

Child Protection Medical Examination Proforma

Patient's Details (affix sticker)

Name:

Date of Birth:

Trust ID Number:

NHS number:

RACH Child Protection Medical Examination Proforma

Before you begin: READ THROUGH ENTIRE PROFORMA SO YOU ARE FAMILIAR WITH IT

- Introduce yourself to child and family and social worker
- Make sure you give child and family an explanation of the process and its purpose
- Date, time and sign bottom of each page
- Identifier on every page
- Extra proforma paper is in the appendix- number this and insert into notes bundle e.g. 1a, 2a
- If you (rarely) examine child without a parent, you must have a chaperone or social worker in the room
- **Ask OPEN-ended questions and record your own questions**
- Record verbatim comments made by carers / child
- **CROSS OUT PAGES / SPACE NOT BEING USED**

CONSENT TO MEDICAL EXAMINATION

Permission must be obtained and recorded from those with parental responsibility / child where appropriate. Written consent is good practice but **verbal consent is acceptable.**

I agree to		Yes	No
Medical Examination			
Medical Photography – storage and teaching purpose			
Interpreter needed (arrange official interpreter)			
I agree for report to be shared with			
1.	GP		
2.	Health Visitor/ School nurse		
3.	Social Care		
4.	Police		

Parent/Carer Consent. SIGNATURE	
DATE OF EXAMINATION:	
TIME STARTED:	TIME COMPLETED:
LOCATION:	
NAME AND GRADE OF EXAMINING DOCTOR:	

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Current address (if different from above):

Telephone Number:

Country of Birth:

Interpreter required: Y / N

	Name	Contact Number
Health visitor		
Social Worker		
Police officer		

Names / roles of persons present during assessment – include social services contact no + team

Persons present during assessment	Relation to child / profession
1	
2	
3	
4	
5	
6	

Background information given to you at point of referral

- **Is the child / sibling on Child Protection Plan** Y / N
If so under which category
- **Is the child / sibling Child In Need / CAF or TAF** Y / N
- **Who has Parental responsibility of the child:**
- **Name of school / Nursery / Childminder:**

Date

Signed / Name / Title



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History (Use verbatim quotes where possible, indicate from whom history has been taken and where possible use the voice of the child. Ask open-ended questions. Use extra sheets where needed.)



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History continued.

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Past Medical History of Child (general health, recent illness, previous injuries / admissions)

- **Birth History** (include feeding and immunisation)
 - < 5 years – review of Red Book growth

- **Medication and allergies**

- **Developmental / School history** (include reported motor abilities and milestones)
 - Gross motor
 - Fine motor
 - Speech and language
 - Vision and hearing
 - Social skills

- **Personal history of dislocations or hypermobility**

- **Bleeding history**
 - bleeding after cord cut / Vit K administration / immunisations Y / N
 - bleeding after dental procedures or operations Y / N
 - recent NSAID use Y / N
 - bleeding gums or prolonged / regular epistaxis Y / N
 - pain / joint swelling or reluctance to move a limb (seen with haemarthroses) Y / N

- **Family history**
 - haemophilia, Von Willebrand disease, or platelet function defects (in 30% of cases, haemophilia may arise secondary to new genetic mutations)
 - post-partum haemorrhage / menorrhagia
 - dislocations / hypermobility / EDS

Date

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Family Tree (*encourage child to explain their household, include questions regarding smoking, alcohol and drug use and mental health issues in parents.*)

Mother name, DOB and occupation:

Father name, DOB and occupation:

Siblings including DOB:

Who else looks after the child/is present in household?

Adolescents:

(Remember to ask about puberty and menstruation in females)

HEADSSS history –

H – Home and environment

E – Education

A – Activities

D – Drugs/smoking/alcohol

S – Sex and relationships

S – Self harm and depression

S – Safety and abuse

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EXAMINATION

Explain to parent that you will / would like to examine first and hear the child's account initially. Children in nappies should have their nappy removed. Some primary school children may allow you to check for buttock bruising but this should be done sensitively. **Older children may prefer not to have a parent or social worker present, in which case ask a nurse / HCA to chaperone.**

EXAMINED IN FRONT OF _____

Height

Weight

OFC

Centile

Centile

General Appearance:

Emotional state:

Developmental abilities noted during assessment:

Scalp and Hair (hidden injuries?)

