indian Medical Graduate (IMG) is able to recognize “**Health for all**” as a national goal. He/she should also be able to fulfil his/her societal obligations. The revised curriculum has specified the competencies that a student must attain and clearly defined teaching learning strategies for the same. With this goal in mind, integrated teaching, skill development, AETCOM and self-directed learning have been introduced. There would be emphasis on communication skills, basic clinical skills and professionalism. There is a paradigm shift from the traditional didactic classroom-based teaching to learning environments where there is emphasis on learning by exploring, questioning, applying, discussing, analysing, reflecting, collaborating and doing. The recognition of this need is enshrined by a greatly enhanced allocation of time to these methods and also the assessment techniques. With this view in mind the log book has been designed as per the guidelines of Competency Based Curriculum.

Name of the College

Admission Year: _____

CERTIFICATE

This is to certify that,

Mr/Ms. _____

Roll No. _____ has satisfactorily attended/completed all assignments mentioned in this logbook as per the guidelines prescribed by **National Medical Commission, India** for Phase II & Phase III (Part 1) MBBS Competency Based Curriculum in the subject of **FORENSIC MEDICINE & TOXICOLOGY**.

Date: ___/___/_____

Place: _____

Teacher In-charge

Professor and Head
Department of FORENSIC MEDICINE & TOXICOLOGY

Instructions

- 1) This logbook is prepared as per the guidelines of NMC for implementation of Competency based curriculum for Phase II MBBS and Phase III Part one students in the subject of Forensic Medicine & Toxicology.
- 2) Students are instructed to keep their logbook entries up to date.
- 3) Students are expected to write minimum 2 reflections on any two activities each of Clinical Forensic Medicine skills & Self-Directed Learning (SDL).
- 4) Students also have to write reflections on AETCOM Module - Reflections should be structured using the following guiding questions:
 - What happened? (What did you learn from this experience)
 - So what? (What are the applications of this learning)
 - What next? (What knowledge or skills do you need to develop so that you can handle this type of situation?)
- 5) The logbook assessment will be based on multiple factors like
 - Attendance
 - Active participation in the sessions
 - Timely completions
 - Quality of write up of reflections
 - Overall presentation

INDEX

Sr. No	Description	Page No's	Status Complete/ Incomplete	Signature of Teacher
1	Clinical Forensic Medicine Skills			
2	Self-Directed Learning, Seminars, Projects, Quizzes			
3	AETCOM Module			
4	Attendance Records			
5	Records of Internal Assessment			

* AETCOM – Competencies for IMG, 2018, Medical Council of India.

Record of Clinical Forensic Medicine & Toxicology Skills

Subject: Forensic Medicine & Toxicology

**Phase II & Phase III part I
MBBS**

Sub Item: Practicals (Student Lab.) / Practicals(Forensic Medicine & Toxicology) / Vertical Integration
/ Early Clinical Exposure / Seminar / Self Directed Learning

Competency # addressed	Name of Activity	Date completed : dd-mm-yyyy	Attempt at activity First or Only (F) Repeat (R) Remedial (Re)	Rating Below (B) expectations Meets (M) expectations Exceeds (E) expectations OR Numerical Score	Decision of faculty Completed (C) Repeat (R) Remedial (Re)	Initial of faculty and date	Feedback Received Initial of learner
FM 14.20	To record and certify dying declaration in a simulated/ supervised environment						
FM 14.22	To give expert medical/ medico-legal evidence in Court of law						
FM 14.9	Demonstrate examination of & present an opinion after examination of skeletal remains in a simulated/ supervised environment						
FM 14.4	Conduct and prepare report of estimation of age of a person for medico-legal and other purposes & prepare medico-legal report in a simulated/ supervised environment						
FM 14.2	Demonstrate the correct						

	technique of clinical examination in a suspected case of poisoning & prepare medico-legal report in a simulated/ supervised environment						
FM 14.3	Assist and demonstrate the proper technique in collecting, preserving and dispatch of the exhibits in a suspected case of poisoning, along with clinical examination						
FM 14.6	Demonstrate and interpret medico-legal aspects from examination of hair (human & animal) fibre, semen & other biological fluids						
FM 14.7	Demonstrate & identify that a particular stain is blood and identify the species of its origin						
FM 14.8	Demonstrate the correct technique to perform and identify ABO & RH blood group of a person						
FM 14.21	To collect, preserve, seal and dispatch exhibits for DNA-Finger printing using various formats of different laboratories.						
FM	To examine &						

14.16	prepare medico-legal report of drunk person in a simulated/ supervised environment						
FM 14.17	To identify & draw medico-legal inference from common poisons e.g. dhatura, castor, cannabis, opium, aconite copper sulphate, pesticides compounds, marking nut, oleander, Nux vomica, abrus seeds, Snakes, capsicum, calotropis, lead compounds & tobacco.						
FM 14.1	Examine and prepare Medico-legal report of an injured person with different etiologies in a simulated/ supervised environment						
FM 14.5	Conduct & prepare post-mortem examination report of varied etiologies (at least 15) in a simulated/ supervised environment						
FM 14.10	Demonstrate ability to identify & prepare medicolegal inference from specimens obtained from various types of injuries e.g. contusion, abrasion,						

	laceration, firearm wounds, burns, head injury and fracture of bone						
FM 14.11	To identify & describe weapons of medicolegal importance which are commonly used e.g. lathi, knife, kripa, axe, gadasa, gupta, farsha, dagger, bhalla, razor & stick. Able to prepare report of the weapons brought by police and to give opinion regarding injuries present on the person as described in injury report/ PM report so as to connect weapon with the injuries. (Prepare injury report/ PM report must be provided to connect the weapon with the injuries)						
FM 14.12	Describe the contents and structure of bullet and cartridges used & to provide medico-legal interpretation from these						
FM 14.13	To estimate the age of foetus by post-mortem examination						
FM 14.14	To examine & prepare report of an alleged accused in						

	rape/unnatural sexual offence in a simulated/supervised environment						
FM 14.15	To examine & prepare medico-legal report of a victim of sexual offence/unnatural sexual offence in a simulated/supervised environment						
FM 14.18	To examine & prepare medico-legal report of a person in police, judicial custody or referred by Court of Law and violation of human rights as requirement of NHRC, who has been brought for medical examination						
FM 14.19	To identify & prepare medico-legal inference from histopathological slides of Myocardial Infarction, pneumonitis, tuberculosis, brain infarct, liver cirrhosis, brain haemorrhage, bone fracture, Pulmonary oedema, brain oedema, soot particles, diatoms & wound healing						

Reflection on Clinical FORENSIC MEDICINE Skills

Name of the session:

Name of the faculty member/ presenter:

Date:

Time:

Duration:

Specific learning objectives of the session:

1)

2)

3)

Teaching Learning Methods:

- What happened? (What did you learn from this experience)

- So what? (What are the applications of this learning)

- What next? (What knowledge or skills do you need to develop so that you can handle this type of situation?)

Signature of Teacher-in- charge

Reflection on Clinical FORENSIC MEDICINE Skills

Name of the session:

Name of the faculty member/ presenter:

Date:

Time:

Duration:

Specific learning objectives of the session:

1)

2)

3)

Teaching Learning Methods:

- What happened? (What did you learn from this experience)

- So what? (What are the applications of this learning)

- What next? (What knowledge or skills do you need to develop so that you can handle this type of situation?)

Signature of Teacher-in- charge

Reflection on Clinical FORENSIC MEDICINE Skills

Name of the session:

Name of the faculty member/ presenter:

Date:

Time:

Duration:

Specific learning objectives of the session:

1)

2)

3)

Teaching Learning Methods:

- What happened? (What did you learn from this experience)

- So what? (What are the applications of this learning)

- What next? (What knowledge or skills do you need to develop so that you can handle this type of situation?)

Signature of Teacher-in- charge

Reflection on Self- Directed Learning (SDL) activities

Name of the session:

Name of the faculty member/ presenter:

Date:

Time:

Duration:

Specific learning objectives of the session:

1)

2)

3)

Teaching Learning Methods:

- What happened? (What did you learn from this experience)

- So what? (What are the applications of this learning)

- What next? (What knowledge or skills do you need to develop so that you can handle this type of situation?)

Signature of Teacher-in- charge

Reflection on Self- Directed Learning (SDL) activities

Name of the session:

Name of the faculty member/ presenter:

Date:

Time:

Duration:

Specific learning objectives of the session:

1)

2)

3)

Teaching Learning Methods:

- What happened? (What did you learn from this experience)

- So what? (What are the applications of this learning)

- What next? (What knowledge or skills do you need to develop so that you can handle this type of situation?)

Signature of Teacher-in- charge

Reflection on Self- Directed Learning (SDL) activities

Name of the session:

Name of the faculty member/ presenter:

Date:

Time:

Duration:

Specific learning objectives of the session:

1)

2)

3)

Teaching Learning Methods:

- What happened? (What did you learn from this experience)

- So what? (What are the applications of this learning)

- What next? (What knowledge or skills do you need to develop so that you can handle this type of situation?)

Signature of Teacher-in- charge

3: AETCOM Module

Reflection on AETCOM module

Name of the session:

Name of the faculty member/ presenter:

Date:

Time:

Duration:

Specific learning objectives of the session:

1)

2)

3)

Teaching Learning Methods:

- What happened? (What did you learn from this experience)

- So what? (What are the applications of this learning)

- What next? (What knowledge or skills do you need to develop so that you can handle this type of situation?)

Signature of Teacher-in- charge

Reflection on AETCOM module

Name of the session:

Name of the faculty member/ presenter:

Date:

Time:

Duration:

Specific learning objectives of the session:

1)

2)

3)

Teaching Learning Methods:

- What happened? (What did you learn from this experience)

- So what? (What are the applications of this learning)

- What next? (What knowledge or skills do you need to develop so that you can handle this type of situation?)

Signature of Teacher-in- charge

Reflection on AETCOM module

Name of the session:

Name of the faculty member/ presenter:

Date:

Time:

Duration:

Specific learning objectives of the session:

1)

2)

3)

Teaching Learning Methods:

- What happened? (What did you learn from this experience)

- So what? (What are the applications of this learning)

- What next? (What knowledge or skills do you need to develop so that you can handle this type of situation?)

Signature of Teacher-in- charge

4A: Attendance Record of the Student

Sr. No	Phase	Theory (%)	Practical (%)	Signature of the Student	Signature of the Teacher
A	Phase II				
B	Phase III – Part - I				
C	OVER ALL ATTENDANCE				

Note: Above information is for the benefit of students and parents. In case of any discrepancy departmental record will be treated as final.

**SECTION 4B: Details of attending extra classes [For poor attendance
(if any)]**

Sr.No	Date	Period	Total hrs	Signature of student	Signature of Teacher
Total hours					

Note: Above information is for the benefit of students and parents. In case of any discrepancy departmental record will be treated as final.

Section 5. Records of Internal Assessment Examinations

Records of Internal Assessment examinations

Sr.No	Exam	Theory	Practical including viva	Signature of student	Signature of Teacher
1	I Internal Assessment	/ 50	/ 50		
2	II Internal Assessment	/ 50	/ 50		
3	III Internal Assessment	/ 50	/ 50		
4	IV Internal Assessment (Prelim)	/100	/100		
4	Internal Assessment marks	/ 250	/ 250		
5	Betterment exam	/ 100	/ 100		
6	Final Internal Assessment	/ 250	/ 250		
7	Final Internal Assessment (After Conversion)				

Note: Above information is for the benefit of students and parents. In case of any discrepancy departmental record will be treated as final.

Maharashtra University of Health Sciences, Nashik

Practical Journal Forensic Medicine and Toxicology



Name of Institute: _____

University Roll No: _____

Name of Student: _____

Roll No: _____

Batch: _____

Session From: _____ to _____

CERTIFICATE

Certified that this is the Bonafide Record of the practical work done by
Mr. / Miss _____
in the Department of Forensic Medicine and Toxicology, _____
_____ during the session from _____ to _____ and
his / her work is satisfactory / not satisfactory.

University Roll No. _____

Phase	Remark	Signature of In-charge with Date
Phase II		
Phase III – Part I		

In-charge Practical Programme

Professor & Head

Sign/s of University Examiner/s & Date

Code of Medical Ethics

1. I solemnly pledge myself to consecrate my life to the service of humanity.
2. Even under threat, I will not use my medical knowledge contrary to the laws of humanity.
3. I will maintain the utmost respect for human life from the time of conception.
4. I will not permit consideration of religion, nationality, race, party politics or social standing to intervene between my duty and my patient.
5. I will practice my profession with conscience and dignity.
6. The health of my patient is my first consideration.
7. I will respect the secrets, which are confided in me.
8. I will give my teachers the respect and gratitude, which is their due.
9. I will maintain in my power, the honour and the noble tradition of medical profession.
10. My colleagues will be my brothers.

I make these promises solemnly, freely and upon my honour.

Signature

Place: -

Name _____

Seal: -

Address _____

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Instructions to the students for Practical work

1. Punctuality in attending practical classes should be maintained, as 80 % attendance in practical is mandatory to appear for university examinations.
2. Silence and discipline should be observed during practical work.
3. Clean apron should be worn before entering the practical hall.
4. Every student should bring the practical record, a piece of clean linen, a measuring tape, stethoscope, torch, hammer and a hand lens and coloured pencils.
5. Listen carefully to the instructions given by the teacher for the day's work.
6. After finishing the practical work, complete them in the record book, get the record checked by the teacher on the same day.

Part- I
Medico-legal and Medical Certificates

01. Examination of Skeletal Remains (Bones) For Medicolegal Purpose

- 1) **List of Bones received** (Name of Bone):--
 - a. Gross anatomical characteristic
- 2) **Condition of Bone:** --
Brittle, Soiled, Stained, Damaged, Partly Burnt
- 3) **Human or not:** --
 - a. Gross anatomical characteristic
 - b. Microscopic examination,
 - c. Chemical analysis of bone ash
 - d. Precipitin test or Antihuman Immunoglobulin
- 4) **Belong to one individual or more?**
 - a. Number, side and size of the bones
 - b. Age and Sex
 - c. Morphological similarities
 - d. Use of short wave ultra violet light
 - e. X-ray comparison or trabecular pattern
 - f. Neutron activation analysis
- 5) **Stature:** --(body Height/ length)
 - a. Use of multiplication Factor/Regression equation
- 6) **Race of Individual:** --
 - a. Racial peculiarities in the individual bones (various indices)
- 7) **Age of Individual:** -
 - a. Dental status if skull or mandible is available
 - b. Ossification status
 - c. Secondary changes in the bones like closure of skull sutures, bony joint surface etc
- 8) **Sex of Individual:** --
 - a. General Characteristic
 - b. Specific Changes in the individual bone
 - c. Examination of soft parts if available
- 9) **Injuries:**
Ante mortem or Post-mortem or Could not be determined
- 10) **Manner of Separation:** -
 - a. State of soft tissue if available with marks of bite/cut etc.
 - b. Changes due to putrefaction
- 11) **Cause of Death:** -
 - a. Any injuries/ fracture
 - b. Foreign body –bullet, pellets or any piece of weapon
 - c. Chemical analysis for poisoning
 - d. Neutron activation analysis
- 12) **Time since Death:** -
 - a. State of soft tissue if available
 - b. Changes due to putrefaction
 - c. Immunological test
 - d. Precipitin test
 - e. Nitrogen content test.
- 13) **Identification of Subject:** -
 - a. Congenital abnormalities or deformities
 - b. Acquired peculiarities –injuries fractures etc.
 - c. Determination of the blood group from the marrow/ tooth pulp
 - d. Age, sex/ Race and stature of the individual
 - e. Radiological examination.

Examination of Skeletal Remains (Bones) For Medicolegal Purpose

To,

The Investigating Officer

_____ Police Station _____

Subject: - Regarding Examination of Bones (Skeletal remains)

Reference: Your letter No. _____ Dated _____ received on Date _____

ADR No/ C.R. No. _____ u/s _____

Here with forwarding opinion regarding Skeletal remains Brought by PC _____ B.No. _____
_____ Police Station _____.

Bones / Skeletal remains received in sealed /not sealed condition. Seal verified and found intact.

Observation / Examination Finding

- 1) List of Bones received: --(Name of Bone)
- 2) Condition of Bone: --
(Brittle, Soiled, Stained, Damaged, Intact)
- 3) Human or not: --
- 4) Belong to one individual or more?
- 5) Stature: -- (Multiplication factor/Regressive equation)
- 6) Race: --
- 7) Age: -
 - A) Ossification Status
 - B) Secondary Changes
 - C) Dental Status (Skull, Mandible, Face)
- 8) Sex: --
 - A) General Characteristic
 - B) Specific Changes
- 9) Injuries: --
- 10) Manner of Separation:-
- 11) Cause of Death: -
- 12) Time since Death: -
- 13) Identification of Subject: -

Opinion: -

- i) From the above finding, I am of opinion that the bone(s) belong to _____
origin of _____ Sex and aged about _____
- ii.) Cause of death _____
- iii) Time since death _____

Place:-
Seal:-

Signature
Name of Doctor _____
Designation _____

Examination of Skeletal Remains (Bones) For Medicolegal Purpose

To,

The Investigating Officer

_____ Police Station _____

Subject: - Regarding Examination of Bones (Skeletal remains)

Reference: Your letter No. _____ Dated _____ received on Date _____
ADR No/ C.R. No. _____ u/s _____

Here with forwarding opinion regarding Skeletal remains Brought by PC _____ B.No. _____
_____ Police Station _____.

Bones / Skeletal remains received in sealed /not sealed condition. Seal verified and found intact.

