Maryland CHAMP
Maryland Child Abuse Medical Professionals

CHILD PHYSICAL ABUSE / ASSAULT FORM

Date: _____ Time: _____ ☐ am ☐ pm Examining Medical Provider:_____

DEMOGRAPHICS:

Child's Name: _____ DOB: _____ Age: _____

Home Address: _____ Race: _____ Gender: _____

_____ Legal Guardian: _____

Telephone: _____ Relationship to Patient: _____

Primary Care Provider:_____ Telephone:_____

HISTORY (BY AGENCY):

Agent:_____ Agency:_____ Phone:_____

_____

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HISTORY (BY ADULT): (Preferably separate from child)

Name and relationship of historian to patient:_____

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CHILD PHYSICAL ABUSE / ASSAULT FORM PATIENT IDENTIFICATION_____

HISTORY (BY CHILD): (Preferably separate from parent; Use exact words in quotations for key information):

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PAST MEDICAL HISTORY:

Perinatal History (gestation, delivery, birthweight, complications):_____

_____

Medications: (OTCs, alternatives)_____ Allergies: _____

Vaccinations: ☐ UTD ☐ Lapsed (shots due)_____

Surgery: _____

Hospitalizations: _____

_____

Trauma: (fractures, bruises, dental trauma, other trauma)_____

_____

Emergency department visits:_____

_____

Previous history of physical abuse? ☐ Yes ☐ No Sexual abuse ☐ Yes ☐ No

If yes, explain: _____

_____

REVIEW OF SYSTEMS:

General health,,Growth: _____

HEENT: (epistaxis)_____

Cardio/Resp:_____

Skin: (eczema, unusual marks, bumps or rashes)_____

GI: (diarrhea, constipation, encopresis, blood)_____

GU: (dysuria, genital pain, itching, discharge, blood) _____

Heme: (bleeding post circ, surgery, dental procedure)_____

Gyn: (menstrual history, genital trauma)_____

Other: _____

_____

_____

CHILD PHYSICAL ABUSE / ASSAULT FORM PATIENT IDENTIFICATION: _____

DEVELOPMENTAL AND BEHAVIORAL HISTORY:

☐ Parent identified developmental problem ☐ Special schooling

_____

_____

Pertinent milestones: (motor, verbal, social)_____

_____

☐ Parent identified behavioral problem ☐ School identified behavioral problem ☐ ADD diagnosis

_____

_____

Temperament:_____

_____

Disciplinary strategies:_____

_____

_____

IPV SCREEN:

As an adult, have you ever been slapped, kicked punched, or otherwise hurt by someone ☐ Yes ☐ No

As an adult, have you ever had unwanted or forced sexual contact with another adult ☐ Yes ☐ No

FAMILY HISTORY:

☐ Osteogenesis imperfecta ☐ Many/easy fractures ☐ Abnormal tooth enamel ☐ Unusual Short Stature ☐ SIDS

☐ Hemophilia ☐ Heavy menstrual bleeding ☐ Post surgical bleeding ☐ Post dental bleeding

☐ Mental illness ☐ Substance use ☐ Frequent fetal loss ☐ Early hearing loss

Other:_____

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SOCIAL HISTORY: Prior CPS history: ☐ YES ☐ No

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CHILD PHYSICAL ABUSE / ASSAULT FORM PATIENT IDENTIFICATION: _____

PHYSICAL EXAMINATION:

Vital Signs: Wt:_____ %ile:_____ Ht:_____ %ile:_____ FOC:_____ %ile_____ BMI:_____