Fontanelle

Ears

Eyes

Face / Neck

Mouth / frenum / teeth

Resp

Cardiac

Abdo

Nappy area of Infants / Genitalia (where appropriate)

Date

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NUMBER THE INJURIES ON BODY MAP – write your open question and the child's

explanation for each injury in their own words.

e.g. Injury 1 – 2x2 cm bruise, located over ASIS, non-tender to touch.

"What happened?"

"I fell off trampoline"

See p11 if you need more space for history

	INJURY DESCRIPTION	EXPLANATION FOR INJURY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

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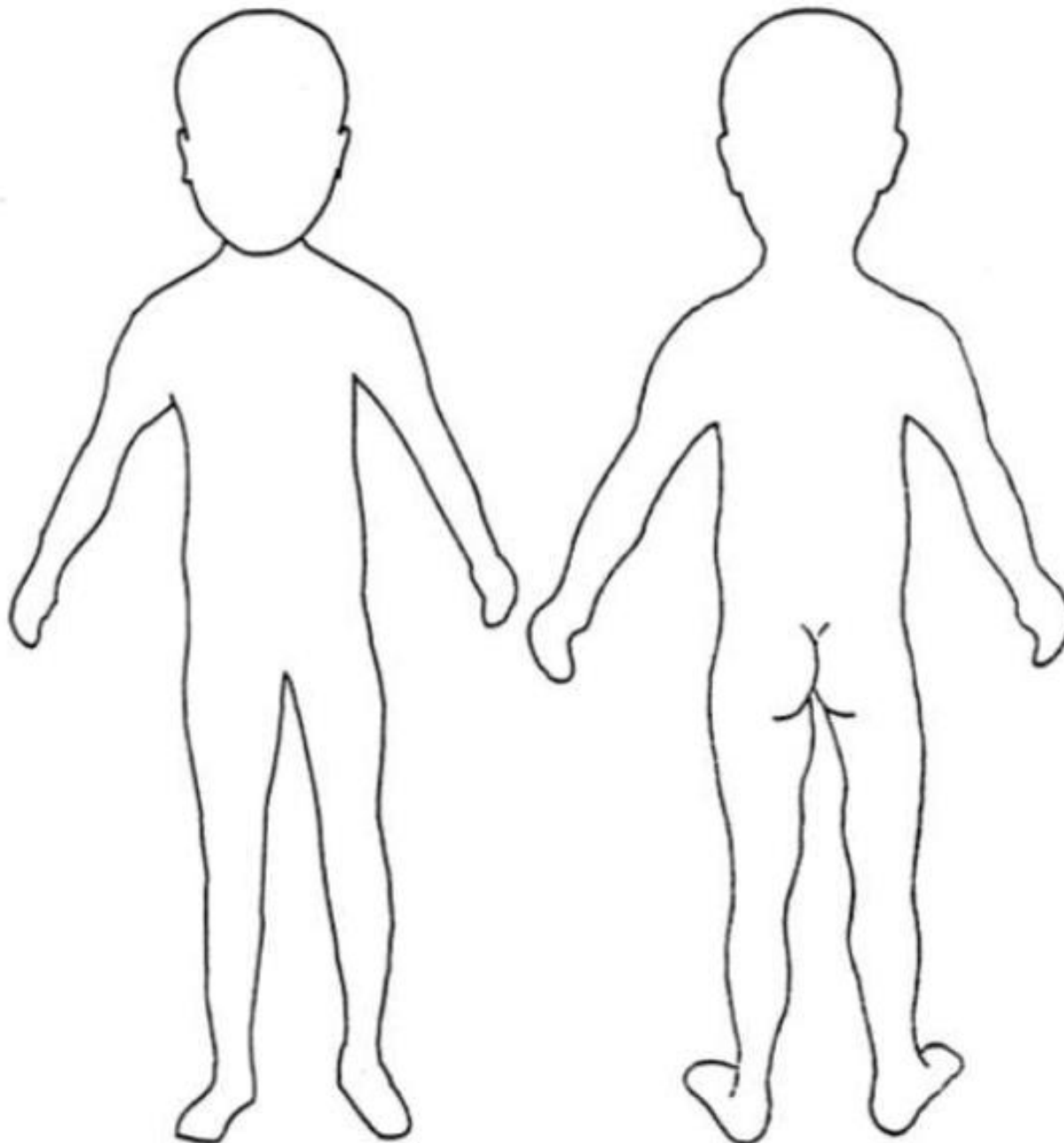
NHS Number:

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Body Map

Child (see page 11 for baby)

Date and time of observation: _____



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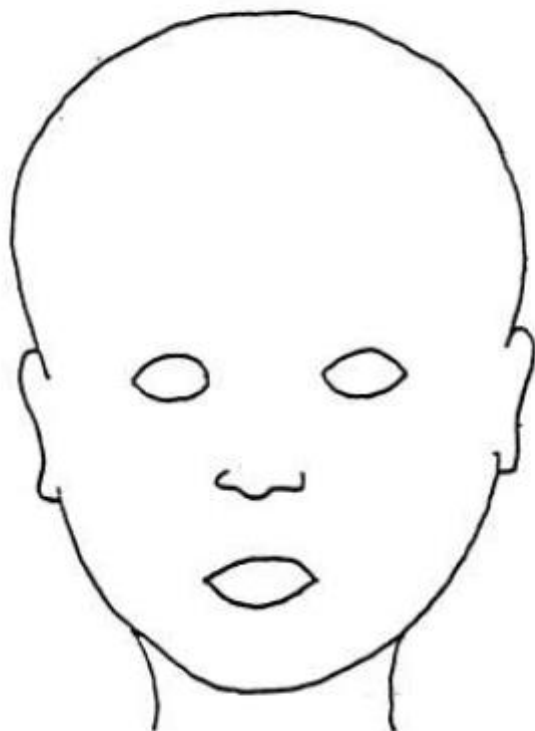
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Trust ID Number:

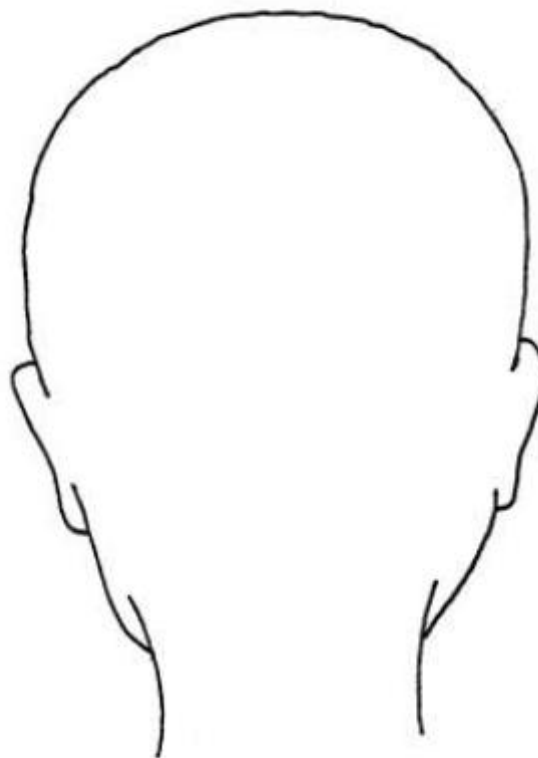
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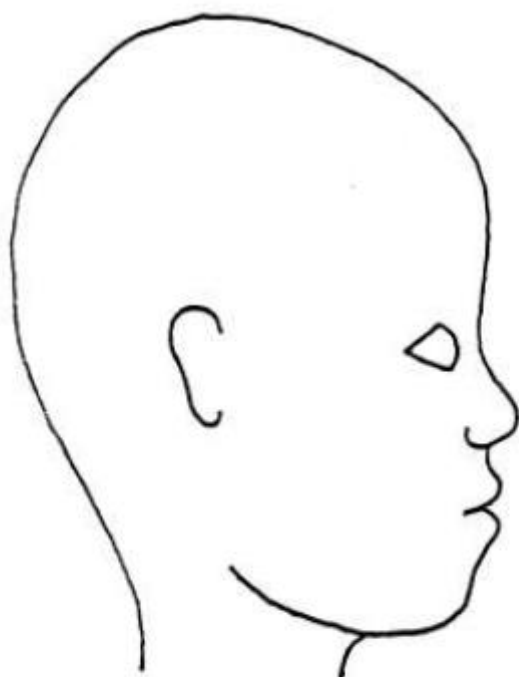
Date and time of observation: _____