Observation / Examination Finding

- 1) List of Bones received: --(Name of Bone)
- 2) Condition of Bone: --
(Brittle, Soiled, Stained, Damaged, Intact)
- 3) Human or not: --
- 4) Belong to one individual or more?
- 5) Stature: -- (Multiplication factor/Regressive equation)
- 6) Race: --
- 7) Age: - A) Ossification Status
 B) Secondary Changes
 C) Dental Status (Skull, Mandible, Face)
- 8) Sex: -- A) General Characteristic
 B) Specific Changes
- 9) Injuries: --
- 10) Manner of Separation: -
- 11) Cause of Death: -
- 12) Time since Death: -
- 13) Identification of Subject: -

Opinion: -

- i) From the above finding, I am of opinion that the bone(s) belong to _____
origin of _____ Sex and aged about _____
- ii.) Cause of death _____
- iii) Time since death _____

Place:-
Seal:-

Signature
Name of Doctor _____
Designation _____

02. Age Estimation Report

Dental eruption and age-

Temporary Teeth	Eruption Time	Permanent Teeth	Eruption Time
Central incisors (Lower)	6-8 months	First molars	6-7 years
Central incisors (Upper)	7-9 months	Central incisors	6-8 years
Lateral incisors (Upper)	7-9 months	Lateral incisors	8-9 years
Lateral incisors (Lower)	10-12 months	First Bicuspid	9-11 years
first molars	12-14 months	Second Bicuspid	10-12 years
Canines	17-18 months	Canines	11-12 years
Second molars	20-30 months	Second molars	12-14 years
		Third molars	17-25 years

Development of hairs-

A) Axillary hair –

- 14 - 15 years : Brownish, soft space growth
- 16 –17 years : Thick, black, well grown

B) Beard and moustaches –

- 15 – 16 years – Begins to appear as downy, brown hair over chin.
Moustaches appear earlier than beard.
1-2 year after eruption hair became blackish and thick.

C) Pubic hairs –

- Stage I – Few brownish, downy hair (12-14 years)
- Stage II – darken and more curled pubic hair (14-16 years)
- Stage III - Darker, thicker, curly adult hair but no hair over medial surface of thigh (16-18 years)
- Stage IV – Thick, black curly pubic hair spread both over Mons pubis and medial surface of thighs (>18 years)

Ossification centres-

Joint	Bone	Appearance of Ossification centres	Fusion of ossification centres
Elbow	Humerus	Lower end- Capitulum-1 year Trochlea- 10 yrs Lateral epicondyle- 11 yrs Medial epicondyle- 6 to 7 yrs	Lower end of humerus complete fusion- 14 to 16 yrs
	Radius	Upper end (head) - 5 yrs	16 yrs
	Ulna	Upper end (Olecranon)- 9 yrs	16 yrs
Wrist	Radius	Lower end- 2 yrs	18-19 yrs
	Ulna	Lower end- 6 yrs	17-18 yrs
	Carpals	Pisiform-11 yrs, Trapezoid, Scaphoid-5yrs	Base of first metacarpal- 15 yrs
Pelvis	Tri-radiate cartilage	Separate centre in acetabulum-13 yrs	Fuses in acetabulum- 15 yrs
	Ischio-Pubic rami	---	Unites with each other- 6 yrs
	Femur	Lesser trochanter – 12 to 14 yrs	Head and both trochanters-17-18 yrs
		Iliac crest- 14 yrs	20-21 yrs
		Ischial tuberosity- 16 yrs	20-21 yrs

Tanner staging- sexual maturity

MALE (Genital development)

Stage 1: Pre-adolescent stage. Testis, penis, scrotum about same size as childhood. No pubic hair.

Stage 2: Enlargement of scrotum and testis. Skin of scrotum reddens and changes in texture. Scanty light pubic hair mainly at base of penis. Little enlargement of penis.

Stage 3: Further growth of scrotum. Pubic hair darkens and begins to curl. Penis enlarges mainly in length.

Stage 4: Increase in breadth of penis. Development of glans. Scrotum enlarges and darkens. Adult type of pubic hair but does not spread to medial part of thigh.

Stage 5: Genitalia adult type. (Penis-10-12cm, Volume of testis-20cc, length of testis-4cm or more)
Pubic hair spreads to medial part of thigh.

FEMALE (Breast / Pubic hair development)

Stage1: Preadolescent; breast shows elevation of papilla only. No pubic hair

Stage2: Breast bud stage. Elevation of breast and papilla as a small mound. Enlargement of areola diameter. Scanty lightly pigmented pubic hair, mainly at labia.

Stage3: Further enlargement of breast and areola, no separation at contours. Pubic hair becomes darker and begins to curl.

Stage4: Projection of areola and papilla to form a secondary mound above the level of breast. Adult type of pubic hair less in amount and no spread to medial surface of thigh.

Stage5: Mature stage. Projection of nipple only; recession of areola to the level of general contour of breast. Adult feminine triangular type of pubic hair, may spread to medial side of thigh.

Age Estimation Report

A. Preliminary Information- Name: Shri/ Smt/ Kum. _____

Age as stated- _____ Sex- _____ Address- _____

Brought by: _____

Date: _____ Time: _____ MLC No: _____ Dated: _____

Consent: I am willing to get examined physically and radiologically for estimation of age.

(This consent is explained to patient in _____ language)

Signature/Thumb impression

(Subject/Guardian)

Examined in presence of-
Signature/Thumb impression

Identification Marks:

1. _____
2. _____

B. Clinical Examination:

Physical development _____ Height _____ Weight _____

Secondary Sexual Characters:

Male moustaches _____ Female Breast development _____

Beard _____ Menarche _____

Voice _____ Last Menstrual period (LMP) _____

Axillary hair _____ Axillary hair _____

Pubic hair _____ Pubic hair _____

External genitalia _____ External genitalia _____

C. Dental status-

Spacing behind second molar- _____ Abnormality if any- _____

D. Radiological Examination: Reference: x-ray plate no. _____ Date- _____

1. _____
2. _____
3. _____
4. _____

Conclusion: From clinical, dental and radiological examinations, the age of the subject on date _____ is between _____ to _____ including margins of errors.

Date: - _____ Seal _____ Signature _____
Place: - _____ Name of Doctor _____
Designation _____

Age Estimation Report

A. Preliminary Information- Name: Shri/ Smt/ Kum. _____

Age as stated- _____ Sex- _____ Address- _____

Brought by: _____

Date: _____ Time: _____ MLC No: _____ Dated: _____

Consent: I am willing to get examined physically and radiologically for estimation of age.

(This consent is explained to patient in _____ language)

Signature/Thumb impression

(Subject/Guardian)

Examined in presence of-

Signature/Thumb impression-

Identification Marks:

1. _____
2. _____

B. Clinical Examination:

Physical development _____ Height _____ Weight _____

Secondary Sexual Characters:

Male moustaches _____ Female Breast development _____

Beard _____ Menarche _____

Voice _____ Last Menstrual period (LMP) _____

Axillary hair _____ Axillary hair _____

Pubic hair _____ Pubic hair _____

External genitalia _____ External genitalia _____

C. Dental status-

Spacing behind second molar- _____ Abnormality if any- _____

D. Radiological Examination: Reference: x-ray plate no. _____ Date- _____

1. _____
2. _____
3. _____
4. _____

Conclusion: From clinical, dental and radiological examinations, the age of the subject on date _____ is between _____ to _____ including margins of errors.

Date: - _____ Seal _____ Signature _____
 Place: - _____ Name of Doctor _____
 Designation _____

03. Examination of Foetus for Age

To

The Investigating Officer

_____ Police Station _____

Subject: Submission of Report of Examination of Foetus for Age.

Reference: Your letter No. _____ Dated _____

Sir,

I am sending to you the Report of Examination of Foetus for Age.

Observations-

I. External Examination:

1. Length:
2. Weight:
3. Lanugo:
4. Scalp Hair:
5. Eyes:
6. Pupillary Membrane:
7. Nails:
8. Vernix Caseosa:
9. Umbilicus:
position & status
10. Genitalia:
11. Any other finding:

II. Internal Examination:

1. Ossification centres:
2. Meconium:
3. Any other findings:

Opinion about the age of foetus: _____

Place:

Date and Time:

Signature

Name of Doctor _____

Designation _____

Receipt: Received original copy of the report, the new-born,
_____ & its belongings.

Name & Signature of I.O.

Table: Age-related Changes in the Foetus

Parameter	Age in Lunar Months							
	3 rd	4 th	5 th	6 th	7 th	8 th	9 th	10 th
Length	About 9 cm	About 16 cm	About 25 cm	About 30 cm	About 35 cm	About 40 cm	About 45 cm	About 45-50 cm
Weight	About 30gm	About 120gm	About 400gm	About 700gm	About 1kg	About 1.5kg	About 2-2.5kg	About 3-3.5kg
Nails	In membranous form	-	Nearing tips of fingers	-	Thicker but do not reach ends of fingers	Reach tips of fingers	Beyond tips of fingers	Beyond tips of fingers but reach only the tips of toes
Lanugo	-	First exhibited between 13 and 16 weeks	Covers face and body	-	Greatest between 28 and 30 weeks	Disappeared from the face	Around shoulders only	-
Scalp Hair	-	-	Appear	Appreciable	About 1.0 cm long	About 1.5 cm long	About 2 cm long	About 2-3 cm long
Sex	Indistinguishable	Differentiable	-	-	-	-	-	-
Eyes	-	-	-	Eyelids adherent. Eyelashes Appear	Eyelids non-adherent. Eyelashes Present	Well-Formed	-	-
Pupil Membrane	Appears	Visible	Present	Present	Disappears	-	-	-
Vernix Caseosa	-	-	Appears	Present	-	-	Present over flexures of joints and neck folds	Present over flexures of joints and neck folds
Meconium	-	In the upper part of small intestine	In the beginning of large intestine	In the upper part of large intestine	In the whole of large intestine	-	In the Rectum	-
Testicles	-	-	-	Lie close to respective kidneys	Lt—near the external inguinal ring; Rt—near the internal inguinal ring	Lt—in the scrotum Rt—near the external inguinal ring	Both testicles in the scrotum	-
Centres of ossification	-	-	For calcaneum and ischium	For manubrium & 1st segment of sternum	For talus, 2nd & 3rd segment of sternum	-	For lower end of femur	For cuboid upper end of tibia, etc.

04. Medical Certificate of Cause of Death (MCCD)

The data on cause of death contained in the certificate serve many purposes: they help in assessing the effectiveness of public health programmes and provide a feed-back for future policy and implementation. They are essential for better health planning and management and for deciding priorities of health and medical research programmes.

- ❖ Legal Provisions: Registration of Birth & Deaths Act (RBD), 1969 for certification by a medical practitioner who has attended the deceased during the latter's last illness. The relevant sections of the Act are: **Section 10(2), Section 10(3), Section 17(1) (b)**

2. SPECIFIC INSTRUCTIONS

2.1 Name of the deceased

To be given in full. Do not use initials. Also give name of father (or husband in case of married female) after the name of the deceased, using appellation S/o or D/o or W/o. In case of infants not yet named, write son (or daughter) of, followed by names of mother and father.

2.2 Age

If more than a year old, give age in years last birthday (completed number of years). If under one year, give age in months and days. If under 24 hours, give in hours and minutes. 2.3 Method of certification of cause of death 2.3.1 The medical part of the certificate is designed by the WHO to facilitate reporting the underlying cause of death and to obtain information of the causal and pathological sequence of events leading to death. It consists of two parts, the first relating to the sequence of events leading to death, and the second to other significant conditions that contributed to the death.

2.3.2 This part should be written by the attending physician or a physician having personal knowledge of the case history. The names of the diseases should be written in full and legibly to avoid the risk of their being misread. Abbreviations and short form of disease condition should not be used. He should avoid indefinite or inadequate terms. Inadequate descriptions may put the statistical office in difficulty at the time of classification of the data. Mention of terminal events or mode of dying as the only entry in the statement leaves the certificate incomplete. Similarly, symptomatic remarks will not suffice. A properly completed certificate will show the underlying cause on the lowest used line of part I and the conditions if any, as a consequence thereof will have been entered above it in ascending casual order of sequence.

2.3.3 PART – I OF THE CAUSE OF DEATH STATEMENT

Only one cause is to be entered on each line of Part I. The underlying cause of death should be entered on the lowest line used in this part. The underlying cause of death is the condition that started the sequence of events between normal health and the (direct) immediate cause of death.

Line (a): Immediate cause

The direct or immediate cause of death is reported on line (a). This is the disease, injury or complication that directly preceded death. It can be the sole entry in the statement if only one condition was present at death. There must always be an entry on line (a). The mode of dying (e.g., heart failure, respiratory failure) should not be stated at all since it is no more than a symptom of the fact that death occurred and provides no useful information. In the case of a violent death, enter the result of the external cause (e.g., fracture of vault or skull, crushed chest).

Line (b): Due to (or as a consequence of) If the condition on line (a) was the consequence of another condition, record that in line (b). This condition must be antecedent to the immediate cause of death, both with respect to time and etiological or pathological violence or circumstances of accident is antecedent to an injury entered on line (a) and should be entered on line (b), although the two events are almost simultaneous (e.g., automobile accident, fall from tree). An antecedent condition might have just prepared the way for the immediate cause of death, by damage to tissues or impairment of function, even after a long interval.

Line (c): The condition, if any which gave rise to the antecedent condition on line (b) is to be reported here. The remarks given for line (b) apply here also. If the condition on line (b) is the underlying cause, nothing more be entered on this line. However, if the sequence of events comprises more than three stages, extra line (and entries) may be made in part I. However, many conditions are involved; write the full sequence, one condition per line, with the most recent condition (immediate cause) at the top, and the earliest (the condition that started the sequence of event between normal health and death) last. Normally the condition or circumstance on the lowest line used in part I will be taken as the basis for underlying cause statistics, though classification of it may be modified to take account of complications or other conditions entered by special provisions of the ICD.

2.3.4 PART-II OTHER SIGNIFICANT CONDITIONS

Enter, in order of significance, all other diseases or conditions believed to have unfavourably influenced the course of the morbid process and thus contributed to the total outcome but which were not related to the disease or condition directly causing death. There will be cases where it will be difficult to decide whether a condition relevant to death should be recorded as part of the fatal sequence in part I or as a contributory condition in part II. Conditions in part I should represent a distinct sequence so that each condition may be regarded as being the consequence of the condition entered immediately below it. Where a condition does not seem to fit into such a sequence, consider whether it belongs to part II. In certifying the causes of death for Part II, any disease, abnormality, injury or late effects of poisoning, believed to have adversely affected the decedent should be reported, including:

- Use of alcohol and/or other substances.
- Smoking history.
- Environmental factors, such as exposure to toxic fumes, history of working in some specific industry, professional exposure to toxins, specific animals etc.
- Recent pregnancy, if believed to have contributed to the death.
- Late effects of injury, including head injury sequelae
- Surgical information, if applicable.
- Any iatrogenic underlying cause.

2.3.5 INTERVAL BETWEEN ONSET AND DEATH

Space is provided, against each condition recorded on the certificate for the interval between the presumed onset of morbid condition and the date of death. Exact period should be written when it is known; in other cases, approximate periods like “from birth”, “several years” or “unknown” should be indicated. This provides a useful check on the sequence of causes as well as useful information about the duration of illness in certain diseases.

2.4 Accidents or suicide or homicide is ruled out, how the fatal injury occurred should be explained indicating briefly the circumstances or cause of the accident. In case of medico-legal cases, the certificate has to be given by the police authorities. However, the Registrar should be informed of such cases, by the hospital.

2.5 Female death Information on pregnancy and delivery is needed in case of death of women in the childbearing age (15 to 49 years) even though the pregnancy may have had nothing to do with the death. 2.6 Ensuring completeness of information

2.6.1 While giving the casual chain of events in the statement of cause of death, a complete case history is not required but, if information is available, enough details may be given to enable proper classification of the underlying cause. The certifier cannot always be certain as to what details are required and therefore, a list giving examples of incomplete descriptions and what additional information are required is included in the annexure for guidance.

The terms included in the annexure are those employed usually and are of the following types: - (i) A symptom that may arise from different group of diseases. (ii) A morbid condition that could result from several types of infection, known or unknown. (iii) With connotation of any of several morbid conditions having distinctive categories in the classification list like acute, sub-acute, chronic, simple etc. (iv) Mention of a disease which is generally localised, without indicating the organ or part of the body affected. (v) A morbid condition that requires for its classification, a knowledge of the circumstances in which it arose.

2.6.2 As a general rule, record diagnoses as precisely as the information permits, incorporating relevant details from histological or autopsy reports. Where an important detail is unknown the fact should be stated.

2.6.3 The following gives the pertinent details required to be spelt out in the medical part of the certificate corresponding to the major cause group of mortality;

1. Infections: Acute, sub-acute or chronic, name of the disease and/or infecting organism, the site if localised; mode of transmission, where relevant.
2. Neoplasms: The morphological type if known; malignant, benign etc., site of origin of primary growth and sites of secondary growths.
3. Endocrine disorders: Nature of disease process or disturbance of function: For thyroid diseases, whether toxic: for diabetes, nature of complication or manifestation in particular site.
4. Nutritional disorders: Type of deficiency, etc., and severity.
5. Blood disorders: Nature of disease process; type and nature of any deficiency for anaemias; whether hereditary (where relevant)
6. Nervous system disorders: Disease process; infecting organism (where relevant) whether hereditary (where relevant).
7. Circulatory diseases: Nature of disease process; site, if localized; acute or chronic where relevant, specify rheumatic or other aetiology for valvular heart conditions; any complications.
8. Respiratory diseased: Nature of disease process; acute or chronic; infecting organism, any external cause.
9. Digestive diseased: Nature of disease process; site of ulcers, hernias, diverticula, etc. Acute or chronic where relevant, nature of any complication for ulcers, appendicitis, hernias.
10. Genitourinary disorders: Acute or chronic, clinical syndrome and pathological lesions; site of calculi, infecting organism and site of infections; nature of complications.
11. Maternal deaths: Nature of complication: whether obstruction occurred during labour; timing of death in relation to delivery; for abortions, whether spontaneous or induced, legal or illegal, if induced.
12. Musculoskeletal disorders: Nature of disease process, infecting organism, underlying systemic diseases (where relevant); site; complication, whether congenital or acquired for deformities.
13. Congenital anomalies: Site and type, complications.

14. Perinatal deaths: Condition in foetus or infant; conditions in mother or of placenta, cord or membranes, if believed to have affected the foetus or infant; for deaths associated with immaturity, state length of gestation and/or birth weight; type of birth trauma; and complications, etc.
15. Injuries: Type, site, complications.
16. Poisoning: Substance involved; whether accidental (if suicide or homicide is ruled out). 17. Adverse effects of drugs in therapeutic use: State this fact and name or drug, nature of adverse effect, complications; condition treated.
17. External cause of accidents: For transport accidents, state vehicle involved, whether deceased was driver, passenger, etc. Description of accident place of occurrence, for other accidents, specifies circumstances and place of occurrence.
18. Old age or senility: This should not be given if a more specific cause is known. If old age was a contributory factor it should be entered in part II only.

ICD classification of diseases

The International Classification of Diseases (ICD) is the standard classification system for epidemiology, health management and clinical purposes. It contains a finite number of mutually exclusive code categories, describing all disease conditions. The classification is hierarchical in structure with subdivisions to identify broad groups and specific entities.

