Istanbul Protocol Clinical Evaluation Short Form for Conflict Settings

Adapted from the Istanbul Protocol 2022 edition for use by independent, non-forensic clinicians for clinical assessments of alleged or suspected torture and ill-treatment in conflict settings where comprehensive medico-legal evaluations are not possible.

### I. Case Information

<table>
<thead>
<tr>
<th>Clinical Examination</th>
<th>Date: ________________</th>
<th>Place: __________________________________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Patient/ Name:</th>
<th>Patient ID #:</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Person Requesting Clinical Evaluation (Name):</th>
<th>Position/Relationship:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Reason For Request:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical harm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological harm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (Specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Informed Consent** (Obtain at onset of clinical evaluation and review alleged victim at the conclusion of the evaluation for any changes)

Identify yourself the purpose and content of the evaluation, how the information may be used, the potential benefits and risks, the steps that will be taken to ensure confidentiality such as data storage and encryption, and that the individual can stop participation at any time.

- Obtain consent for the clinical evaluation and photographs of alleged injuries:
  - Clinical evaluation findings: Yes No
  - Photographs of alleged injuries: Yes No

- Obtain consent for specific purposes:
  - Human rights reports: Yes No
  - Advocacy, media reports: Yes No
  - Investigations by international legal bodies: Yes No
  - Future criminal prosecution of alleged perpetrators: Yes No

- Ask the alleged victim if they want their evaluation to be anonymous (no name or identifying information disclosed) or to disclose their name and identifying information:
  - Consent to USE ONLY ANONYMOUS information: Yes No
  - Consent to USE NAME AND OTHER IDENTIFYING INFORMATION: Yes No

<table>
<thead>
<tr>
<th>Interpreter Needed?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpreter provided: Yes</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
**Others Present During Examination:** (law enforcement & prosecutors should be barred from the exam room)

- Yes
- No [If “Yes,” list others present below.]

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note any of the following limitations on the clinical evaluation:

- Detainee Restrained (Describe): __________________________ Yes No
- Inadequate Time for Evaluation (Explain): __________________________ Yes No
- Inappropriate Location (Explain): __________________________ Yes No
- Lack of Privacy (Explain): __________________________ Yes No
- Remote virtual evaluation (Platform): __________________________ Yes No

**II. Relevant Clinical History**

**Clinical Records/Forensic Report Available for Review:**

- Yes
- No

<table>
<thead>
<tr>
<th>Date</th>
<th>Findings &amp; Conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Past medical, Psychiatric history: __________________________

**III. Allegations of Abuse:** (open-ended, chronological inquiry followed by direct questions as indicated - include circumstances of detention, place and conditions of detention, and allegations of abuse, and be sure to ask about the possibility of sexual assault.)

“Please describe to me in detail what happened to you:”

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________
List Alleged Perpetrators:
Name __________________________        Institution: __________________________        Position: __________________________
Alleged Abuses: __________________________

Name __________________________        Institution: __________________________        Position: __________________________
Alleged Abuses: __________________________

Name __________________________        Institution: __________________________        Position: __________________________
Alleged Abuses: __________________________

IV. Physical Symptoms and/or Disabilities Related to Alleged Abuse (Describe acute and chronic symptoms and disabilities including location, intensity, frequency, duration, potentiating and alleviating factors, and subsequent healing processes)

Acute Symptoms and Disabilities:
1. __________________________
2. __________________________
3. __________________________
4. __________________________
5. __________________________

Chronic Symptoms and Disabilities:
1. __________________________
2. __________________________
3. __________________________
4. __________________________
5. __________________________

V. Examination of Physical Evidence (Include all pertinent positive and negative findings; for skin lesions include: size, pattern, elevation, color, location, shape, consistency, and border; for reported head trauma, loss of consciousness or asphyxiation, conduct a complete neurologic exam including mental status using the attached MoCA form; for acute vaginal or anal rape, obtain indicated tests and forensic evidence for analysis. Use attached body diagrams and/or take photographs of all relevant physical findings)

General Appearance & vital signs: __________________________
Skin: __________________________
VI. Psychological Symptoms and Assessment of Depression and PTSD

Ask the following:

"Do you feel that your mental state (thoughts and emotions) has been significantly affected by the abuse that you reported?"