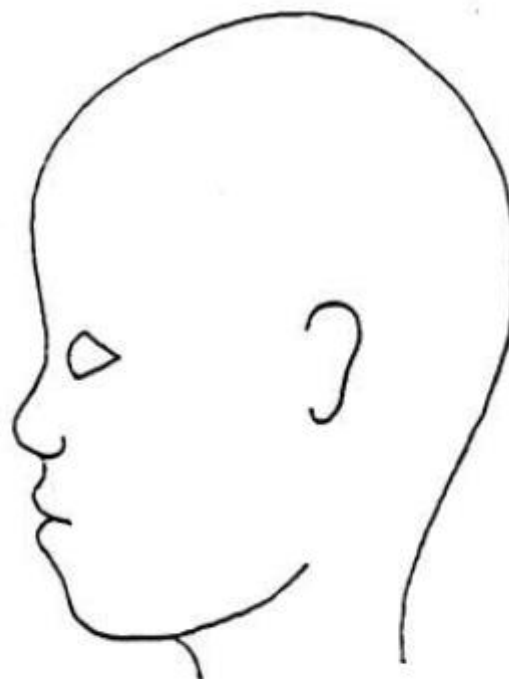
FRONT



BACK



RIGHT



LEFT

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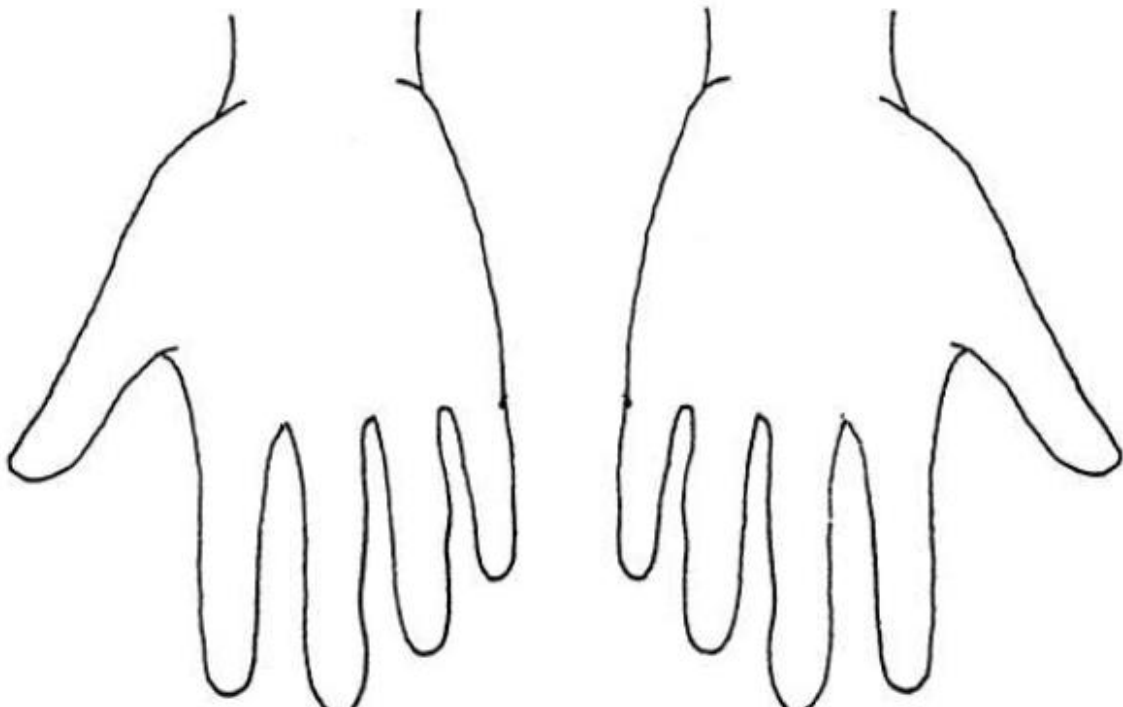
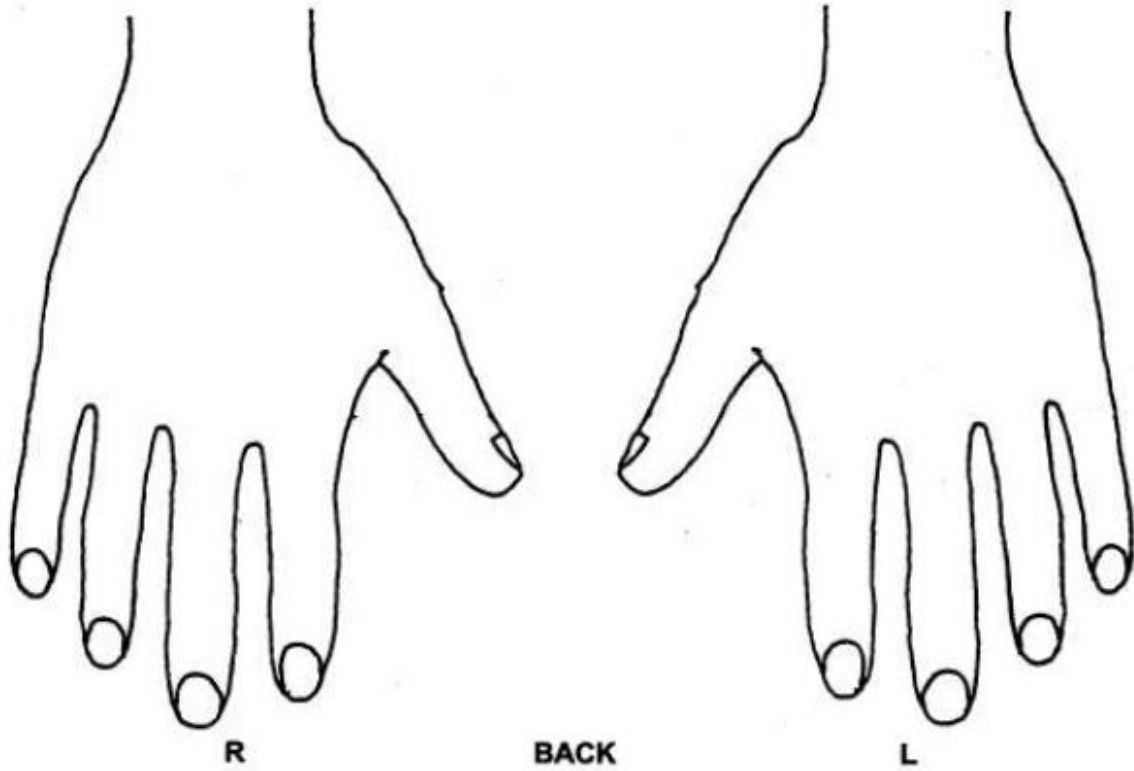