There are 3 key elements to the structure of ICD-10:

1. It has 3 volumes
 - i. Volume 1 -- a tabular listing of diseases
 - ii. Volume 2 -- an instruction manual
 - iii. Volume 3 -- the comprehensive alphabetical index of diseases
2. It has 22 chapters
3. The structure of the ICD code is alphanumeric

Filling ICD code on a death certificate

The ICD code should be coded for all causes of death (immediate, intermediate and underlying causes) on a death certificate. ICD code for each cause of death should be filled against the particular cause of death in the death certificate.

Example: Patient XYZ is admitted with Acute Gastroenteritis and Dehydration & then dies in the ward.

Name of the Deceased					For use of Statistical office
Sex	Age at Death				
	If 1 year or more, age in years	If less than 1 year, age in Months	If less than one month, age in days	If less than one day, age in hours	
1. Male 2. Female 3. Transgender					
CAUSE OF DEATH					
I					
Immediate Cause State the disease, injury or complication which caused death, not the mode of dying such as heart failure, asthenia, etc...			(a)..... Dehydration Due to (or consequences of)	Interval between onset & death approx	<div style="border: 1px solid black; background-color: #4a4a8a; color: white; padding: 5px; text-align: center; width: 40px; margin: 0 auto;">E86</div>
Antecedent Cause Morbid conditions, if any, giving rise To the above Cause, stating underlying conditions last			(b)..... Acute Gastroenteritis Due to (or consequences of) (c).....		
II					
Other significant conditions contributing to the death but not related to the disease or conditions causing it					

FORM NO. 4

(See Rule 7)

MEDICAL CERTIFICATE OF CAUSE OF DEATH
(Hospital In-patients. Not to be used for still births)

To be sent to Registrar along with Form No. 2 (Death Report)

Name of the Hospital _____

I hereby certify that the person whose particulars are given below died in the hospital in Ward No. _____ On _____ At _____ AM/PM.

Name of the deceased				For use of statistical purpose
Sex	Age at death			
	If 1 year or more, age in years	If less than 1 year, age in month	If less than one month, age in days	If less than one day, age in hours
1, Male 2, Female				
<p style="text-align: center;">CAUSE OF DEATH</p> <p>I. Immediate cause: State the disease, injury or complication which caused death, not the mode of dying such as heart failure, asthenia, etc.</p> <p style="text-align: right;">a) due to (or as a consequence of)</p> <p>Antecedent cause: Morbid conditions, if any, giving rise to the above cause, stating the underlying conditions last.</p> <p style="text-align: right;">b) due to (or as a consequence of)</p> <p>II. Other significant conditions contributing to the death, but not related to the diseases or conditions causing it.</p> <p style="text-align: right;">c)</p>				Interval between onset and death approx.

Manner of Death

How did the injury occur?

1. Disease 2. Accident 3. Assault 4. Intentional self-harm 5. Legal intervention 6. War
7. Pending investigation 8. Could not be determined.

If deceased was a female, was pregnancy the death associated with?

1. Yes 2. No

If yes, was there a delivery?

1. Yes 2. No

Name and signature of the Medical Attendant certifying the cause of death
Date of verification _____

(To be detached and handed over to the relative of the deceased)

Certified that Shri/Smt/Kum _____ S/W/D of Shri _____

R/O _____ was admitted to this hospital on _____

and expired on _____.

Doctor _____

(Medical Superintendent & Name of Hospital)

FORM NO. 4

(See Rule 7)

MEDICAL CERTIFICATE OF CAUSE OF DEATH
(Hospital In-patients. Not to be used for still births)

To be sent to Registrar along with Form No. 2 (Death Report)

Name of the Hospital _____

I hereby certify that the person whose particulars are given below died in the hospital in Ward No. _____ On _____ At _____ AM/PM.

Name of the deceased				For use of statistical purpose
Sex	Age at death			
	If 1 year or more, age in years	If less than 1 year, age in month	If less than one month, age in days	If less than one day, age in hours
1, Male 2, Female				
<p style="text-align: center;">CAUSE OF DEATH</p> <p>I. Immediate cause: State the disease, injury or complication which caused death, not the mode of dying such as heart failure, asthenia, etc.</p> <p style="text-align: right;">a) due to (or as a consequence of)</p> <p>Antecedent cause: Morbid conditions, if any, giving rise to the above cause, stating the underlying conditions last.</p> <p style="text-align: right;">b) due to (or as a consequence of)</p> <p>II. Other significant conditions contributing to the death, but not related to the diseases or conditions causing it.</p> <p style="text-align: right;">c)</p>				Interval between onset and death approx.

Manner of Death

How did the injury occur?

1. Disease 2. Accident 3. Assault 4. Intentional self-harm 5. Legal intervention. 6. War
7. Pending investigation 8. Could not be determined.

If deceased was a female, was pregnancy the death associated with?

1. Yes 2. No

If yes, was there a delivery?

1. Yes 2. No

Name and signature of the Medical Attendant certifying the cause of death
Date of verification _____

(To be detached and handed over to the relative of the deceased)

Certified that Shri/Smt/Kum _____ S/W/D of Shri _____

R/O _____ was admitted to this hospital on _____

and expired on _____.

Doctor _____
(Medical Superintendent & Name of Hospital)

FORM NO. 4 A

(See Rule 7)

MEDICAL CERTIFICATE OF CAUSE OF DEATH
(For non-institutional deaths. Not to be used for still births)

To be sent to Registrar along with Form No. 2 (Death Report)

Name of the Hospital _____

I hereby certify that the person whose particulars are given below died in the hospital in
Ward No. _____ On _____ At _____ AM/PM.

Name of the deceased				For use of statistical purpose
Sex	Age at death			
	If 1 year or more, age in years	If less than 1 year, age in month	If less than one month, age in days	If less than one day, age in hours
1, Male 2, Female				
<p style="text-align: center;">CAUSE OF DEATH</p> <p>I. Immediate cause: a) State the disease, injury or due to (or as a consequence of) complication which caused death, not the mode of dying such as heart failure, asthenia, etc.</p> <p>Antecedent cause: b) Morbid conditions, if any, due to (or as a consequence of) giving rise to the above cause, stating the underlying conditions last.</p> <p>II. Other significant conditions c) contributing to the death, but not related to the diseases or conditions causing it.</p>				Interval between onset and death approx.

If deceased was a female, was pregnancy the death associated with?

1. Yes 2. No

If yes, was there a delivery?

1. Yes 2. No

Name and signature of the Medical Attendant certifying the cause of death
Date of verification _____

(To be detached and handed over to the relative of the deceased)

Certified that Shri/Smt/Kum _____ S/W/D of Shri _____

R/O _____ was under my treatment from _____ to _____

and expired on _____ at _____ AM/PM.

Doctor _____
Signature and address of Medical Practitioner/
Medical attendant with Registration No.

FORM NO. 4 A

(See Rule 7)

MEDICAL CERTIFICATE OF CAUSE OF DEATH
(For non-institutional deaths. Not to be used for still births)

To be sent to Registrar along with Form No. 2 (Death Report)

Name of the Hospital _____ I hereby certify
that the person whose particulars are given below died in the hospital in Ward No. _____
On _____ At _____ AM/PM.

Name of the deceased				For use of statistical purpose
Sex	Age at death			
	If 1 year or more, age in years	If less than 1 year, age in month	If less than one month, age in days	If less than one day, age in hours
1, Male 2, Female				
<p style="text-align: center;">CAUSE OF DEATH</p> <p>I. Immediate cause: a) State the disease, injury or due to (or as a consequence of) complication which caused death, not the mode of dying such as heart failure, asthenia, etc.</p> <p>Antecedent cause: b) Morbid conditions, if any, due to (or as a consequence of) giving rise to the above cause, stating the underlying conditions last.</p> <p>II. Other significant conditions c) contributing to the death, but not related to the diseases or conditions causing it.</p>				Interval between onset and death approx.

If deceased was a female, was pregnancy the death associated with? 1. Yes 2. No
If yes, was there a delivery? 1. Yes 2. No

Name and signature of the Medical Attendant certifying the cause of death
Date of verification _____

(To be detached and handed over to the relative of the deceased)

Certified that Shri/Smt/Kum _____ S/W/D of Shri _____
R/O _____ was under my treatment from _____ to _____
and expired on _____ at _____ AM/PM.

Doctor _____
Signature and address of Medical Practitioner/
Medical attendant with Registration No.

05. Medical Sickness / Under Treatment Certificate

Recent
Passport
size photo

Name of Patient: _____

Age: _____ Sex : _____

Address : _____

OPD/IPD No. _____

ID Proof & No. (Any Govt ID) : _____

Identification Marks:

1. _____

2. _____

Signature & Thumb Impression of the Applicant: _____

I, Dr _____ after careful personal examination of the case hereby certify that _____ whose signature is given above is suffering from _____.

He/she is under my treatment for the same as outdoor/indoor patient and I consider that a period of absence from duty with effect from _____ to _____ (____ Days) is absolutely necessary for the restoration of his/her health.

Place:

Date and Time:

Signature

Name of Doctor _____

Designation _____

06. Medical Fitness Certificate

Recent
Passport size
photo

Name of Patient: _____

Age: _____ Sex: _____

Address: _____

OPD/IPD No. _____

ID Proof & No. (Any Govt ID) : _____

Identification Marks:

1. _____

2. _____

Signature & Thumb Impression of the Applicant: _____

I, Dr _____ after careful personal examination of the case hereby certify that _____ on restoration of his/her health is now fit to resume service from _____.

Place:

Date and Time:

Signature

Name of Doctor _____

Designation _____

07. Fitness Certificate for Employment

Recent
Passport
size photo

We hereby certify that, we have examined Shri/Smt. _____
a candidate for employment in the _____ Department and cannot
discover that he/she has any disease, constitutional weakness or bodily infirmity except _____

_____.

Fit:

*He / She is Temp. Unfit:

Unfit:

We do not consider this is a disqualification for employment in the Office of _____
_____. His / Her age is according to his/her own statement _____ years and
by appearance about _____ years.

Identification Marks:

1. _____

2. _____

Signature/Thumb impression of the Candidate

Place: _____

Date: _____

Member
Medical Board

Member
Medical Board

Chairman
Medical Board

08. Examination \ Certificate of the injured (Injury Report)

1. Medico-legal injury cases should be examined without delay after adopting the lifesaving procedure.
2. Valid consent for examination must be obtained from the injured or the competent authority.
3. All observation should be entered at once in the accident register with appropriate sketches and diagrams. Injury should be photographed whenever possible.
4. Relevant information should always be entered in injury certificate or report and be prepared in duplicate.
5. Whenever there is apprehension of death of the injured person *or* he is likely to die from the effect of the injury, arrangement should be made for recording dying declaration.

Definitions:

Injury: Legal definition as per sec. 44 IPC.

Hurt: Legal definition as per sec. 319 IPC.

Simple injury:

Grievous hurt: Legal definition as per sec. 320 IPC.

Examination / Certification of Injured. [Injury Report]

To,
The Investigating Officer,
 _____ Police Station _____

Subject: Submission of report of examination of injured person

Reference: Your letter No. _____ Dated _____

Sir,

I am forwarding herewith the report of examination of:

Name of Injured: _____ Son/Wife/Daughter/Widow of _____

Surname _____ resident of _____

Brought by PC _____ NO. _____ P.S. _____

Consent:

(This consent is explained to patient in _____ language).

Signature/LTI
(Subject/Guardian)

Examined in presence of-
 Signature/Thumb impression-

Identification marks: 1. _____
 2. _____

History: History narrated by _____

Sr. No.	Nature of injury	Size in cms	Situation over the body	Type of injury	Possible/ Kind of weapon	Age of injury	Remarks / Investigation done, if any

Opinion:

Place:
 Date and Time:

Signature
 Name of Doctor _____
 Designation _____

To,
The Investigating Officer,
_____ Police Station _____

Subject: Submission of report of examination of injured person

Reference: Your letter No. _____ Dated _____

Sir,

I am forwarding herewith the report of examination of:

Name of Injured: _____ Son/Wife/Daughter/Widow of _____

Surname _____ resident of _____

Brought by PC _____ NO. _____ P.S. _____

Consent:

(This consent is explained to patient in _____ language).

Signature/LTI
(Subject/Guardian)

Examined in presence of-

Signature/Thumb impression-

Identification marks: 1. _____

2. _____

History: History narrated by _____

Sr. No.	Nature of injury	Size in cms	Situation over the body	Type of injury	Possible/ Kind of weapon	Age of injury	Remarks / Investigation done, if any

Opinion:

Place:
Date and Time:

Signature
Name of Doctor _____
Designation _____

To,
The Investigating Officer,
_____ Police Station _____

Subject: Submission of report of examination of injured person

Reference: Your letter No. _____ Dated _____

Sir,

I am forwarding herewith the report of examination of:

Name of Injured: _____ Son/Wife/Daughter/Widow of _____

Surname _____ resident of _____

Brought by PC _____ NO. _____ P.S. _____

Consent:

(This consent is explained to patient in _____ language).

Signature/LTI
(Subject/Guardian)

Examined in presence of-

Signature/Thumb impression-

Identification marks: 1. _____

2. _____

History: History narrated by _____

Sr. No.	Nature of injury	Size in cms	Situation over the body	Type of injury	Possible/ Kind of weapon	Age of injury	Remarks / Investigation done, if any

Opinion:

Place:
Date and Time:

Signature
Name of Doctor _____
Designation _____

To,
The Investigating Officer,
_____ Police Station _____

Subject: Submission of report of examination of injured person

Reference: Your letter No. _____ Dated _____

Sir,

I am forwarding herewith the report of examination of:

Name of Injured: _____ Son/Wife/Daughter/Widow of _____

Surname _____ resident of _____

Brought by PC _____ NO. _____ P.S. _____

Consent:

(This consent is explained to patient in _____ language).

Signature/LTI
(Subject/Guardian)

Examined in presence of-

Signature/Thumb impression-

Identification marks: 1. _____

2. _____

History: History narrated by _____

Sr. No.	Nature of injury	Size in cms	Situation over the body	Type of injury	Possible/ Kind of weapon	Age of injury	Remarks / Investigation done, if any

Opinion:

Place:
Date and Time:

Signature
Name of Doctor _____
Designation _____

To,
The Investigating Officer,
_____ Police Station _____

Subject: Submission of report of examination of injured person

Reference: Your letter No. _____ Dated _____

Sir,

I am forwarding herewith the report of examination of:

Name of Injured: _____ Son/Wife/Daughter/Widow of _____

Surname _____ resident of _____

Brought by PC _____ NO. _____ P.S. _____

Consent:

(This consent is explained to patient in _____ language).

Signature/LTI
(Subject/Guardian)

Examined in presence of-

Signature/Thumb impression-

Identification marks: 1. _____

2. _____

History: History narrated by _____

Sr. No.	Nature of injury	Size in cms	Situation over the body	Type of injury	Possible/ Kind of weapon	Age of injury	Remarks / Investigation done, if any

Opinion:

Place:
Date and Time:

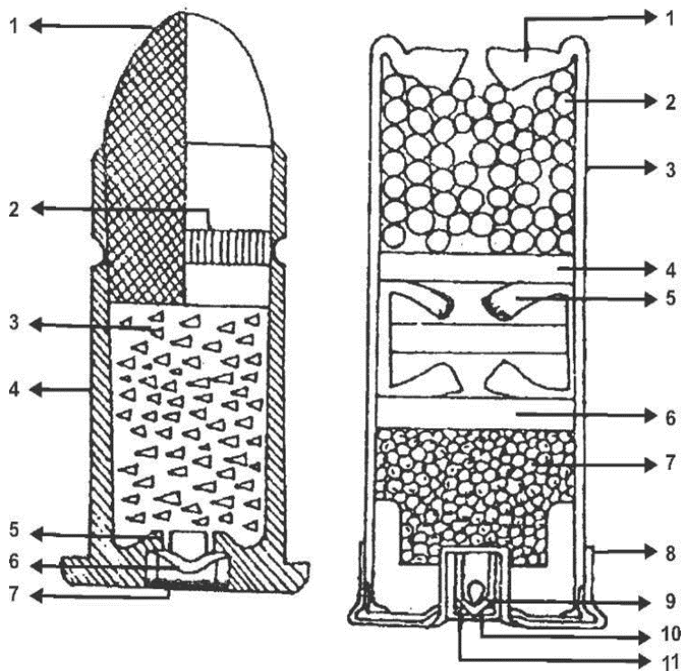
Signature
Name of Doctor _____
Designation _____

09. Examination of Weapon

Definition:

Dangerous Weapon as per sec 324 & 326 IPC.:

Label various parts of ammunition of fire arm.



Draw & label Weapon	Describe Weapon
	Kind of Weapon- Type of Weapon- Injuries Possible-
	Kind of Weapon- Type of Weapon- Injuries Possible-
	Kind of Weapon- Type of Weapon- Injuries Possible-
	Kind of Weapon- Type of Weapon- Injuries Possible-

Draw & label Weapon	Describe Weapon
	Kind of Weapon- Type of Weapon- Injuries Possible-
	Kind of Weapon- Type of Weapon- Injuries Possible-
	Kind of Weapon- Type of Weapon- Injuries Possible-
	Kind of Weapon- Type of Weapon- Injuries Possible-

Draw & label Weapon	Describe Weapon
	Kind of Weapon- Type of Weapon- Injuries Possible-
	Kind of Weapon- Type of Weapon- Injuries Possible-
	Kind of Weapon- Type of Weapon- Injuries Possible-
	Kind of Weapon- Type of Weapon- Injuries Possible-

1) Examination of the Weapon in Cases of Injuries (Sharp Edge Weapon)

To,
The Investigating Officer

_____ Police Station _____

Sub: Submission of report of examination of weapon in connection with _____

Reference:

1) Your letter No. _____ Dated _____ with sealed packed weapon.

2) Injury Report / MLPM No.: _____ issued by _____ Date: _____

Sir,

With reference to the above letter, I am sending the report about the weapon sent in sealed condition in connection with the injuries of _____

Name of weapon _____

Kind of weapon _____

Type of weapon _____

Description of the weapon:

Weight of weapon: _____ (gm)

Total length of weapon: _____ (cms)

Blade: is of _____, Texture: _____

Length: _____, Breadth: _____, Thickness: _____

Edges / Margins: _____ Point: _____

Stains / Foreign body if any: _____

Joint: Type: _____, Hilt: Size: _____

Handle: is of, _____ Texture: _____

Length: _____, Breadth/ Maximum Circumference: _____

Stains / Foreign body if any: _____

Opinion:

Injuries possible by above weapon:

Identification marks if any on the weapon.