Child's behavior & appearance: _____

Head/Scalp: _____

Eyes/Fundi**:** _____

Ears/Pinnae: _____

Mouth/Pharynx: _____

Neck: _____

Breasts: _____

Chest: _____

Cardiovascular: _____

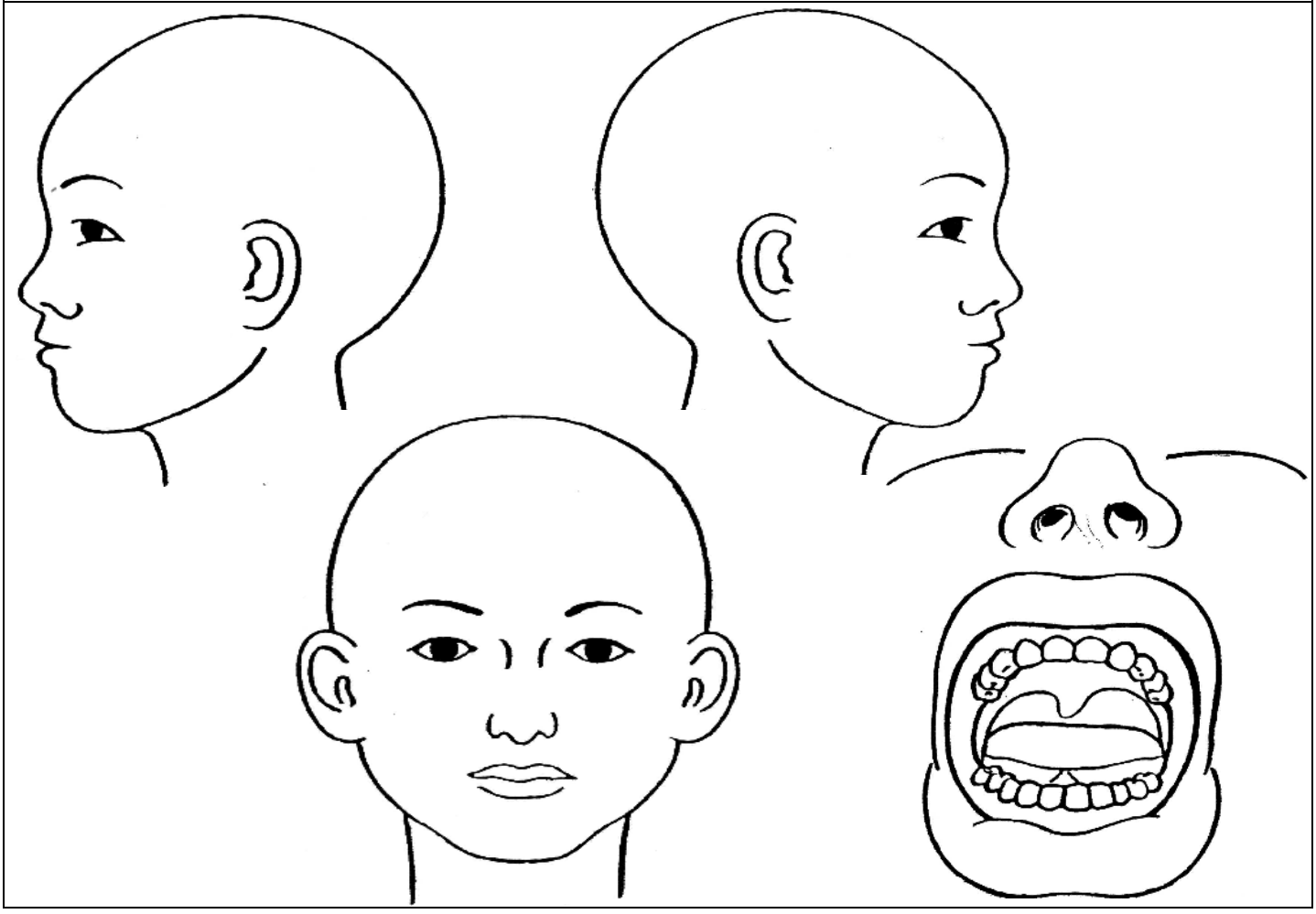
Abdomen: _____

Extremities: _____

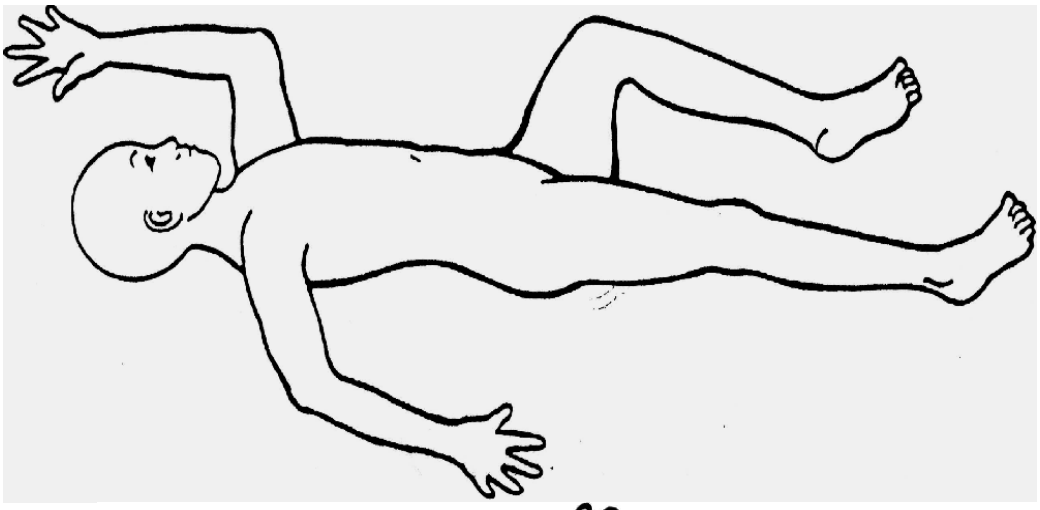
Neurologic: _____

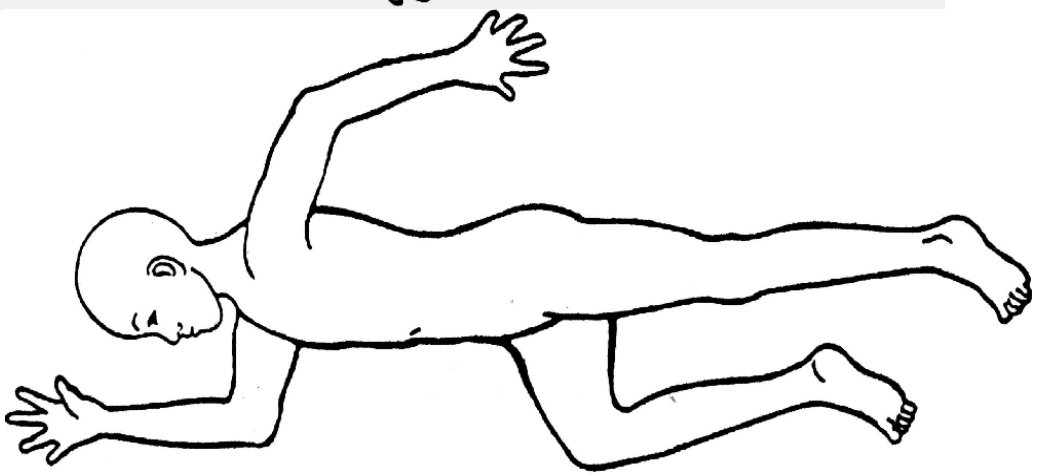
Skin: _____

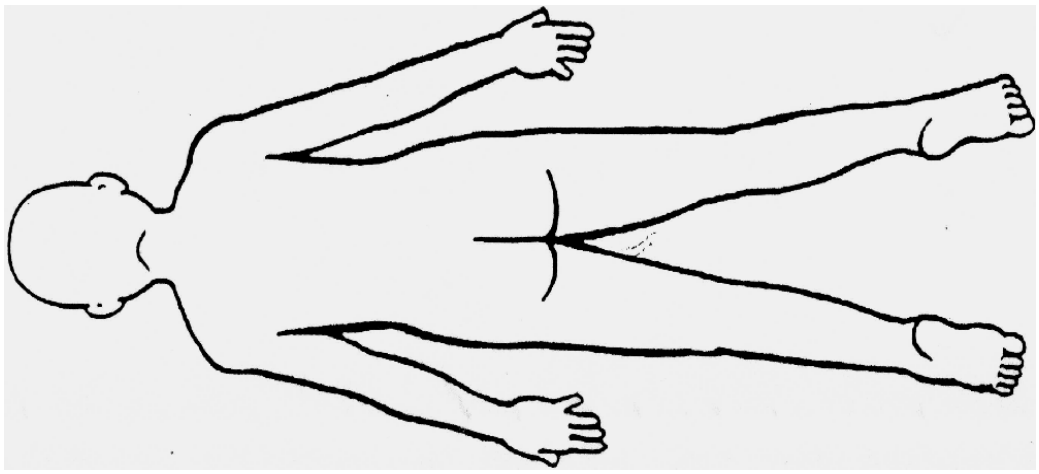
Ano/genital _____

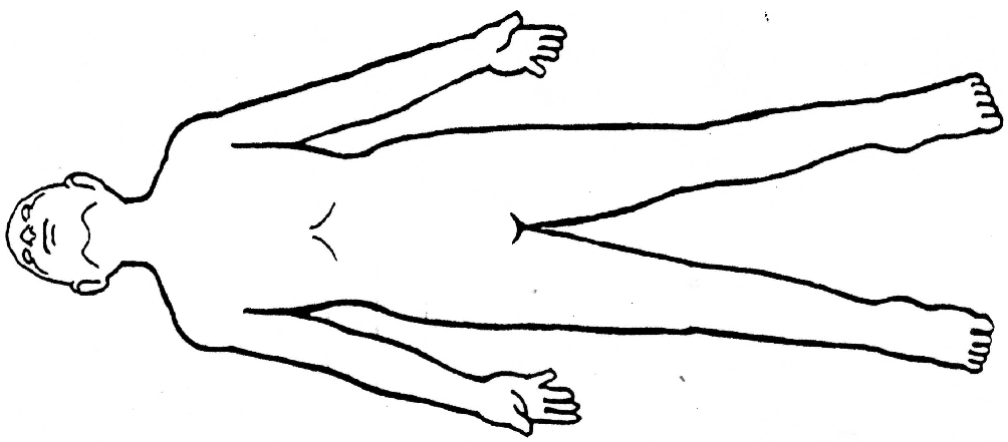


CILD PHYSICAL ABUSE / ASSAULT FORM PATIENT IDENTIFICATION: _____









CHILD PHYSICAL ABUSE / ASSAULT FORM PATIENT IDENTIFICATION: _____

RECORDED IMAGES:

Video recorded: ☐ Yes ☐ No Photographs taken: ☐ Yes ☐ No

ADDITIONAL STUDIES:

- ☐ Skeletal X-ray survey
- ☐ Nuclear bone scan
- ☐ Intracranial imaging ☐ CT ☐ MRI
- ☐ CBC, PT/PTT, other coag studies
- ☐ ALT, AST
- ☐ Amylase, Lipase
- ☐ Urinalysis
- ☐ Others:_____