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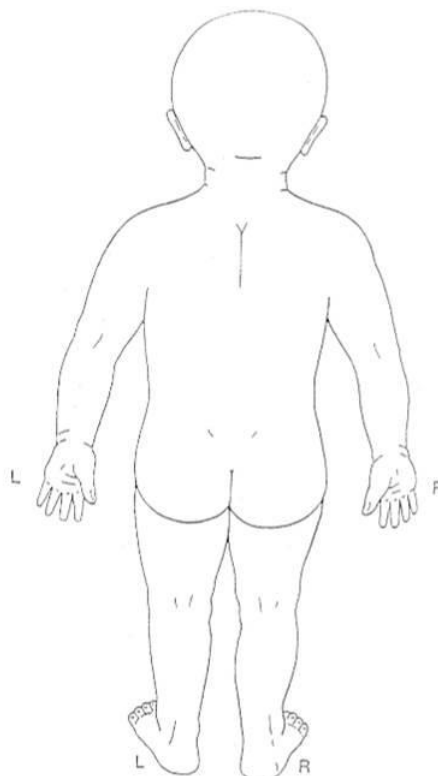
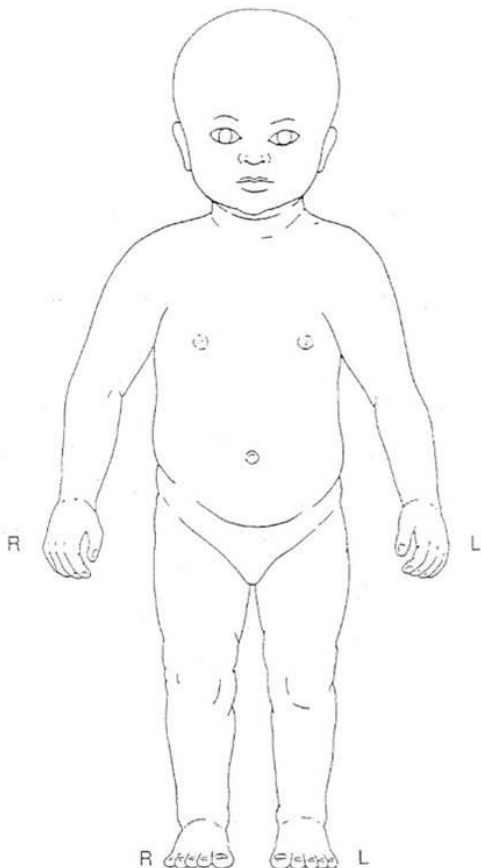
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Baby