(Put the signature on the weapon)

The weapon was packed, sealed and handed over to _____ of police station _____ for forwarding to FSL for chemical analysis.

Place: _____

Date & Time: _____

Receipt of weapon and report

(Impression of seal)

Signature

Name of Doctor _____

Designation _____

2) Examination of the Weapon in Cases of Injuries (Hard & Blunt weapon)

To,
The Investigating Officer

_____ Police Station _____

Sub: Submission of report of examination of weapon in connection with _____

Reference:

1) Your letter No. _____ Dated _____ with sealed packed weapon.

2) Injury Report / MLPM No.: _____ issued by _____ Date: _____

Sir,

With reference to the above letter, I am sending the report about the weapon sent in sealed condition in connection with the injuries of _____

Name of weapon: _____

Kind of weapon: _____

Type of weapon: _____

Description of the weapon:

Weight of weapon: _____ (gm)

Length: _____ Breadth / Maximum circumference: _____

Thickness: _____

Surface: _____

Texture: _____

Stains / Foreign body if any: _____

Opinion:

Injuries possible by above weapon:

Identification marks if any on the weapon.

(Put the signature on the weapon)

The weapon was packed, sealed and handed over to _____ of police station _____ for forwarding to FSL for chemical analysis.

Place: _____

Date & Time: _____

Receipt of weapon and report

(Impression of seal)

Signature

Name of Doctor _____

Designation _____

10. Medico-legal Examination of Survivors / Victims of Sexual Violence

Definition of Rape:

CONFIDENTIAL

Medico-legal Examination Report of Sexual Violence

- 1. Name of the Hospital _____ OPD No. _____ Inpatient No. _____
- 2. Name _____ D/o or S/o (where known) _____
- 3. Address _____
- 4. Age (as reported) _____ Date of Birth (if known) _____
- 5. Sex (M/F/Others) _____
- 6. Date and Time of arrival in the hospital _____
- 7. Date and Time of commencement of examination _____
- 8. Brought by _____ (Name & signatures)
- 9. MLC No. _____ Police Station _____
- 10. Whether conscious, oriented in time and place and person _____
- 11. Any physical/intellectual/psychosocial disability _____

(Interpreters or special educators will be needed where the survivor has special needs such as hearing/speech disability, language barriers, intellectual or psychosocial disability.)

12. Informed Consent/refusal

I _____ D/o or S/o _____

hereby give my consent for:

- a) Medical examination for treatment Yes/No
- b) This medico-legal examination Yes/No
- c) Sample collection for clinical & forensic examination Yes/No

I also understand that as per law the hospital is required to inform police and this has been explained to me. I want the information to be revealed to the police Yes/No

I have understood the purpose and the procedure of the examination including the risk and benefit, explained to me by the examining doctor. My right to refuse the examination at any stage and the consequence of such refusal, including that my medical treatment will not be affected by my refusal, has also been explained and may be recorded. Contents of the above have been explained to me in _____ language with the help of a special educator/interpreter/support person (circle as appropriate) _____.

If special educator/interpreter/support person has helped, then his/her name and signature _____

Name & signature/thumb impression of Witness

With Date, time and place

Name & signature of survivor or parent/Guardian/person in whom the child reposes trust in case of child (<12 yrs)

With Date, time and place

13. Marks of identification (Any scar/mole):

(1) _____

(2) _____



Left Thumb impression

15C.

- i. Emotional abuse or violence if any (insulting, cursing, belittling, terrorizing) _____
- ii. Use of restraints if any _____
- iii. Used or threatened the use of weapon(s) or objects if any _____
- iv. Verbal threats (for example, threats of killing or hurting survivor or any other person in whom the survivor is interested; use of photographs for blackmailing, etc.) if any: _____
- v. Luring (sweets, chocolates, money, job) if any _____
- vi. Any other: _____

15D.

- i. Any H/O drug/alcohol intoxication: _____
- ii. Whether sleeping or unconscious at the time of incident: _____

15E. If survivor has left any marks of injury on assailant/s, enter details: _____

15F. Details regarding sexual violence:

Was penetration by penis, fingers or object or other body parts (Write Y=Yes, N=No, DNK=Don't know) Mention and describe body part/s and/or object/s used for penetration.

Orifice of victim	Penetration			Emission of semen		
	By penis	By body part of self or assailant or third-party finger, tongue or any other)	By object	Yes	No	Don't know
Genitalia (vagina and/or urethra)						
Anus						
Mouth						

Oral sex performed by assailant on survivor	Y	N	DNK
Forced masturbation of self by survivor	Y	N	DNK
Masturbation of assailant by survivor, forced manipulation of genitals of assailant by survivor	Y	N	DNK
Exhibitionism (perpetrator displaying genitals)	Y	N	DNK
Did ejaculation occur outside body orifice (Vagina/anus/mouth/urethra)?	Y	N	DNK
If yes, describe where on body			
Kissing, licking or sucking any part of survivor's body	Y	N	If yes, describe
Touching/ fondling	Y	N	If yes, describe
Condom used*	Y	N	DNK
If yes, status of condom	Y	N	DNK
Lubricant used*	Y	N	DNK
If yes, describe kind of lubricant used			
If object used, describe object:			
Any other form of sexual violence			

*Explain what condom and lubricant is to the survivor

Post incident has the survivor	Yes/No/Do not know	Remarks
Changed clothes		
Changed undergarments		
Cleaned/washed clothes		
Cleaned/washed clothes undergarments		
Bathed		
Douched		
Passed urine		
Passed stools		
Rinsing of mouth/brushing/vomiting (circle any or all as appropriate)		

Time since incident _____

H/o vaginal/anal/oral bleeding/discharge prior to the incident of sexual violence _____

H/o vaginal/anal/oral bleeding/discharge since the incident of sexual violence _____

H/o painful urination/ painful defecation/ fissures/ abdominal pain/pain in genitals or any other part since the incident of sexual violence _____

16. General Physical Examination-

i. Is this the first examination _____

ii. Pulse _____ BP _____

iii. Temp _____ Resp. Rate _____

iv. Pupils _____

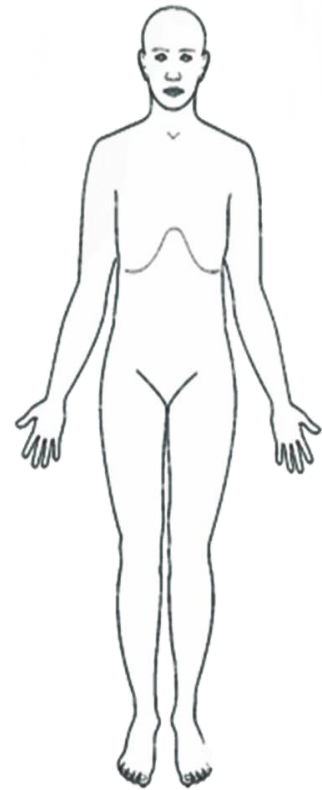
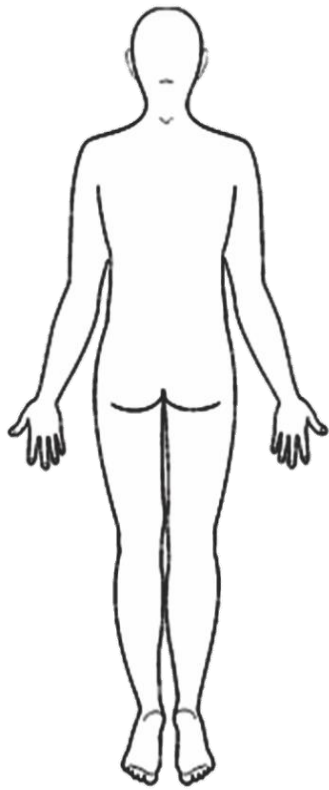
v. Any observation in terms of general physical wellbeing of the survivor _____

17. Examination for injuries on the body if any

The pattern of injuries sustained during an incident of sexual violence may show considerable variation. This may range from complete absence of injuries (more frequently) to grievous injuries (very rare).

(Look for bruises, physical torture injuries, nail abrasions, teeth bite marks, cuts, lacerations, fracture, tenderness, any other injury, boils, lesions, discharge specially on the scalp, face, neck, shoulders, breast, wrists, forearms, medial aspect of upper arms, thighs and buttocks) Note the Injury type, site, size, shape, colour, swelling signs of healing simple/grievous, dimensions.)

Scalp examination for areas of tenderness, if hair pulled out/ dragged by hair)	
Facial bone injury: Orbital blackening, tenderness	
Petechial haemorrhages in eyes and other places	
Lips and Buccal mucosa/ gums	
Behind the ears	
Ear drum	
Neck, Shoulders and Breast	
Upper limb	
Inner aspect of upper arms	
Inner aspect of thighs	
Lower limb	
Buttocks	
Other, please specify	



18. Local examination of genital parts/other orifices*

A. External genitalia: record finding and state NA where not applicable.

Body parts to be examined	Findings
Urethral meatus and vestibule	
Labia majora	
Labia minora	
Fourchette and introitus	
Hymen	
Perineum	
External urethral meatus	
Penis	
Scrotum	
Testes	
Clitoropenis	
Labioscrotum	
Any other	

B. Per Vaginum /Per Speculum examination should not be done unless required for detection of injuries or for medical treatment.

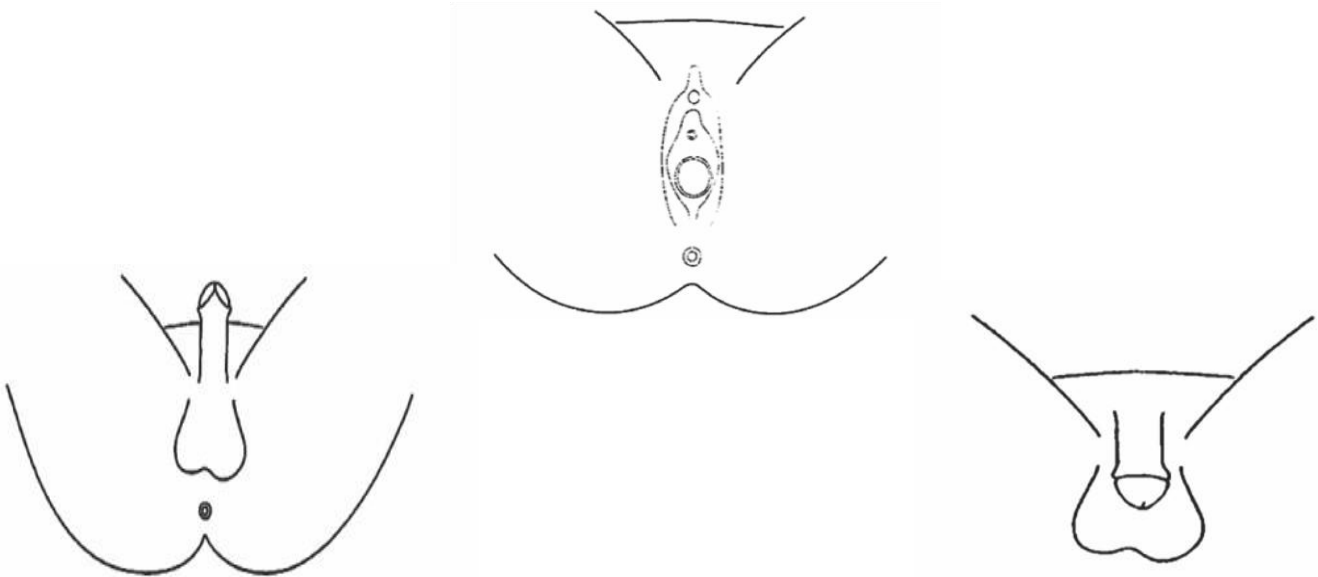
P/S findings if performed _____

P/V findings if performed _____

Record reasons if P/V of P/S examination performed _____

C. Anus and Rectum (encircle the relevant)
Bleeding/tear/discharge/oedema/tenderness

D. Oral Cavity - (encircle the relevant)
Bleeding/ discharge/ tear/oedema/ tenderness



19. Systemic examination:

- 1) Central Nervous System: _____
- 2) Cardio Vascular System: _____
- 3) Respiratory System: _____
- 4) Chest: _____
- 5) Abdomen: _____

20. Sample collected/ Investigations for hospital laboratory/ clinical laboratory:

1. Blood for HIV, VDRL, HbsAg _____
2. Urine test for pregnancy _____
3. Ultrasound for pregnancy/ internal injury _____
4. X-ray for injury _____

21. samples collection for central /state forensic laboratory.

1. Debris collection paper _____
2. Clothing evidence where available-(to be packed in separate paper bags after air drying)

List of Details of clothing worn by the survivor at time of incident of sexual violence

3. Body evidence samples as appropriate (duly labelled and packed separately)

	Collected/ Not collected	Reason for not collecting
Swabs from stains on the body (Blood, semen, foreign material, others)		
Scalp hairs (10-15 strands)		
Head hair combing		
Nail scrapings (Both hands separately)		
Nail clippings (Both hands separately)		
Oral swab		
Blood for grouping, testing drug/ alcohol intoxication (plain vial)		
Blood for alcohol levels (Sodium fluoride vial)		
Blood for DNA analysis (EDTA vial)		
Urine (drug testing)		
Any other (tampon/sanitary napkin/condom/object)		

4. Genital and anal evidence (each sample to be packed, sealed and labelled separately to be placed in bag).
 * swab sticks for collecting samples should be moistened with distilled water provided.

	Collected / Not collected	Reason for not collecting
Matted pubic hair		
Pubic hair combing (mention if shaved)		
Cutting of pubic hair (mention if shaved)		
Two vulval swabs (for semen examination and DNA testing)		
Two vaginal swabs (for semen examination and DNA testing)		
Two anal swabs (for semen examination and DNA testing)		
Vaginal smear (air-dried) for semen examination		
Vaginal washing		
Urethral swab		
Swab from glans penis/ clitoropenis		

*samples to be preserved as directed till handed over to police along with duly attested sample seal.

11. Examination of Accused of Sexual Violence

Name of Hospital: _____

OPD/ IPD No: _____ MLC No : _____ Date : _____

1. Case Particulars:

Requisition from _____ vide letter No. _____ Dated _____
brought and identified by _____

2. Particulars of the alleged accused:

i. Name: _____ S/o _____

ii. Address: _____

iii. Age as stated _____ iv. Occupation _____

v. Married/Single/Divorcee _____ vi. Religion: _____

vii. Marks of Identification:

(a) _____ (b) _____

viii. Examined in presence of (name with signature) _____

3. Consent given in writing

I _____ hereby voluntarily consent and agree to following
(Mark each that applies)

- a) Medical examination and examination of genitals, examination of other secondary sexual characters and examination of other body parts.
- b) Collection of samples for medical and Forensic examination and treatment.

All this has been explained to me in the manner and language, which I can understand



Left Thumb impression

Signature of accused/ Guardian

Note: Age estimation is mandatory if the alleged accused is minor

4. Brief History:

i. As given by police: _____

ii. As given by alleged accused:

- a. If he admits or denies the incidence(Account of incidence as per his statement)
- b. Did he know the victim before? _____
- c. Date and time of incidence: _____
- d. Any history of S.T.D : YES / NO _____
- e. Did he take bath, wash etc. after the alleged incidence? : YES / NO _____
- f. Has he changed clothes after the incidence? : YES / NO _____
- g. Condom used while sexual intercourse: YES / NO _____
- h. Frequency and number of sexual intercourse: _____
- i. Brief description of acts of penetration/ejaculation: _____
- j. History of alcohol/other drug abuse: _____
- k. Allergies: _____ Current medication: _____
- l. Any Relevant Surgical history: _____
- m. Any other: _____

5. Physical examination:

Clothing: If same was worn during the incidence look for presence of blood stains, semen, vaginal stain, female pubis hair, mud, grass, lipstick, any tear etc. and describe

6. General examination:

Height: _____ Weight: _____ Body Built: _____

Blood Pressure: _____ Pulse: _____ RR: _____

Axillary hair: _____

Beard & Moustaches: _____

Pubic hair (including tanner staging) _____

Dentition: (8/8) _____

7. Systemic Examination

CNS : (Mental status) _____

CVS: _____ RS: _____

8 Marks of violence if any (Tick mark if present and describe):

Bite marks: _____

Abrasions: _____

Contusions: _____

Any other: _____

9. Genital Examination:

a. (Indicate as Y = Yes, N = No)

Observation	Pubic region	Thigh and adjoining part
Matted hair		
Seminal stain		
Blood		
Loose foreign hair		

b. Penis:

Observations	Remark
Development (Tanner Stage)	
Any defect/ Deformity	
Whether foreskin can be freely rolled up or is circumcised	
Evidence of any disease e.g. STD	
Presence of smegma under the foreskin	
Hair under prepuce	
Any stains nearby	

Injuries over Genital:

Prepuce: _____

Glans penis: _____

Frenulum: _____

Scrotum: _____

Any other: _____

10. Sample collection for Hospital/Clinical Laboratory

Sr No	Sample Name	Test For	Preservative/ Packing collected?	Yes/No
1.	Urethral Swab	Microscopy& Culture	Plain Sterile Bulb	
2.	Swab from discharge	Microscopy& Culture	Plain Sterile Bulb	
3.	Blood	Serology (For STD and Hep. B)	Plain Sterile Bulb	
4.	Urine (midstream)	Microscopy& Culture	Plain Sterile Bulb	

Note: Every forensic examination room should have adjacent laboratory for detection of sperms and vaginal epithelium (Lugol's iodine test).

