

CHAIN OF CUSTODY FORM

Patient Label:

(if anonymous, use MRN only)

MRN _____

[Place patient label here]

Date of Service: _____

Items Collected: ☐ Sexual Assault Evidence Collection Kit ☐ Clothing
☐ Other: _____

Total number of brown bags: _____

Collector’s Name/Initials: _____

Date and time of evidence collection: _____

DATE/TIME	RELINGUISHED BY:	RECEIVED BY:
	Name: _____ Agency: _____ Signature: _____	Name: _____ Agency: _____ Signature: _____
	Name: _____ Agency: _____ Signature: _____	Name: _____ Agency: _____ Signature: _____
	Name: _____ Agency: _____ Signature: _____	Name: _____ Agency: _____ Signature: _____
	Name: _____ Agency: _____ Signature: _____	Name: _____ Agency: _____ Signature: _____