Detainee’s Response  □ Yes  □ No  [If “Yes,” complete attached PHQ-9 & PC-PTSD-5]

"To what extent has the change in your mental state affected your life or your ability to function?"

Detainee’s Response  □ None  □ Mild  □ Moderate  □ Extreme

PHQ-9 completed: □ Yes  □ No  Total Score: _______  Depression Diagnosis: ________________

PC-PTSD-5 completed  □ Yes  □ No  Total Score: _______  Depression Severity: ________________

(Note, a score of 4-5 indicates PTSD)

(Note, a score of 3 indicates possible PTSD)

VII. Diagnostic Tests and Referrals:

Diagnostic Tests / Studies Ordered: □ Yes  □ No

1. ____________________________  Date: _____  Ref #: _______  Findings: ______________________________

2. ____________________________  Date: _____  Ref #: _______  Findings: ______________________________

Referrals/Consultations Requested: □ Yes (Explain): ___________________________________________  □ No
VIII. Assessment of Correlation Between Physical Findings and Alleged Methods of Injury

*(NC=Not Consistent With; C=Consistent With; HC=Highly Consistent With; TO=Typical of; DO=DiaOn osta

<table>
<thead>
<tr>
<th>Physical Finding(s)</th>
<th>Alleged Method of Injury</th>
<th>*Correlation (check one for each finding)</th>
<th>Photograph #s (attach to report)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td>NC</td>
<td>Yes #</td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td>C</td>
<td>Yes #</td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td>HC</td>
<td>Yes #</td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td>TO</td>
<td>Yes #</td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td>DO</td>
<td>Yes #</td>
</tr>
</tbody>
</table>

IX. Assessment of psychological findings

The alleged victim’s psychological symptoms and/or disabilities are (check one)

☐ Not Consistent With ☐ Consistent With ☐ Highly Consistent With ...

the allegations of abuse reported. (Note, “Typical of” and “Diagnostic of” are not usually appropriate correlations for psychological findings)

X. Conclusion and Recommendations

Based on my qualifications, knowledge, and experience, it is my opinion that the alleged victim’s clinical findings (physical and psychological findings, historical information, photographic findings, diagnostic test results, knowledge of regional practices of torture, consultation reports etc.) are (check one)

☐ Not Consistent With ☐ Consistent With ☐ Highly Consistent With ☐ Typical of ☐ Diagnostic Of ...

Torture as defined by the UN Convention against Torture (The intentional infliction of severe physical and/or mental pain by State officials for gathering information, punishment or for any reason based on discrimination of any kind.)

I have reviewed and confirmed all informed consent responses above: ☐ Yes ☐ No

I have provided relevant referrals for medical and mental health care: ☐ Yes (Explain): ___________________________ ☐ No

XI. Signatures

Evaluator’s Signature ___________________________ Evaluator’s Printed Name ___________________________ Date ____________


Body Diagrams

### PHQ-9

Over the last two weeks, how often have you been bothered by the following problems? (Circle your response.)

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several Days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling asleep, staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself - or that you’re a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

### Scoring:

**Part A. Diagnosis**

**Depressive Disorder:** If there are at least 4 answers circled in the shaded section (including Questions #1 and #2). Add score to determine severity.

**Major Depressive Disorder:** If there are 5 answers circled in the shaded section (one of which includes Questions #1 and #2).

**Other Depressive Disorder:** If there are 2-4 answers circles in the shaded section.

**Part B. Severity:**

Add up all of the scores in each section. This is the final “Total” number.

1–4: minimal depression

5–9: mild depression

10–14: moderate depression

15–19: moderately severe depression,

20–27: severe depression

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? (Check one the boxes to the right)

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Somewhat Difficult</th>
<th>Very Difficult</th>
<th>Extremely Difficult</th>
</tr>
</thead>
</table>
### PC PTSD-5

**In the past month, have you…**

1. Had nightmares about the event(s) or thought about the event(s) when you did not want to? □ Yes  □ No
2. Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)? □ Yes  □ No
3. Been constantly on guard, watchful, or easily startled? □ Yes  □ No
4. Felt numb or detached from people, activities, or your surroundings? □ Yes  □ No
5. Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused? □ Yes  □ No

**The Total Score is the sum of all “Yes” answers:** Score: ___ / 5

(Note, a score of 4-5 indicates PTSD)

(Note, a score of 3 indications possible PTSD)