11. Collection of Samples for Forensic Analysis:

- a) Clothing, where available (Each garment to be wrapped separately and packed in paper bags after air drying)
-
-

b) Sample collection for Forensic science laboratory:

Sr No	Name of sample	Test (for evidence of)	Preservative / Packing	Collected YES/NO
1	Clothes (outer & inner)	For identification of any biological stains/ material from victim and scene of crime	Paper envelope	
2	Matted pubic hair	For detection of semen and identification of any hairs from victim	Paper envelope	
3	Combed pubic hairs	To identify foreign hairs by comparing with victim	Paper envelope	
4	Scalp hairs (10 to 15)	For comparison those found on victim and scene of crime	Paper envelope	
5	One swab & smear from prepuce, coronal sulcus	For detection of vaginal/buccal epithelial cells and DNA	Sterile tube & Paper envelope	
6	One swab & smear from glans and urethral meatus	For detection of vaginal/buccal epithelial cells and DNA	Sterile tube & Paper envelope	
7	Scrotal swab and smear	For detection of any biological stains	Sterile tube	
8	Swab and smear from stains on body	For detection of any biological stains	Sterile tube & Paper envelope	
9	Penile washing	For detection of vaginal/buccal epithelial cells and DNA	Sterile tube	
10	Buccal swab and smear	For detection of any biological stains and DNA	Paper envelope	
11	Nail clipping / scrapping	For detection of skin, blood, hair fiber of victim if human tissue blood group and DNA	Paper envelope	
12	Blood	Blood grouping	Plain bulb	
13	Blood	DNA analysis	EDTA bulb	
14	Blood	Drugs /alcohol	Fluoride and oxalate bulb	
15	Urine	Drugs /alcohol	Fluoride bulb	
16	Other object if any swab and smear	For detection of vaginal/buccal epithelial cells and DNA	Sterile tube & Paper envelope	

Note: Samples must be collected as per time elapsed between assault and examination, history received from alleged accused and clinical examination.

12. Provisional opinion:

I have examined _____ Sex _____

Aged _____ reporting on dated _____, _____ days/hours after the incidence.

My findings are as follows:

- Samples collected (for FSL): _____
- Samples collected (for hospital laboratory): _____
- Significant clinical findings: _____
- Additional observations (if any): _____

“The Opinion is kept pending awaiting the above laboratory reports”.

(This report contains _____ number of sheets and _____ number of envelopes.)

Place: _____

Signature of examining doctor _____

Name of examining doctor _____

Seal

13. Final Opinion (After receiving Lab reports)

Taking into consideration the history of the case, the data on clinical examination and the report of FSL (all being considered together) and other investigations

- A. 1. Penetrative sexual assault i.e., of vaginal/ anal/ urethral/ oral penetration by the male sex organ. (when presence of genital & physical injuries & the subject’s penile washings show vaginal / buccal epithelium or faecal matter)
- 2. Sexual assault by objects other than genitals (when presence of physical injuries & the object shows presence of vaginal /buccal epithelium or faecal matter)
- 3. No sexual and penetrative assault.

B. Intoxications (Lab report positive for drugs/alcohol)

C. Injuries suggestive of sexual assault (when presence of genital & physical injuries over body & the subject’s penile washings are negative for vaginal/buccal epithelium or faecal matter)

D. Any other comments: _____

Place: _____

Signature of examining doctor/s _____

Date & Time: _____

Name of examining doctor/s _____

Seal

12. Potency Certificate

Name of the Hospital: _____ MRD No: _____

Name of Person: _____

Age: _____ yrs, Sex: _____, Marital Status: _____

Address: _____

Brought By: _____

MLC No: _____ (If Applicable)

Consent: _____

(This consent is explained to patient in _____ language)

Signature/Thumb impression

Identification Mark:

1. _____

2. _____

3. Left Thumb Impression



History:

1. Present History: _____

2. Past History: _____

3. Sexual History: _____

Examination:

1. General Examination:

i) Height: _____

ii) Weight: _____

iii) Physical Development: _____

iv) Secondary Sexual Characters: _____

v) Any Disease / Deformity: _____

vi) Examination of spine: _____

Systemic Examination

- i) C.V.S.: _____
- ii) R.S.: _____
- iii) G.I.T.: _____
- iv) C.N.S. _____

2. Local Examination:

- i) Penis: _____
Development: _____
Sensation over glans: _____
Disease / Deformity: _____
Injury: _____
Any other: _____
- ii) Scrotum: _____
Testis: _____
Descended / Undescended: _____
Disease / Deformity: _____
- iii) Epididymis / Spermatic Cord: _____

3. Psychological Examination

4. Laboratory Test:

- 1.
- 2.
- 3.
- 4.
- 5.

Opinion: _____

Date: -
Place: -

Seal

Signature
Name of Doctor _____
Designation _____

13. Examination of Alcoholic Person (Drunkenness)

AIM:

- a) To decide whether the subject is under the influence of alcohol, and if so to what extent.
- b) To decide whether his condition is due to illness or injury;
- c) To decide whether it is safe for him to be detained in a police station or to decide whether he is to be admitted to a hospital.

A doctor should attend the case as soon as possible without any delay.

DEFINITION:

Drunkenness: 'It is a condition produced in a person who has taken alcohol in a quantity sufficient to cause him to lose control of his faculties to such an extent, that he is unable to execute safely, the occupation in which he is engaged at the particular time.'

Use of alcohol in human population –

Laboratory investigations –

Clinical Interpretation

a). The individual examined has not consumed alcohol.

No smell of alcohol in breath and / or lab analysis is negative, clinical examination normal.

b) The individual examined has consumed alcohol but not under influence of it.

Smell of alcohol in breath present and / or lab. Analysis reveals the presence of alcohol, but clinical examination reveals normal findings.

c) The individual examined has consumed alcohol and is under influence of it.

Smell of alcohol in breath present and / or lab. Analysis reveals the presence of alcohol, and clinical examination reveals *abnormal* findings (definite signs of muscular in co-ordination, dilated pupils with sluggish reaction to light, fine lateral nystagmus, slurred in-coherent speech, staggering gait, delayed reaction time, etc).

Under the influence (100 -200mg%) – flushed face, dilated sluggish pupil, euphoria, loss of restrain, increased reaction time, test errors, stagger on sudden turning.

Drunk (200-300mg%) - flushed face, dilated sluggish inactive pupils, clouding of intellect, incoordination of thoughts, speech and action, staggering gate with reeling and lurching while making sudden turn.

Very drunk – flushed or pale face, pupils inactive contracted or dilated, mental confusion, marked incoordination of thoughts, speech and action, staggering and reeling gate with tendency to lurch and fall, vomiting, amnesia.

Differential Diagnosis of Alcohol Intoxication

Head injury. Cerebral tumour, Incipient C.V.A., Epilepsy, Disseminated sclerosis. Acute aural vertigo. Hypoglycaemia, Hyperglycaemia, Thyrotoxicosis, Delirium. Uraemia, Hepatic failure. Fatigue, Carbon monoxide poisoning, Hypomania, Psychosis, Hysteria and, Drugs esp. *Insulin, Barbiturates, Antihistamines, Narcotics, Sedatives, Antidepressants.*

Medico-Legal Aspects of Drunkenness

Drunkenness and criminal responsibility –

- **Sec 85 IPC** – act of a person incapable of judgment of reason of intoxication caused against his will.
- **Sec 86 IPC** – offence requiring a particular intent or knowledge, committed by one who is intoxicated.

Drunkenness and consent –

- **Sec 90 IPC** – the consent given by an insane or intoxicated person who is unable to understand the nature and consequences of that to which he gives his consent is invalid.

Drunkenness and driving –

- **Sec 185 of Motor Vehicle Act (1988, Amend. 1994)** – 30 mg%
- **Sec 279 IPC** – Rash driving on a public way
- **Sec 287 IPC** – Negligent conduct with respect to machines.

Drunkenness and disturbance of the peace –

- **Sec 510** – Misconduct in by drunken person

Medico-legal examination

- **Sec 53 & 54 Cr.P.C**
Bombay High court ruling – collection of samples does not violate constitutional right to privacy

Examination of Alcoholic Person (Drunkenness)

Date:

To,

The Investigating officer,

_____ Police station _____

Subject: Regarding examination of person with alleged history of intoxication.

Reference: Your letter No _____ Dated _____ Police Station _____

Date and Exact time of examination:

Name of Person examined _____, Age _____ (in years)

Address: _____ Occupation: _____

Consent: (Informed consent) _____

(This consent is explained to patient in _____ language)

Signature / Thumb impression
(Subject/Guardian)

Examined in presence of-
Signature/Thumb impression-

Identification marks: (At least two unique identification marks)

i) _____

ii) _____

iii) Left Thumb Impression



History:

As stated by person examined _____

a. Has he consumed alcohol? If so, note the time, nature & quantity of the drink? _____

b. What food and drink he took last and when? _____

c. H/o fits, illness or other disability? _____

d. Is he Chronic alcoholic? Frequency of alcohol intake? _____

e. History of any medication? Nature & dose? _____

f. H/o Diabetes? Time of insulin taken & dose taken? _____

General appearance and demeanor:

- a. State of clothing- Decent, disarrayed, soiled
- b. Disposition- Calm, talkative, abusive, obscene
- c. Speech- Incoherent/ slurred/clear
- d. Gait- Steady/ staggering, self-control

General examination-

- 1) B.P.: _____
- 2) Pulse (rapid & bounding, slow, etc.): _____
- 3) Temperature (surface temp. raised, lowered, normal): _____
- 4) Skin (dry, moist, flushed or pale): _____
- 5) Mouth (smell of alcohol, dribbling of saliva, _____
furred tongue, dry lips, etc.): _____
- 6) Eyes (lids swollen or red, conjunctivae congested or _____
not, visual acuity, pupils dilated or contracted, _____
nystagmus (+/-) & reaction of pupil to light & accommodation): _____
- 7) Gait:
 - (a) Manner of walking (unsteady/ steady). _____
 - (b) Reaction time to a direction to turn. _____
 - (c) Manner of turning (normal/ staggering). _____
- 8. Muscular coordination: _____

(Perform any of the test enumerated below

- a. Walking along a straight line, b. Finger nose test _____
- c. Picking up a coin from the floor, d. Romberg's sign/test _____
- e. Handwriting, f. Copying simple geometric figures) _____

Examination of System (to exclude any other condition)

- a. Central Nervous system _____
- b. Cardiovascular system _____
- c. Respiratory System _____
- d. Abdomen _____

Examination of bodily Injuries (If any): _____

Laboratory investigation:

Blood / Urine for chemical examination: _____

Any other: _____

Diagnosis: _____

Opinion: I am of opinion that the above person has:

- (1) Consumed alcohol and is under its influence.
- (2) Consumed alcohol, but is not under its influence.
- (3) Not consumed alcohol.

Place:

Signature of Doctor:

Date:

Name:

Designation:

Chapter—XIII—Blood Test

{136} THE BOMBAY PROHIBITION (MEDICAL EXAMINATION AND BLOOD TEST) RULES, 1959

“**Registered Medical Practitioner**” means any registered medical practitioner authorised by general or special order by the State Government under sub-section (4) of section 129-A of the Act;

“**Testing Officer**” means the Chemical Examiner or assistant Chemical examiner to government or any other officer appointed by the State Government for testing blood under sub-section (1) of section 129-A of the Act.

Medical examination.—A registered medical practitioner before whom a person is produced under sub-section (1) of section 129-A of the Act by a Police Officer or a Prohibition Officer for the purpose of medical examination of such person or collection of his blood, shall examine such person and if he deems necessary, collect and forward in the manner prescribed in these Rules, the blood of such person and furnish to the officer by whom such person was produced a certificate in Form ‘A’ containing the result of his examination and shall keep a copy of such certificate on his record.

Manner of collection and forwarding of blood—

- (1) The registered medical practitioner shall use a syringe for the collection of the blood of the person produced before him under rule 3 the syringe shall be sterilised by purring in boiling water before it is used for the aforesaid purpose. He shall clean with sterilized water and swab the skin surface of the part of such person’s body from which he intends to withdraw the blood. No alcohol shall be touched at any stage while withdrawing blood from the body of the person. He shall withdraw not less than 5 c. c. of venous blood in the syringe from the body of the person. The blood collected in the syringe shall then be transferred into a phial containing anti-coagulant and preservative and the phial shall then be shaken vigorously to dissolve the anti-coagulant and preservative in the blood. The phial shall be labelled and its cap sealed by means of sealing wax with the official seal or the monogram of the registered medical practitioner.
- (2) The sample blood collected in the phial in the manner stated in sub-rule (1) shall be forward for test to the Testing Officer either by post or with a special messenger so as to reach him within seven days from the date of its collection. It shall be accompanied by a forwarding letter in form ‘B’ which shall bear a facsimile of the seal or monogram used for sealing the phial of the sample blood.

Certificate of test of sample blood. —The Testing Officer shall on receipt of the sample blood, test it and shall certify the result of his test in Form ‘C.’ The Testing Officer shall send the certificate in duplicate to the registered medical practitioner by whom the blood was forwarded to him for test and retain a copy thereof on his record. On receipt of the certificate from the Testing Officer, the registered medical practitioner shall forward the original copy of the certificate to the Police Officer or the Prohibition Officer concerned. The duplicate copy of the certificate shall be kept by him on his record.

FORM 'A'

(See rule 3)

Certificate by a registered medical practitioner showing whether a person examined by him has or has not consumed an intoxicant.

Serial No. _____ (Name and location of the Dispensary or Hospital)

Certified that Shri/Smt./Kumari. _____

of _____ was brought to this hospital/dispensary by _____

_____ (here state name and designation of the Officer) on _____ 20____, at _____ A.M./P.M.

and was examined by me on _____ 20____, at _____ A.M./P.M

A clinical examination of the above-named person disclosed the following:

Age _____

Weight _____

Breath : Smelling
(Alcohol / ganja / bhang/ charas / opium) Not smelling

Speech : Incoherent
Normal

Gait : Unsteady
Steady

Pupils : Dilated
Normal

Additional remarks, if any. : _____

I find that the above-named person has consumed alcohol/opium/ charas/ ganja/ bhang.
has not consumed any intoxicant.

I also find that he is
is not under the influence of alcohol.

N. B.—

(Blood from the body of the above named was
was not collected by me for chemical examination).

Dated: _____ 20____ (Signature) _____

Place: _____ Designation _____

Signature/Thumb-impression
of the person examined.

Marks of identification of the person examined in case he refuses to give his signature or thumb-impression.

FORM 'B'
[See rule 4 (2)]

No. _____

From

(Name, designation and address of the registered medical practitioner.)

To,

(Name, designation and address of the Testing Officer.)

Dated _____ 20

Sir,

I, forward herewith by post/with Shri* _____
of _____ a phial bearing serial No. _____
containing _____ c. c. of venous blood collected by me on _____
at. _____ A.M./P.M. of _____
who was produced before me for medical examination † and / or collection of blood from his / her body
‡ by _____
and request you to test the blood and issue a certificate (in duplicate) regarding the result of the test.

Yours faithfully,
Signature and designation of the
registered medical practitioner.

Facsimile of the seal or monogram used for
sealing the phial containing the blood.

* Here specify the name, designation and address of the messenger with whom the phial containing the blood is forwarded for delivery to the Testing Officer.

† Strike off, if these words are not required.

‡ Here state the name and designation of the officer by whom the said person was produced for collection of blood.

FORM 'C'

(See rule 5)

Alcohol Examination Certificate

No. R _____ of _____

I. Case No. _____

Dated _____

From,

(Here mention name, designation and address of testing officer.)

To,

(_____,
(Here mention the name, designation and address of Registered Medical Practitioner.)

Your letter No. _____ Dated _____, forwarding a phial containing blood of
Shri/Smt./Kumari. _____
of _____ bearing Serial No. _____
labelled. _____ received here on _____
by post/with messenger Shri _____ of _____
sealed/unsealed, seal perfect and as per copy sent/seals intact device no copy sent.

Result of the test of the blood

The blood contained _____ per cent. W/V of ethyl-alcohol.

Method, Factual Data and Reasons leading to the Result of Blood analysis

(1) *Method of Analysis*—Modified Cavette's Method Journal Analytical Chemistry, 1959, 31, 1908. It is based on oxidation of alcohol by chromic acid as that in Cavette's Method but the oxidation is carried out in vacuum and at room temperature. It takes only a fraction of a minute instead of a few hours to complete the reaction. Ketonic bodies are volatile acids do not interfere in this method. All usual precautions essential in microanalytical work mentioned in the paper referred to above have been strictly followed, e.g., all chemical used in the test were of reagent quality the apparatus was first cleaned with hot chromic acid, then repeatedly with tap water and finally with distilled water. 2[It was then dried in hot air oven.] No grease was used anywhere in the apparatus. The atmosphere of the room where the test was carried out was free from all gases or suspended impurities. Fresh glass-distilled water used throughout the test.

(2) *Factual Data and Reasons for arriving at the findings pertaining to the blood sample in question.*-

Analysed on _____

Smell: Nothing to note/Has characteristic smell of _____

Quantity of blood taken for analysis : 0.5 ml.

Quantity of N/20 dichromate taken : 5.00 ml.

Quantity of N/20 dichromate used up in oxidising alcohol in the sample _____ ml.

1 ml. of N/20 dichromate oxidises 0.000575 gramme of ethyl-alcohol.

2[Therefore, 100 ml. of blood contained. $0.000575 \times$ _____ ml. of dichromate used $\times 100$
_____ gramme of 0.50 ethyl-alcohol.]

Signature and Designation of testing officer

Note.—(1) WV = _____ grammes of ethyl-alcohol in 100 c. c. of blood.

(2) The blood sample was stored in refrigerator from the time it was received in the laboratory till it was taken for analysis.

1. Subs. by G. N. of 26-9-1963.

2. Subs. by G. N. of 6-12-1963.

Format of Medico-Legal report of a person in Police, Judicial Custody or Referred by court of Law and Violation of Human rights as requirement of NMRC, who has been brought for Medical Examination.

14. Medico-Legal Examination of person at the time of entry into in Police / Judicial Custody and periodically thereafter

To, _____ Date: _____
The Investigating Officer,
_____ Police station, _____

Sub: - Submission of Medico-legal report of person in Police / Judicial Custody

Ref: - 1. Your Order / letter No. _____ Dated _____
2. Case No. _____

Sir,

I /We hereby certify that, I/We have examined Mr./Mrs. _____

S/O or D/O _____ Age (as Stated) _____ Sex _____

Residing at _____ as a person in police / Judicial custody
brought by PC/PN/HC _____ of _____ Police station.

