CENTRACARE Health

A	**Suspected Maltreatment of a Child-Reporting Form**	Date:	Time:

Name of Child:			Med. Rec. #
Sex:	Date of Birth:	Age:	Phone:

Child's Street Address:	City:	State:	Zip:	County:

Suspected Date of Incident:	Time:	Incident Location:
Suspected Perpetrator Name:	Relationship:	Phone:
Address:	City: / Zip:	State: / County:
Who Brought Child to Hospital:	Relationship:	Phone:
Witness Name (if any) :	Relationship:	Phone:

B	**Family Relationship/ Household**	Mother's Name:	Marital Status	Father's Name:	Marital Status
		Mother's DOB:		Father's DOB:	
Name/Age of Siblings in Home:		Address (if different from child's)		Address (if different from child's)	
		Home #:	Work/Cell #:	Home #:	Work/Cell#:

C	**Other Caregivers**	Name:	Relationship:	
		Address:	Home#:	Work/Cell#:

D **Assessment of Presenting Problem** –Summary of explanation of injury or maltreatment, quote direct explanation by child, witness, caregiver or others. Describe behavior. Note: FOR CONFIDENTIALITY of reporter, DO NOT document about this report in the Medical Record. Document clinical facts in the Medical Record

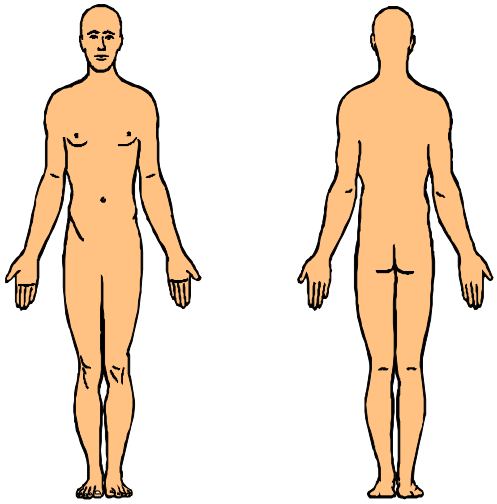
ABUSE: ☐ Physical ☐ Sexual ☐ Emotional / Mental

NEGLECT OF: ☐ Food ☐ Clothing ☐ Shelter ☐ Education ☐ Of Supervision ☐ Medical Needs

EXPOSURE: ☐ Alcohol ☐ Amphetamine ☐ Cocaine ☐ Heroine ☐ Marijuana ☐ Methamphetamine ☐ Opium ☐ Phencyclidine

OTHER: (Describe)

E	**Physical Exam –** Include accurate description of injury location, actual measurements, color of bruises, lacerations, burns, fx



photos Taken: Yes No

F	**REPORTING**	Reported to: ☐ County ☐ Law Enforcement

Verbal report is to be completed to the County where the minor resides.

County Verbally Reported to:	Date:	Time:
County Contact Person:	Phone:	
Written report faxed to number:	Date:	Time:
Law Enforcement Agency:		
Law Enforcement Contact Person:	Date:	Time:
Law Enforcement Phone Number:	Report Number:	

G	**MANDATED REPORTERS** (persons completing this form)

#1 Mandated Reporter Print Name:		#2 Mandated Reporter Print Name:	
Signature:		Signature:	
Title:		Title:	
Dept:	Phone: ext:	Dept:	Phone: ext:
Mandated Reporter work address:		Mandated Reporter work address:	
For County Intake: following investigation, please send results of investigation to: The Mandated Reporter(s) work address		For County Intake: following investigation, please send results of investigation to: The Mandated Reporter(s) work address	

H	ADDENDUM FORM – Suspected Maltreatment of a Child		
Medical Tests Completed		Date	Results
I	**Examining Physicians**	**Title:**	**Phone:**
Name:			
Name:			
Name:			
Name:			
Name:			
Medical Follow-Up		**Date:**	**Clinic:**

Other Observations/Assessments/Notes:

Print Name:	
Signature:	
Title:	Dept:
Phone:	Ext:

Original to: Medical Records
Fax copy to county