Date and time of observation: _____



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INVESTIGATIONS to be arranged - see NAI blood tests guideline

	Yes	No	Date	Result
FBC			/ /	
Clotting screen			/ /	
vWF, Factor 8			/ /	
U&E/LFT/amylase			/ /	
Bone profile, Vit D, PTH			/ /	
X-Ray			/ /	
Skeletal survey			/ /	
CT Head			/ /	
Ultrasound Head			/ /	
MRI Head			/ /	
Ophthalmology (ideal = within 24 hrs)			/ /	See separate documentation

Previous RACH Medical Records Requested and Reviewed **Yes / No**

OVERALL OPINION

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	Yes	No	
Does child need paediatric review?			If yes, date
Do siblings need assessment?			If yes, date
Does child need admission to hospital? - have you handed child over to COW			
If you are a registrar – has the case and management been seen and discussed with Consultant?			

Medical Management Plan

e.g.) dietician referral

e.g.) eczema management

e.g.) referral to community to paed's if disordered development

****Please now complete the provisional opinion form (next page) and start a ward checklist if being admitted****

<p><u>Discussed at Peer Review</u> Y / N</p> <p><u>Date</u></p>

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CP provisional medical opinion form

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.....

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<p>The purpose of the provisional report is to give the professional medical opinion regarding the likelihood of abuse based on the history and clinical findings in writing at the time of the initial discussion between examining paediatrician and social worker.</p> <p>Paediatric opinion (indicate all that apply)</p> <p>Name of consultant:</p>		
More likely to be accidental than inflicted	Yes	No
Diagnosis uncertain further paediatric review required	Yes	No
Suggestive of inflicted injury	Yes	No
Suggestive of an organic condition/alternative explanation	Yes	No
If allegation has been made		
Consistent with the allegation made	Yes	No
Incidental to the allegation made	Yes	No
Not consistent with the allegation made <i>(although the absence of marks does not preclude the possibility of reported events having occurred in the majority of cases).</i>	Yes	No
Rationale for opinion		
Opinion must be discussed with parent/carer by paediatrician & social worker NB take care when perplexing case or FII suspected	Completed <input type="checkbox"/>	
Other actions to be taken		
Photos taken Y <input type="checkbox"/> N <input type="checkbox"/>		
Have you considered need for admission and further investigations? Y <input type="checkbox"/> N <input type="checkbox"/>		



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EXTRA PAPER – please file where needed

Date

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