Consent for Medical Examination:

(This consent is explained to patient in _____ language)

Signature/Thumb impression
(Subject/Guardian)

Examined in presence of-
Signature/Thumb impression-

Date and time of admission in prison: _____

Identification Marks:

1. _____

2. _____

3 Left Thumb Impression

Previous history of illness: _____ **History of drug abuse, if any?** _____

Any information the prisoner may volunteer: _____

Physical Examination:

Hight _____ Weight _____ Pulse _____/sec BP _____/_____ of Hg

RR _____/ min Temperature _____ LMP: _____

Pallor: _____ Clubbing: _____ Cyanosis: _____ Icterus: _____

CNS _____ CVS _____

RS _____ GIT _____

Eye/ENT _____ Urinary system _____

Investigations, if any clinically required:

Pathological tests: _____

X-ray Chest: _____

ECG: _____

Blood tests: _____

Bodily Injuries if any:

(Please see for all body areas & Prepare Separate Injury report of if any injury/injuries are present)

(If any history of previous mental illness/ finding of suicidal tendencies etc., psychiatrist's opinion to be sought)

(The medical examination and investigations were conducted with the consent of the prisoner after explaining to him/ her that it was necessary for diagnosis and treatment.)

The Medical examination done on Mr. _____, By Me/Us bearing above mentioned identification marks does not show any disease, constitutional weakness or bodily infirmity except _____ (NIL)

$$\frac{\text{He}}{\text{She}} \text{ is } \frac{\text{- Fit.}}{\text{-Temporary Unfit.}} \\ \text{- Unfit.}$$

Time of commencement of medical examination:

Date of completion of medical examination:

Place: -

Seal: -

Signature

Name of Doctor _____

Designation _____

Part- II
Medico-legal Articles

Photographs

I. Post-mortem lividity



1. Identify the photograph- _____

2. Observations- _____

3. Medicolegal Importance (MLI)- _____

II. Decomposition changes-



1. Identify the photograph- _____

2. Observations- _____

3. Medicolegal Importance (MLI)- _____

III. Decomposition changes-



1. Identify the photograph- _____

2. Observations- _____

3. Medicolegal Importance (MLI)- _____

IV. Injury-

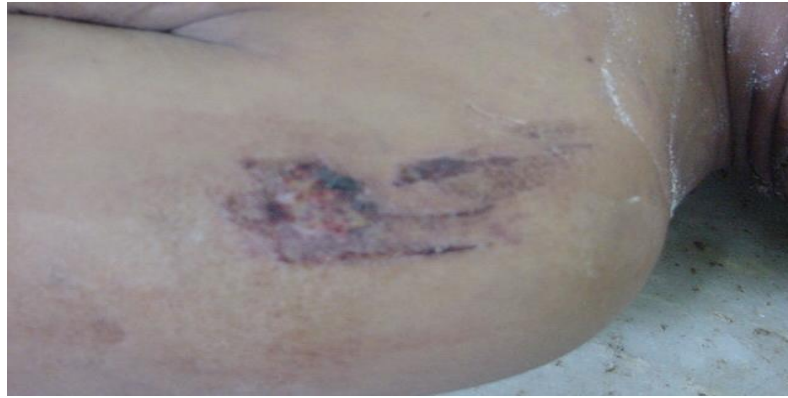


1. Identify the photograph- _____

2. Observations- _____

3. Medicolegal Importance (MLI)- _____

V. Injury-



1. Identify the photograph- _____

2. Observations- _____

3. Medicolegal Importance (MLI)- _____

VI. Injury



1. Identify the photograph- _____

2. Observations- _____

3. Medicolegal Importance (MLI)- _____

VII. Injury-



1. Identify the photograph- _____

2. Observations- _____

3. Medicolegal Importance (MLI)- _____

VIII. Injury



1. Identify the photograph- _____

2. Observations- _____

3. Medicolegal Importance (MLI)- _____

IX. Injury-



- 1. Identify the photograph- _____

- 2. Observations- _____

- 3. Medicolegal Importance (MLI)- _____

X. Injury-



- 1. Identify the photograph- _____

- 2. Observations- _____

- 3. Medicolegal Importance (MLI)- _____

XI. Injury-



1. Identify the photograph- _____

2. Observations- _____

3. Medicolegal Importance (MLI)- _____

XII. Injury and identification-



1. Identify the photograph- _____

2. Observations- _____

3. Medicolegal Importance (MLI)- _____

XIII. Injury-



- 1. Identify the photograph- _____

- 2. Observations- _____

- 3. Medicolegal Importance (MLI)- _____

XIV. Injury-



- 1. Identify the photograph- _____

- 2. Observations- _____

- 3. Medicolegal Importance (MLI)- _____

XV. Asphyxia-



- 1. Identify the photograph- _____

- 2. Observations- _____

- 3. Medicolegal Importance (MLI)- _____

XVI.



- 1. Identify the photograph- _____

- 2. Observations- _____

- 3. Medicolegal Importance (MLI)- _____

Asphyxia-



1. Identify the photograph- _____

2. Observations- _____

3. Medicolegal Importance (MLI)- _____

XVII.



1. Identify the photograph- _____

2. Observations- _____

3. Medicolegal Importance (MLI)- _____

XVIII.



- 1. Identify the photograph- _____

- 2. Observations- _____

- 3. Medicolegal Importance (MLI)- _____

XIX.



- 1. Identify the photograph- _____

- 2. Observations- _____

- 3. Medicolegal Importance (MLI)- _____

XX.



1. Identify the photograph- _____

2. Observations- _____

3. Medicolegal Importance (MLI)- _____

XXI.



1. Identify the photograph- _____

2. Observations- _____

3. Medicolegal Importance (MLI)- _____

XXII.



1. Identify the photograph- _____

2. Observations- _____

3. Medicolegal Importance (MLI)- _____

XXIII.



1. Identify the photograph- _____

2. Observations- _____

3. Medicolegal Importance (MLI)- _____

Museum Specimens

Sr. No.	Observation	Identification / Opinion	Medicolegal Importance
1			
2			
3			
4			
5			

Sr. No.	Observation	Identification / Opinion	Medicolegal Importance
6			
7			
8			
9			
10			

Sr. No.	Observation	Identification / Opinion	Medicolegal Importance
11			
12			
13			
14			
15			

Sr. No.	Observation	Identification / Opinion	Medicolegal Importance
16			
17			
18			
19			
20			

Instruments

Sr. No.	Identification	Medico-legal Significance / Uses
1		
2		
3		
4		
5		

Sr. No.	Identification	Medico-legal Significance / Uses
6		
7		
8		
9		
10		

Sr. No.	Identification	Medico-legal Significance / Uses
11		
12		
13		
14		
15		

Sr. No.	Identification	Medico-legal Significance / Uses
16		
17		
18		
19		
20		

X-Rays

1.



Describe X-Ray: _____

Observation: _____

Opinion: _____

2.

Describe X-Ray: _____

Observation: _____

Opinion: _____



3.



Describe X-Ray: _____

Observation: _____

Opinion: _____

4.

Describe X-Ray: _____

Observation: _____

Opinion: _____



5.



Describe X-Ray: _____

Observation: _____

Opinion: _____

6.

Describe X-Ray: _____

Observation: _____

Opinion: _____



7.



Describe X-Ray: _____

Observation: _____

Opinion: _____

8.

Describe X-Ray: _____

Observation: _____

Opinion: _____



9.



Describe X-Ray: _____

Observation: _____

Opinion: _____

10 Describe X-Ray: _____

Observation: _____

Opinion: _____



11



Describe X-Ray: _____

Observation: _____

Opinion: _____

12 Describe X-Ray: _____

Observation: _____

Opinion: _____



13



Describe X-Ray: _____

Observation: _____

Opinion: _____

14 Describe X-Ray: _____

Observation: _____

Opinion: _____



15



Describe X-Ray: _____

Observation: _____

Opinion: _____





Poisons



Madar (*Calotropis Gigantea*)



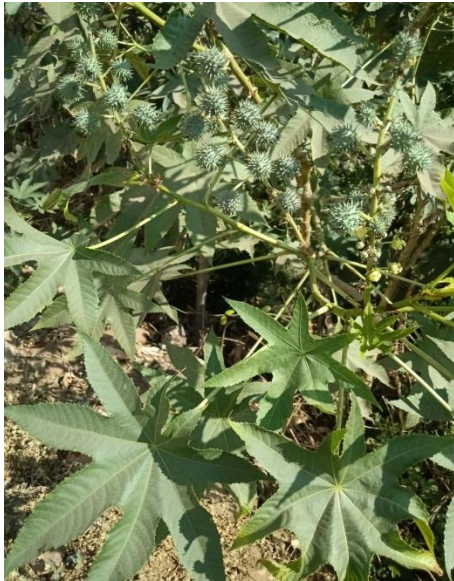
Yellow Oleander Plant
(*Cerbera Thevetia*)



Pink Kaner (*Nerium Odorum*)



Millipede



Castor Plant (*Ricinus Communis*)
with fruits



Castor Seeds (*Ricinus Communis*)



Ratti /Gunja seeds
(Abrus Precatorius)



Chilli seeds (Capsicum annum)



Marking Nuts/ Bhilawa
(Semecarpus anacardium)



Nux Vomica (Strychnine)



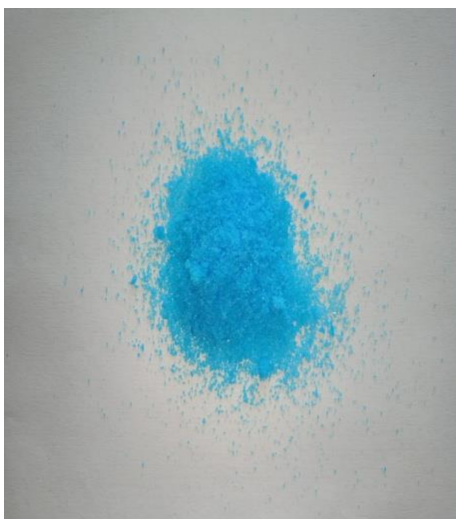
Tobacco (Nicotiana Tabacum)



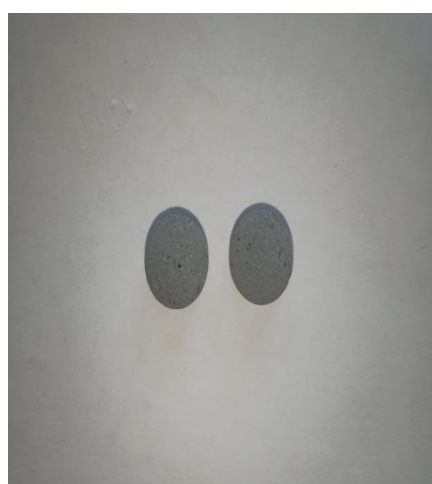
Datura Seeds



Bitter Almonds



Copper Sulphate Crystals



Aluminium Phosphide
(Celphos)



Poppy Seeds (Khaskhas)



Lead tetroxide (Sindur)



Alcohol (Ethanol)

Study of Common Poisons of Medico-legal Importance

Sr. No.	Name of Poison	Type of Poison	Physical Characters	Salient Clinical Features	Fatal Dose
1	Sulphuric Acid				
2	Nitric Acid				
3	Hydrochloric acid				
4	Carbolic Acid (Phenol)				

Fatal Period	Treatment	Post-mortem Features	Medicolegal Significance

Sr. No.	Name of Poison	Type of Poison	Physical Characters	Salient Clinical Features	Fatal Dose
5	Oxalic Acid				
6	Sodium Hydroxide				
7	Potassium Hydroxide				
8	Phosphorus				

Fatal Period	Treatment	Post-mortem Features	Medicolegal Significance

Sr. No.	Name of Poison	Type of Poison	Physical Characters	Salient Clinical Features	Fatal Dose
9	Lead Oxide				
10	Arsenic Oxide				
11	Mercuric Sulphide				
12	Copper Sulphate				

Fatal Period	Treatment	Post-mortem Features	Medicolegal Significance

Sr. No.	Name of Poison	Type of Poison	Physical Characters	Salient Clinical Features	Fatal Dose
13	Glass Powder				
14	Castor Seeds (Ricinus Communis)				
15	Croton Seeds (Croton Tiglium)				
16	Red chillies (Capsicum annum)				

Fatal Period	Treatment	Post-mortem Features	Medicolegal Significance

Sr. No.	Name of Poison	Type of Poison	Physical Characters	Salient Clinical Features	Fatal Dose
17	Marking Nut/ Bhilwa (Semicarpus Anacardium)				
18	Madar (Calotropis Gigantea)				
19	Ratti /Gunja (Abrus Precotorius)				
20	Dhatura (Thorn apple)				

Fatal Period	Treatment	Post-mortem Features	Medicolegal Significance

Sr. No.	Name of Poison	Type of Poison	Physical Characters	Salient Clinical Features	Fatal Dose
21	Bhang/ Ganja (Canabis Indica)				
22	Opium/ Afeem (Papaver Somniferum)				
23	Bitter Almond (Hydrocynic acid)				
24	Aconite (Mitha Jahar)				

Fatal Period	Treatment	Post-mortem Features	Medicolegal Significance

Sr. No.	Name of Poison	Type of Poison	Physical Characters	Salient Clinical Features	Fatal Dose
25	Yellow Oleander (Cerebra Thevecia)				
26	Nux Vomica (Strychnine)				
27	Snakes: Cobra				
28	Snakes: Krait				

Fatal Period	Treatment	Post-mortem Features	Medicolegal Significance

Sr. No.	Name of Poison	Type of Poison	Physical Characters	Salient Clinical Features	Fatal Dose
29	Snakes: Viper				
30	Scorpion				
31	Honey bees (sting Bite)				
32	Methyl Alcohol				

Fatal Period	Treatment	Post-mortem Features	Medicolegal Significance

Sr. No.	Name of Poison	Type of Poison	Physical Characters	Salient Clinical Features	Fatal Dose
33	Kerosene				
34	Barbiturates				
35	Organophosphorus compound (Follidon & Tik-20)				
36	Organo-chloro compound (D.D.T.)				

Fatal Period	Treatment	Post-mortem Features	Medicolegal Significance

Sr. No.	Name of Poison	Type of Poison	Physical Characters	Salient Clinical Features	Fatal Dose
37	Organo-chloro compound (Endrine)				
38	Carbamates (Carbaryl)				
39	Tobacco (Nicotiana Tobacum)				
40	Tincture Iodine				

Fatal Period	Treatment	Post-mortem Features	Medicolegal Significance

Sr. No.	Name of Poison	Type of Poison	Physical Characters	Salient Clinical Features	Fatal Dose
41	Celphos/ Alphos (Aluminium Phosphide)				
42	Amphetamines /Ecstasy / Designer drug				
43	Cocaine (Erythroxyllum coca)				
44	Mushrooms (Amanita Phalloides & Amanita Muscaria)				

Fatal Period	Treatment	Post-mortem Features	Medicolegal Significance

Sr. No.	Name of Poison	Type of Poison	Physical Characters	Salient Clinical Features	Fatal Dose
45	Paracetamol (Acetaminophen)				
46	Fish Poisoning				
47	Mother-in-law's tongue (Dumbcane) Dieffenbachia Snake plant (common)				
48					

Fatal Period	Treatment	Post-mortem Features	Medicolegal Significance

Sr. No.	Name of Poison	Type of Poison	Physical Characters	Salient Clinical Features	Fatal Dose
49					
50					
51					
52					

Fatal Period	Treatment	Post-mortem Features	Medicolegal Significance

Part- III
Medico-legal Autopsy

Medico-legal Autopsies observed by students

Sr. No.	<u>P.M. No./ Year</u> Date	Cause of Death	Signature
1	/		
2	/		
3	/		
4	/		
5	/		
6	/		
7	/		
8	/		
9	/		
10	/		
11	/		
12	/		
13	/		
14	/		
15	/		

Indoor/Casualty no:	PM No:
Hospital:	ADR No.:
	Police station:
Memorandum of a Post-mortem Examination held at _____ Hospital on the body	
of Name	, Age- Yrs, Sex , Religion
of village/City:	Taluka: District:
by Dr	/ _____ Hospital _____.

I. General Particulars: -

1. (a) By whom was the corpse sent?
 (b) Name of place from which sent.
 (c) Distance of place from which sent.
2. By whom was the corpse brought?
3. By whom identified?
 - i.
 - ii
4. (a) The date, hour and minute of its receipt.
 (b) The date, hour and minute of beginning of post mortem Examination
 (c) The date, hour and minute of ending of postmortem examination.
5. Substance of accompanying report from police office or magistrate, together with the date of death, if known.
 Supposed cause of death or reason, for examination.
6. If not examined at dispensary or hospital-
 (a) Name of place where examined -
 (b) Distance from Dispensary or hospital.
 (c) Reason why the body was not sent to the dispensary or hospital.

II. External Examination: -

7. Sex, apparent age, race or caste,
 Description of clothes and of ornaments on the body.
8. Condition of the clothes –
 Whether wet with water, stained with blood or soiled with vomit or faecal matter.
9. Special marks on the skin such as scars, tattooing etc, any malformations peculiarities or other marks of identification.
 State of the teeth.

In newly-born infants: -

- The length and (if possible), the weight of the body is to be recorded together with the state of the hair, nails and umbilical cord, its length, whether placenta is attached or not, and if present, its size and condition.
10. Condition of Body- Whether well nourished, thin or emaciated warm or cold.
11. Rigor Mortis- Well-marked, slight or absent whether present

12. Extent and signs of decomposition, presence or post-mortem lividity of buttocks, loins, back and thighs or any other part. Whether bullae present and the nature of the fluid it contains, condition of the cuticle.
13. Feature- Whether natural or swollen, state of eyes, position of tongue; nature of fluid (if any) oozing from mouth, nostrils or ears.
14. Conditions of skin etc.
In suspected drowning the presence or absence of cutaneous anserine is to be noted.
15. Injuries to external genitals.
Indication of purging.

16. Position of limbs- Especially of arms and of fingers or on the skin of hands and feet.

17. Surface wounds, and injuries- Their nature, position, dimensions (measured) and directions to be accurately stated- their probable age and causes to be noted.
If bruises be present, what is the condition of the subcutaneous tissues?
(N.B- When injuries are numerous and cannot be mentioned within the space available they should be mentioned on a separate paper which should be signed.)

18. Other injuries discovered by external examination or palpation of fractures etc.
18a. Can you say definitely that the injuries shown against serial nos. 17 and 18 are *ante-mortem injuries*?

III. Internal Examination: -

19. Head: -

(i) Injuries under the scalp and their nature.

(ii) Skull: vault and base-describe fractures their sites, dimensions, direction etc.

(iii) Brain: The appearance of its coverings, size, weight and general condition of the organ itself and any abnormality found in its examination to be carefully noted.