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Results:

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ASSESSMENT :

History: (Check all that apply)

- ☐ 3rd party witness of inflicted trauma
- ☐ Confessed inflicted trauma
- ☐ Child report of inflicted trauma
- ☐ No history of trauma
- ☐ History inconsistent with findings
- ☐ History possibly inconsistent with findings
- ☐ History consistent with findings

Comment:

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CHILD PHYSICAL ABUSE / ASSAULT FORM PATIENT IDENTIFICATION: _____

Physical Examination Reveals: (Check all that apply) ☐ Normal exam ☐ Findings indicate a diagnosis other than trauma ☐ Evidence of acute injury ☐ Evidence of healing injury ☐ Clearly inflicted pattern of injury	Comment:
Overall abuse Assessment: (Check one) ☐ Cannot diagnose nor exclude abuse ☐ Suspicious for abuse ☐ Diagnostic of abuse	Comment:
Other medical condition: (Check one) ☐ Absent ☐ Present	
Other Medical Needs:	Other Psycho-Social Needs:

TREATMENT:_____

RECOMMENDED FOLLOW-UP

- ☐ Acute skeletal X-ray survey
- ☐ 2 Wk skeletal X-ray survey
- ☐ Nuclear bone scan
- ☐ Intracranial imaging ☐ CT ☐ MRI
- ☐ CBC, PT/PTT, other coag studies
- ☐ ALT, AST
- ☐ Amylase, Lipase
- ☐ Urinalysis

Others:_____

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MENTAL HEALTH REFERRAL

Crisis care

Mental health evaluation of the child

Mental health evaluation of adult(s)

Name _____

_____

_____

Developmental assessment of the child

DISPOSITION:

Reported to CPS worker:_____ Reported to LE officer:_____

Badge #:_____

Admitted Facility:_____ Transferred Facility:_____

Discharged

☐ Home ☐ DSS ☐ Foster Care ☐ Kinship Care

ADDITIONAL NOTES:

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MEDICAL PROVIDER'S SIGNATURE PRINTED NAME