20. Thorax: -

- (a) Walls, ribs, cartilages
- (b) Pleura
- (c) Larynx, Trachea and bronchi
- (d) Right Lung with weight
- (e) Left Lung with weight
- (f) Pericardium
- (g) Heart with weight

- (h) Large vessels
- (i) Additional remarks

21. Abdomen: -

- (a) Walls -

- (b) Peritoneum -
- (c) Cavity-
- (d) Buccal cavity, teeth, tongue and pharynx-
- (e) Oesophagus-
- (f) Stomach and its contents-

- (g) Small intestine and its contents-
- (h) Large intestine and its contents-
- (i) Liver and gall bladder with weight-
- (j) Pancreas and suprarenals-
- (k) Spleen with weight.
- (l) Kidneys with weights
- (m) Bladder-
- (o) Organ of generation-

- (p) Additional remarks with, wherever possible, Medical Officer's deduction from the state of contents of the stomach as to the time of death and last meal.

- (q) State which viscera, (if any) have been retained for chemical examination and also quote the numbers on the bottles containing the same-

22. Spine and spinal cord-
23. a) Whether the ante-mortem injuries found on the dead body were sufficient in the ordinary course of nature to cause death?
- (b) If yes, which of the injuries were individually sufficient in the ordinary course of nature to cause death?
- (c) Which of the injuries collectively are sufficient in the ordinary course of nature to cause death?

Opinion as to the probable/Final cause of death: -

Sign

Name of Doctor and seal

PM no:

Dated:

*The spinal cord need not be examined unless there are any indications of disease, strychnine poisoning or injury.

Note: - The report must be written and signed immediately after the examination. Medical officers will at once dispatch a duplicate copy to the Civil Surgeon of their district for in his office.

Great care should be taken not to cut viscera before they have been inspected in *Situ*.

Post Mortem No. :-

, Dated:

1. Place:

Forwarded to the _____, P.S. _____ for information with reference to his No. / _____ of Dated: _____.

2. Viscera has been/ **not** been preserved.

Sign

Name of Doctor and seal

PM no:

Dated:

Indoor/Casualty no:	PM No:
Hospital:	ADR No.:
	Police station:
Memorandum of a Post-mortem Examination held at _____ Hospital on the body	
of Name	, Age- Yrs, Sex , Religion
of village/City:	Taluka: District:
by Dr	/ _____ Hospital _____.

I. General Particulars: -

1. (a) By whom was the corpse sent?
 (b) Name of place from which sent.
 (c) Distance of place from which sent.
2. By whom was the corpse brought?
3. By whom identified?
 i.
 ii
4. (a) The date, hour and minute of its receipt.
 (b) The date, hour and minute of beginning of post mortem Examination
 (c) The date, hour and minute of ending of postmortem examination.
5. Substance of accompanying report from police office or magistrate, together with the date of death, if known. Supposed cause of death or reason, for examination.
6. If not examined at dispensary or hospital-
 (a) Name of place where examined -
 (b) Distance from Dispensary or hospital.
 (c) Reason why the body was not sent to the dispensary or hospital.

II. External Examination: -

7. Sex, apparent age, race or caste, Description of clothes and of ornaments on the body.
8. Condition of the clothes – Whether wet with water, stained with blood or soiled with vomit or faecal matter.
9. Special marks on the skin such as scars, tattooing etc, any malformations peculiarities or other marks of identification. State of the teeth.

In newly-born infants: -

- The length and (if possible), the weight of the body is to be recorded together with the state of the hair, nails and umbilical cord, its length, whether placenta is attached or not, and if present, its size and condition.
10. Condition of Body- Whether well nourished, thin or emaciated warm or cold.
 11. Rigor Mortis- Well-marked, slight or absent whether present

12. Extent and signs of decomposition, presence or post-mortem lividity of buttocks, loins, back and thighs or any other part. Whether bullae present and the nature of the fluid it contains, condition of the cuticle.
13. Feature- Whether natural or swollen, state of eyes, position of tongue; nature of fluid (if any) oozing from mouth, nostrils or ears.
14. Conditions of skin etc.
In suspected drowning the presence or absence of cutaneous anserine is to be noted.
15. Injuries to external genitals.
Indication of purging.

16. Position of limbs- Especially of arms and of fingers or on the skin of hands and feet.

17. Surface wounds, and injuries- Their nature, position, dimensions (measured) and directions to be accurately stated- their probable age and causes to be noted.
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(N.B- When injuries are numerous and cannot be mentioned within the space available they should be mentioned on a separate paper which should be signed.)

18. Other injuries discovered by external examination or palpation of fractures etc.
18a. Can you say definitely that the injuries shown against serial nos. 17 and 18 are *ante-mortem injuries*?

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19. Head: -

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20. Thorax: -

- (a) Walls, ribs, cartilages
- (b) Pleura
- (c) Larynx, Trachea and bronchi
- (d) Right Lung with weight
- (e) Left Lung with weight
- (f) Pericardium
- (g) Heart with weight

- (h) Large vessels
- (i) Additional remarks

21. Abdomen: -

- (a) Walls -

- (b) Peritoneum -
- (c) Cavity-
- (d) Buccal cavity, teeth, tongue and pharynx-
- (e) Oesophagus-
- (f) Stomach and its contents-

- (g) Small intestine and its contents-
- (h) Large intestine and its contents-
- (i) Liver and gall bladder with weight-
- (j) Pancreas and suprarenals-
- (k) Spleen with weight.
- (l) Kidneys with weights
- (m) Bladder-
- (o) Organ of generation-

- (p) Additional remarks with, wherever possible, Medical Officer's deduction from the state of contents of the stomach as to the time of death and last meal.

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22. Spine and spinal cord-
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Sign

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- (d) Right Lung with weight
- (e) Left Lung with weight
- (f) Pericardium
- (g) Heart with weight

- (h) Large vessels
- (i) Additional remarks

21. Abdomen: -

- (a) Walls -

- (b) Peritoneum -
- (c) Cavity-
- (d) Buccal cavity, teeth, tongue and pharynx-
- (e) Oesophagus-
- (f) Stomach and its contents-

- (g) Small intestine and its contents-
- (h) Large intestine and its contents-
- (i) Liver and gall bladder with weight-
- (j) Pancreas and suprarenals-
- (k) Spleen with weight.
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Sign

Name of Doctor and seal

PM no:

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Sign

Name of Doctor and seal

PM no:

Dated:

Indoor/Casualty no:

PM No:

Hospital:

ADR No.:

Police station:

Memorandum of a Post-mortem Examination held at _____ Hospital on the body of **Name**

of village/City:

Taluka:

District:

, **Age-** **Yrs, Sex** , **Religion**

by **Dr**

/ _____ Hospital _____.

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- (b) Pleura
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- (d) Right Lung with weight
- (e) Left Lung with weight
- (f) Pericardium
- (g) Heart with weight

- (h) Large vessels
- (i) Additional remarks

21. Abdomen: -

- (a) Walls -

- (b) Peritoneum -
- (c) Cavity-
- (d) Buccal cavity, teeth, tongue and pharynx-
- (e) Oesophagus-
- (f) Stomach and its contents-

- (g) Small intestine and its contents-
- (h) Large intestine and its contents-
- (i) Liver and gall bladder with weight-
- (j) Pancreas and suprarenals-
- (k) Spleen with weight.
- (l) Kidneys with weights
- (m) Bladder-
- (o) Organ of generation-

- (p) Additional remarks with, wherever possible, Medical Officer's deduction from the state of contents of the stomach as to the time of death and last meal.

- (q) State which viscera, (if any) have been retained for chemical examination and also quote the numbers on the bottles containing the same-

22. Spine and spinal cord-
23. a) Whether the ante-mortem injuries found on the dead body were sufficient in the ordinary course of nature to cause death?
- (b) If yes, which of the injuries were individually sufficient in the ordinary course of nature to cause death?
- (c) Which of the injuries collectively are sufficient in the ordinary course of nature to cause death?

Opinion as to the probable/Final cause of death: -

Sign

Name of Doctor and seal

PM no:

Dated:

*The spinal cord need not be examined unless there are any indications of disease, strychnine poisoning or injury.

Note: - The report must be written and signed immediately after the examination. Medical officers will at once dispatch a duplicate copy to the Civil Surgeon of their district for in his office.

Great care should be taken not to cut viscera before they have been inspected in *Situ*.

Post Mortem No. :-

, Dated:

1. Place:

Forwarded to the _____, P.S. _____ for information with reference to his No. / _____ of Dated: _____.

2. Viscera has been/ **not** been preserved.

Sign

Name of Doctor and seal

PM no:

Dated:

Indoor/Casualty no:	PM No:
Hospital:	ADR No.:
	Police station:
Memorandum of a Post-mortem Examination held at _____ Hospital on the body	
of Name	, Age- Yrs, Sex , Religion
of village/City:	Taluka: District:
by Dr	/ _____ Hospital _____.

I. General Particulars: -

1. (a) By whom was the corpse sent?
 (b) Name of place from which sent.
 (c) Distance of place from which sent.
2. By whom was the corpse brought?
3. By whom identified?
 - i.
 - ii
4. (a) The date, hour and minute of its receipt.
 (b) The date, hour and minute of beginning of post mortem Examination
 (c) The date, hour and minute of ending of postmortem examination.
5. Substance of accompanying report from police office or magistrate, together with the date of death, if known. Supposed cause of death or reason, for examination.
6. If not examined at dispensary or hospital-
 (a) Name of place where examined -
 (b) Distance from Dispensary or hospital.
 (c) Reason why the body was not sent to the dispensary or hospital.

II. External Examination: -

7. Sex, apparent age, race or caste, Description of clothes and of ornaments on the body.
8. Condition of the clothes – Whether wet with water, stained with blood or soiled with vomit or faecal matter.
9. Special marks on the skin such as scars, tattooing etc, any malformations peculiarities or other marks of identification. State of the teeth.

In newly-born infants: -

- The length and (if possible), the weight of the body is to be recorded together with the state of the hair, nails and umbilical cord, its length, whether placenta is attached or not, and if present, its size and condition.
10. Condition of Body- Whether well nourished, thin or emaciated warm or cold.
11. Rigor Mortis- Well-marked, slight or absent whether present

12. Extent and signs of decomposition, presence or post-mortem lividity of buttocks, loins, back and thighs or any other part. Whether bullae present and the nature of the fluid it contains, condition of the cuticle.
13. Feature- Whether natural or swollen, state of eyes, position of tongue; nature of fluid (if any) oozing from mouth, nostrils or ears.
14. Conditions of skin etc.
In suspected drowning the presence or absence of cutaneous anserine is to be noted.
15. Injuries to external genitals.
Indication of purging.
16. Position of limbs- Especially of arms and of fingers or on the skin of hands and feet.
17. Surface wounds, and injuries- Their nature, position, dimensions (measured) and directions to be accurately stated- their probable age and causes to be noted.
If bruises be present, what is the condition of the subcutaneous tissues?
(N.B- When injuries are numerous and cannot be mentioned within the space available they should be mentioned on a separate paper which should be signed.)
18. Other injuries discovered by external examination or palpation of fractures etc.
18a. Can you say definitely that the injuries shown against serial nos. 17 and 18 are *ante-mortem injuries*?

III. Internal Examination: -

19. Head: -

(i) Injuries under the scalp and their nature.

(ii) Skull: vault and base-describe fractures their sites, dimensions, direction etc.

(iii) Brain: The appearance of its coverings, size, weight and general condition of the organ itself and any abnormality found in its examination to be carefully noted.

20. Thorax: -

- (a) Walls, ribs, cartilages
- (b) Pleura
- (c) Larynx, Trachea and bronchi
- (d) Right Lung with weight
- (e) Left Lung with weight
- (f) Pericardium
- (g) Heart with weight

- (h) Large vessels
- (i) Additional remarks

21. Abdomen: -

- (a) Walls -

- (b) Peritoneum -
- (c) Cavity-
- (d) Buccal cavity, teeth, tongue and pharynx-
- (e) Oesophagus-
- (f) Stomach and its contents-

- (g) Small intestine and its contents-
- (h) Large intestine and its contents-
- (i) Liver and gall bladder with weight-
- (j) Pancreas and suprarenals-
- (k) Spleen with weight.
- (l) Kidneys with weights
- (m) Bladder-
- (o) Organ of generation-

- (p) Additional remarks with, wherever possible, Medical Officer's deduction from the state of contents of the stomach as to the time of death and last meal.

- (q) State which viscera, (if any) have been retained for chemical examination and also quote the numbers on the bottles containing the same-

22. Spine and spinal cord-
23. a) Whether the ante-mortem injuries found on the dead body were sufficient in the ordinary course of nature to cause death?
- (b) If yes, which of the injuries were individually sufficient in the ordinary course of nature to cause death?
- (c) Which of the injuries collectively are sufficient in the ordinary course of nature to cause death?

Opinion as to the probable/Final cause of death: -

Sign

Name of Doctor and seal

PM no:

Dated:

*The spinal cord need not be examined unless there are any indications of disease, strychnine poisoning or injury.

Note: - The report must be written and signed immediately after the examination. Medical officers will at once dispatch a duplicate copy to the Civil Surgeon of their district for in his office.

Great care should be taken not to cut viscera before they have been inspected in *Situ*.

Post Mortem No. :-

, Dated:

1. Place:

Forwarded to the _____, P.S. _____ for information with reference to his No. / _____ of Dated: _____.

2. Viscera has been/ **not** been preserved.

Sign

Name of Doctor and seal

PM no:

Dated:

Indoor/Casualty no:	PM No:
Hospital:	ADR No.:
	Police station:
Memorandum of a Post-mortem Examination held at _____ Hospital on the body	
of Name	, Age- Yrs, Sex , Religion
of village/City:	Taluka: District:
by Dr	/ _____ Hospital _____.

I. General Particulars: -

1. (a) By whom was the corpse sent?
 (b) Name of place from which sent.
 (c) Distance of place from which sent.
2. By whom was the corpse brought?
3. By whom identified?
 - i.
 - ii
4. (a) The date, hour and minute of its receipt.
 (b) The date, hour and minute of beginning of post mortem Examination
 (c) The date, hour and minute of ending of postmortem examination.
5. Substance of accompanying report from police office or magistrate, together with the date of death, if known. Supposed cause of death or reason, for examination.
6. If not examined at dispensary or hospital-
 (a) Name of place where examined -
 (b) Distance from Dispensary or hospital.
 (c) Reason why the body was not sent to the dispensary or hospital.

II. External Examination: -

7. Sex, apparent age, race or caste, Description of clothes and of ornaments on the body.
8. Condition of the clothes – Whether wet with water, stained with blood or soiled with vomit or faecal matter.
9. Special marks on the skin such as scars, tattooing etc, any malformations peculiarities or other marks of identification. State of the teeth.

In newly-born infants: -

- The length and (if possible), the weight of the body is to be recorded together with the state of the hair, nails and umbilical cord, its length, whether placenta is attached or not, and if present, its size and condition.
10. Condition of Body- Whether well nourished, thin or emaciated warm or cold.
11. Rigor Mortis- Well-marked, slight or absent whether present

12. Extent and signs of decomposition, presence or post-mortem lividity of buttocks, loins, back and thighs or any other part. Whether bullae present and the nature of the fluid it contains, condition of the cuticle.
13. Feature- Whether natural or swollen, state of eyes, position of tongue; nature of fluid (if any) oozing from mouth, nostrils or ears.
14. Conditions of skin etc.
In suspected drowning the presence or absence of cutaneous anserine is to be noted.
15. Injuries to external genitals.
Indication of purging.
16. Position of limbs- Especially of arms and of fingers or on the skin of hands and feet.
17. Surface wounds, and injuries- Their nature, position, dimensions (measured) and directions to be accurately stated- their probable age and causes to be noted.
If bruises be present, what is the condition of the subcutaneous tissues?
(N.B- When injuries are numerous and cannot be mentioned within the space available they should be mentioned on a separate paper which should be signed.)
18. Other injuries discovered by external examination or palpation of fractures etc.
18a. Can you say definitely that the injuries shown against serial nos. 17 and 18 are *ante-mortem injuries*?

III. Internal Examination: -

19. Head: -

(i) Injuries under the scalp and their nature.

(ii) Skull: vault and base-describe fractures their sites, dimensions, direction etc.

(iii) Brain: The appearance of its coverings, size, weight and general condition of the organ itself and any abnormality found in its examination to be carefully noted.

20. Thorax: -

- (a) Walls, ribs, cartilages
- (b) Pleura
- (c) Larynx, Trachea and bronchi
- (d) Right Lung with weight
- (e) Left Lung with weight
- (f) Pericardium
- (g) Heart with weight

- (h) Large vessels
- (i) Additional remarks

21. Abdomen: -

- (a) Walls -

- (b) Peritoneum -
- (c) Cavity-
- (d) Buccal cavity, teeth, tongue and pharynx-
- (e) Oesophagus-
- (f) Stomach and its contents-

- (g) Small intestine and its contents-
- (h) Large intestine and its contents-
- (i) Liver and gall bladder with weight-
- (j) Pancreas and suprarenals-
- (k) Spleen with weight.
- (l) Kidneys with weights
- (m) Bladder-
- (o) Organ of generation-

- (p) Additional remarks with, wherever possible, Medical Officer's deduction from the state of contents of the stomach as to the time of death and last meal.

- (q) State which viscera, (if any) have been retained for chemical examination and also quote the numbers on the bottles containing the same-

22. Spine and spinal cord-
23. a) Whether the ante-mortem injuries found on the dead body were sufficient in the ordinary course of nature to cause death?
- (b) If yes, which of the injuries were individually sufficient in the ordinary course of nature to cause death?
- (c) Which of the injuries collectively are sufficient in the ordinary course of nature to cause death?

Opinion as to the probable/Final cause of death: -

Sign

Name of Doctor and seal

PM no:

Dated:

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Note: - The report must be written and signed immediately after the examination. Medical officers will at once dispatch a duplicate copy to the Civil Surgeon of their district for in his office.

Great care should be taken not to cut viscera before they have been inspected in *Situ*.

Post Mortem No. :-

, Dated:

1. Place:

Forwarded to the _____, P.S. _____ for information with reference to his No. / _____ of Dated: _____.

2. Viscera has been/ **not** been preserved.

Sign

Name of Doctor and seal

PM no:

Dated:

Indoor/Casualty no:	PM No:
Hospital:	ADR No.:
	Police station:
Memorandum of a Post-mortem Examination held at _____ Hospital on the body	
of Name	, Age- Yrs, Sex , Religion
of village/City:	Taluka: District:
by Dr	/ _____ Hospital _____.

I. General Particulars: -

1. (a) By whom was the corpse sent?
 (b) Name of place from which sent.
 (c) Distance of place from which sent.
2. By whom was the corpse brought?
3. By whom identified?
 - i.
 - ii
4. (a) The date, hour and minute of its receipt.
 (b) The date, hour and minute of beginning of post mortem Examination
 (c) The date, hour and minute of ending of postmortem examination.
5. Substance of accompanying report from police office or magistrate, together with the date of death, if known. Supposed cause of death or reason, for examination.
6. If not examined at dispensary or hospital-
 (a) Name of place where examined -
 (b) Distance from Dispensary or hospital.
 (c) Reason why the body was not sent to the dispensary or hospital.

II. External Examination: -

7. Sex, apparent age, race or caste, Description of clothes and of ornaments on the body.
8. Condition of the clothes – Whether wet with water, stained with blood or soiled with vomit or faecal matter.
9. Special marks on the skin such as scars, tattooing etc, any malformations peculiarities or other marks of identification. State of the teeth.

In newly-born infants: -

- The length and (if possible), the weight of the body is to be recorded together with the state of the hair, nails and umbilical cord, its length, whether placenta is attached or not, and if present, its size and condition.
10. Condition of Body- Whether well nourished, thin or emaciated warm or cold.
11. Rigor Mortis- Well-marked, slight or absent whether present

12. Extent and signs of decomposition, presence or post-mortem lividity of buttocks, loins, back and thighs or any other part. Whether bullae present and the nature of the fluid it contains, condition of the cuticle.
13. Feature- Whether natural or swollen, state of eyes, position of tongue; nature of fluid (if any) oozing from mouth, nostrils or ears.
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15. Injuries to external genitals.
Indication of purging.

16. Position of limbs- Especially of arms and of fingers or on the skin of hands and feet.

17. Surface wounds, and injuries- Their nature, position, dimensions (measured) and directions to be accurately stated- their probable age and causes to be noted.
If bruises be present, what is the condition of the subcutaneous tissues?
(N.B- When injuries are numerous and cannot be mentioned within the space available they should be mentioned on a separate paper which should be signed.)

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18a. Can you say definitely that the injuries shown against serial nos. 17 and 18 are *ante-mortem injuries*?

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19. Head: -

(i) Injuries under the scalp and their nature.

(ii) Skull: vault and base-describe fractures their sites, dimensions, direction etc.

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20. Thorax: -

- (a) Walls, ribs, cartilages
- (b) Pleura
- (c) Larynx, Trachea and bronchi
- (d) Right Lung with weight
- (e) Left Lung with weight
- (f) Pericardium
- (g) Heart with weight

- (h) Large vessels
- (i) Additional remarks

21. Abdomen: -

- (a) Walls -

- (b) Peritoneum -
- (c) Cavity-
- (d) Buccal cavity, teeth, tongue and pharynx-
- (e) Oesophagus-
- (f) Stomach and its contents-

- (g) Small intestine and its contents-
- (h) Large intestine and its contents-
- (i) Liver and gall bladder with weight-
- (j) Pancreas and suprarenals-
- (k) Spleen with weight.
- (l) Kidneys with weights
- (m) Bladder-
- (o) Organ of generation-

- (p) Additional remarks with, wherever possible, Medical Officer's deduction from the state of contents of the stomach as to the time of death and last meal.

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Opinion as to the probable/Final cause of death: -

Sign

Name of Doctor and seal

PM no:

Dated:

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Post Mortem No. :-

, Dated:

1. Place:

Forwarded to the _____, P.S. _____ for information with reference to his No. / _____ of Dated: _____.

2. Viscera has been/ **not** been preserved.

Sign

Name of Doctor and seal

PM no:

Dated:

12. Extent and signs of decomposition, presence or post-mortem lividity of buttocks, loins, back and thighs or any other part. Whether bullae present and the nature of the fluid it contains, condition of the cuticle.
13. Feature- Whether natural or swollen, state of eyes, position of tongue; nature of fluid (if any) oozing from mouth, nostrils or ears.
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21. Abdomen: -

- (a) Walls -

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- (f) Stomach and its contents-

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Opinion as to the probable/Final cause of death: -

Sign

Name of Doctor and seal

PM no:

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Post Mortem No. :-

, Dated:

1. Place:

Forwarded to the _____, P.S. _____ for information with reference to his No. / _____ of Dated: _____.

2. Viscera has been/ **not** been preserved.

Sign

Name of Doctor and seal

PM no:

Dated:

Indoor/Casualty no:	PM No:
Hospital:	ADR No.:
	Police station:
Memorandum of a Post-mortem Examination held at _____ Hospital on the body	
of Name	, Age- Yrs, Sex , Religion
of village/City:	Taluka: District:
by Dr	/ _____ Hospital _____.

I. General Particulars: -

1. (a) By whom was the corpse sent?
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 (a) Name of place where examined -
 (b) Distance from Dispensary or hospital.
 (c) Reason why the body was not sent to the dispensary or hospital.

II. External Examination: -

7. Sex, apparent age, race or caste, Description of clothes and of ornaments on the body.
8. Condition of the clothes – Whether wet with water, stained with blood or soiled with vomit or faecal matter.
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- (g) Heart with weight

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- (i) Additional remarks

21. Abdomen: -

- (a) Walls -

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Opinion as to the probable/Final cause of death: -

Sign

Name of Doctor and seal

PM no:

Dated:

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Post Mortem No. :-

, Dated:

1. Place:

Forwarded to the _____, P.S. _____ for information with reference to his No. / _____ of Dated: _____.

2. Viscera has been/ **not** been preserved.

Sign

Name of Doctor and seal

PM no:

Dated:

Indoor/Casualty no:

PM No:

Hospital:

ADR No.:

Police station:

Memorandum of a Post-mortem Examination held at _____ Hospital on the body
of **Name** _____, **Age-** _____ **Yrs, Sex** _____, **Religion**

of village/City:

Taluka:

District:

by **Dr**

/ _____ Hospital _____.

I. General Particulars: -

1. (a) By whom was the corpse sent?
(b) Name of place from which sent.
(c) Distance of place from which sent.
2. By whom was the corpse brought?
3. By whom identified?
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Supposed cause of death or reason, for examination.
6. If not examined at dispensary or hospital-
 - (a) Name of place where examined -
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 - (c) Reason why the body was not sent to the dispensary or hospital.

II. External Examination: -

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Description of clothes and of ornaments on the body.
8. Condition of the clothes –
Whether wet with water, stained with blood or soiled with vomit or faecal matter.
9. Special marks on the skin such as scars, tattooing etc, any malformations peculiarities or other marks of identification.
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12. Extent and signs of decomposition, presence or post-mortem lividity of buttocks, loins, back and thighs or any other part. Whether bullae present and the nature of the fluid it contains, condition of the cuticle.
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17. Surface wounds, and injuries- Their nature, position, dimensions (measured) and directions to be accurately stated- their probable age and causes to be noted.
If bruises be present, what is the condition of the subcutaneous tissues?
(N.B- When injuries are numerous and cannot be mentioned within the space available they should be mentioned on a separate paper which should be signed.)

18. Other injuries discovered by external examination or palpation of fractures etc.
18a. Can you say definitely that the injuries shown against serial nos. 17 and 18 are *ante-mortem injuries*?

III. Internal Examination: -

19. Head: -

(i) Injuries under the scalp and their nature.

(ii) Skull: vault and base-describe fractures their sites, dimensions, direction etc.

(iii) Brain: The appearance of its coverings, size, weight and general condition of the organ itself and any abnormality found in its examination to be carefully noted.

20. Thorax: -

- (a) Walls, ribs, cartilages
- (b) Pleura
- (c) Larynx, Trachea and bronchi
- (d) Right Lung with weight
- (e) Left Lung with weight
- (f) Pericardium
- (g) Heart with weight

- (h) Large vessels
- (i) Additional remarks

21. Abdomen: -

- (a) Walls -

- (b) Peritoneum -
- (c) Cavity-
- (d) Buccal cavity, teeth, tongue and pharynx-
- (e) Oesophagus-
- (f) Stomach and its contents-

- (g) Small intestine and its contents-
- (h) Large intestine and its contents-
- (i) Liver and gall bladder with weight-
- (j) Pancreas and suprarenals-
- (k) Spleen with weight.
- (l) Kidneys with weights
- (m) Bladder-
- (o) Organ of generation-

- (p) Additional remarks with, wherever possible, Medical Officer's deduction from the state of contents of the stomach as to the time of death and last meal.

- (q) State which viscera, (if any) have been retained for chemical examination and also quote the numbers on the bottles containing the same-

22. Spine and spinal cord-
23. a) Whether the ante-mortem injuries found on the dead body were sufficient in the ordinary course of nature to cause death?
- (b) If yes, which of the injuries were individually sufficient in the ordinary course of nature to cause death?
- (c) Which of the injuries collectively are sufficient in the ordinary course of nature to cause death?

Opinion as to the probable/Final cause of death: -

Sign

Name of Doctor and seal

PM no:

Dated:

*The spinal cord need not be examined unless there are any indications of disease, strychnine poisoning or injury.

Note: - The report must be written and signed immediately after the examination. Medical officers will at once dispatch a duplicate copy to the Civil Surgeon of their district for in his office.

Great care should be taken not to cut viscera before they have been inspected in *Situ*.

Post Mortem No. :-

, Dated:

1. Place:

Forwarded to the _____, P.S. _____ for information with reference to his No. / _____ of Dated: _____.

2. Viscera has been/ **not** been preserved.

Sign

Name of Doctor and seal

PM no:

Dated:

Part- IV
**Common Medico-legal proforma routinely used in medico-legal
Practice**

**Form in which to report post mortem examination to be used when forwarding
Viscera to the Chemical Analyser**

From:

TO

**THE CHEMICAL ANALYSER TO GOVERNMENT
OF MAHARASHTRA, _____**

Date: _____

Description of Viscera forwarded for examination:

Mode of packing:		Copy of the label attached to bottle		
Box No.	Bottle No.	<table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="padding: 5px;">Impression of Seal</td> </tr> </table>		Impression of Seal
Impression of Seal				
Weight of parcel				
Mode of dispatch	Date of Dispatch			

Information furnished by police officer or precis of case :

Name:

Sex:

Age:

Caste:

Thana or village:

Story of the case -

Date and hour of dispatch of body	Date and hour of autopsy	Names of officer by whom Examination was actually made
Date of receipt		

Appearance of Body –

Muscularity:

Stout:

Emaciated:

Special Marks:-

Scars:

Tattooing:

Amount of Hairs etc.

Signs of decomposition:-

Wounds and bruises:

(a) Position:

(b) Character:

(c) Size:

State of natural orifices:

Nostrils:

Mouth:

Vagina:

Anus:

Urethra:

State of limbs etc.

Rigor mortis:

Position:

Contents of hands if clenched:

Feature

Relaxed
Contracted

Eyelids:

Pupils:

Contents of mouth:

Position of tongue:

State of teeth:

Thorax -

Ribs:

Cartilages:

Pleura:

Pericardium:

Heart: Shape and appearance

Cavities

Clots ante or post-mortem

Muscular structure

Vessels: Clots
 Aneurysm
 Atheroma

Lungs : Appearance
 Colour
 Consistence
 Adhesions

Larynx, trachea and bronchi for foreign bodies or disease:

Abdomen: -

Peritoneum

Peritoneal cavity, contents

Liver and gall bladder -form and size, disease or injury

Pancreas disease or injury

Spleen disease or injury

Kidney disease or injury

Stomach Size and general appearance
 Appearance of coats
Contents, appearance, odour and quantity.

Intestine Size and general appearance
Appearance of coats

General Organs: -

Bladder and contents

Uterus appearance, size and contents

Vagina, contents

Head:

Scalp

Bones, Disease or Injury

Membranes

Brain substance and ventricles

Base of skull fracture, caries, extravasations, etc.

The Spinal cord need not be examined unless any indication of disease or injury exists.

Fracture and dislocation

More detailed description of injury or disease

Opinion as to the cause of death: -

Station

Date

Civil Surgeon / Medical Officer in Charge / Autopsy Surgeon

Form No II

**Form or report to be used when forwarding substance
Other than viscera to the chemical analyser**

From:

To
THE CHEMICAL ANALYSER
GOVERNMENT OF MAHARASHTRA,

Dated: / /

Forwarding the article mentioned below for examination for _____
_____ In connection with the case of _____

Description of Articles

Mode of packing and weight of parcel If standard boxes and bottles are used a) Box No. b) Bottle No.	Copy of the label attached to bottle
Mode of Dispatch Date Date:	Date of receipt in Chemical Analyzer's office

Facts of Medico legal importance in connection with case:

Station

Date

Civil Surgeon / Medical Officer in Charge / Autopsy Surgeon

Form for Dispatch of Viscera for Histopathological Examination

**TO,
HOD / In-charge,
Histopathology Section,
Department of Pathology,**

_____.

(Through: _____)

Subject : Regarding Histopathological examination and report.

Reference : MLPM No. _____ Date: _____

Name of deceased: _____

Age: _____ Sex: _____

Hospital Reg./MLC No _____ Ward: _____

DOA & Time _____ DOD & Time _____

Nature Of specimen:

Preservative Used:

Clinical Details:

Clinical Diagnosis:

Autopsy findings in brief:

Probable cause of death on Autopsy:

Special instruction, if any: -

Place:

Date & Time:

Signature

Name of Doctor

Designation & seal

✂-----

Histopathology Examination Bottle No. 1

Name of the Hospital: _____

P.M. No: _____ Date: _____

Name of Deceased: _____

Police Station: _____

Nature of Specimen: _____

Preservative Used: _____

Date: _____

Place: _____

Autopsy Surgeon

Sign & seal

✂-----

Labels for Viscera Bottles

Bottle No. 1

Name of the Hospital: _____

P.M. No: _____ Date: _____

Name of Deceased: _____

Police Station: _____

Nature of Specimen: _____

Preservative Used: _____

Date: _____

Autopsy Surgeon

Place: _____

Sign & seal



Bottle No. 2

Name of the Hospital: _____

P.M. No: _____ Date: _____

Name of Deceased: _____

Police Station: _____

Nature of Specimen: _____

Preservative Used: _____

Date: _____

Autopsy Surgeon

Place: _____

Sign & seal



Bottle No. 3

Name of the Hospital: _____

P.M. No: _____ Date: _____

Name of Deceased: _____

Police Station: _____

Nature of Specimen: _____

Preservative Used: _____

Date: _____

Autopsy Surgeon

Place: _____

Sign & seal



Bottle No. 4

Name of the Hospital: _____

P.M. No: _____ Date: _____

Name of Deceased: _____

Police Station: _____

Sample Preservative Used: _____

Date: _____

Autopsy Surgeon

Place: _____

Sign & seal

Instructions for Forwarding Blood/Tissue For DNA Fingerprinting/ Paternity Testing.

1. Medical officer should collect fresh blood in 2 ml plastic tubes (2 blood samples from each person) provided by Regional Forensic Science Laboratory.
2. Please shake the tube for 7-8 times after collecting blood.
3. Duly labelled tube should be kept in sterile plastic bottle which should be immediately sealed.
4. Duly filled IDENTIFICATION FORM should be sent along with the sample.
5. COPY OF SEAL should be provided at the end of IDENTIFICATION FORM.
6. For each person, a separate IDENTIFICATION FORM should be filled by Medical Officer while forwarding samples for DNA profiling.
7. Photograph of person on IDENTIFICATION FORM should be duly signed and attested by the Medical Officer.
8. IDENTIFICATION FORM should be signed by Witnesses in front of Medical Officer.
9. The samples should be sent to the Regional Forensic Science Laboratory in ice box with ice, if more than 4 Hours are required to submit the samples.
10. Products of abortion/ other tissue should be sealed in a sterile plastic bottle and sent to the Regional Forensic Science Laboratory in ice box with ice. If available, 4% EDTA could be used as preservative.
11. Don't use formalin or other preservatives. Formalin preserved samples are considered unacceptable/ inappropriate for DNA analysis by Forensic Science Laboratories.
12. In case of blood transfusion to donor within last three months, blood sample should not be collected. In such case, donor's blood sample should be collected after four months of blood transfusion.

Identification form for forwarding samples for DNA Fingerprinting/ Profiling

To
Deputy Director,
Regional Forensic Science Laboratory,
State of Maharashtra, _____.

Prefix
photograph.

Photograph to be
attested by
Medical Officer

IDENTIFICATION FORM

Name : _____
Age: _____ Sex: _____
Father's / Husband's / Guardian's Name : _____
Address (with Tel. No. Fax. If any): _____
Description of sample : _____
Genetic abnormalities, if any (specify): _____
Date and Time of Sample collection :- Date: _____ Time: _____
Forwarded by:
(a) Hon'ble Court of / Police Station : _____
(b) C. R. No. /FIR/Case /MC/OP No., etc. : _____

**DECLARATION BY DONOR
(OR BY GUARDIAN IN CASE OF MINOR DONOR)**

I, _____ hereby declare that the blood given by me / my ward to Regional Forensic Science Laboratory, State of Maharashtra, _____ is with my consent and I / my ward did not receive a blood transfusion within last three months. (This consent is explained to patient in _____ language)

Signature/Thumb impression
(Subject/Guardian)

The blood is collected in presence of following witnesses:

(1) Name: _____ Signature: _____
(2) Name: _____ Signature: _____

Copy of Seal



Sign. and designation of M.O. with Stamp

- STRIKE OUT WHICHEVER NOT APPLICABLE,
- IN CASE OF BLOOD TRANSFUSION TO DONOR WITHIN LAST THREE MONTHS, BLOOD SAMPLE SHOULD NOT BE COLLECTED.
- PASSPORT SIZE PHOTOGRAPH TO BE ATTESTED BY MEDICAL OFFICER.

Summons to Witness

In the District & Sessions Court

At

Session Case No. _____ of 20

Summon to witness

To,

Whereas complaint has been made before me that _____

Of _____

has committed the offence of _____

on or above the _____ day of _____ 20____ at _____

and it appears to me that you are likely to give material evidence for the _____

You are hereby summoned to appear before this court on the _____ day _____

at _____ hours to _____

testify what you know concerning the matter of the said complaint, and not to depart thence, without leave of the court, and you are hereby warned that if you shall, without just excuse neglect or refuse to appear at the said time and place a warrant will be issued to compel your attendance.

Given under my hand and the seal of the court this _____ day of _____ 20____

Superintendent

(By order of Session Judge)

