

**State of California
Governor's Office of Emergency Services
(www.caloes.ca.gov)**

**MEDICAL REPORT:
SUSPECTED CHILD PHYSICAL ABUSE AND NEGLECT
EXAMINATION**

CAL OES 2-900



For copies of this form or assistance in completing the Cal OES 2-900, please contact
California Clinical Forensic Medical Training Center
www.ccfmtc.org

MEDICAL REPORT: SUSPECTED CHILD PHYSICAL ABUSE AND NEGLECT EXAMINATION
State of California
Office of Emergency Services
Cal OES 2-900

Confidential Document

Patient Identification

A. GENERAL INFORMATION See Patient Label/Registration Face Sheet

1. Name of Medical Facility Where Exam Performed	Facility Address	2. Date of Exam	Time of Exam
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3. Patient's Last Name	First Name	M.I.	Telephone	Cell Phone
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4. Street Address	City	County	State	Zip Code
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5. Age	Date of Birth	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Ethnicity
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6. Interpreter Used: No Yes Language Used: _____
 Name of Interpreter: _____ Telephone: _____
 Affiliation of interpreter: Facility Interpreting Services
 Contracted Agency, specify: _____
 Family Friend Other, specify: _____

7. Name of Child's Caregiver <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other, specify: _____	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Telephone (w) (h) (c)		
Street Address	City	County	State	Zip Code

8. Name of Child's Caregiver <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other, specify: _____	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Telephone (w) (h) (c)		
Street Address	City	County	State	Zip Code

9. Name(s) of Siblings	Gender	Age	DOB	Name(s) of Siblings	Gender	Age	DOB
	M F				M F		
	M F				M F		

B. MANDATORY REPORTING FOR SUSPECTED CHILD ABUSE AND NEGLECT

Mandatory Child Abuse/Neglect Report made to both Law Enforcement and CPS Agencies (Pursuant to Penal Code §11166):

<input type="checkbox"/> Law Enforcement	<input type="checkbox"/> Telephone Report	<input type="checkbox"/> Written Report Submitted	Name of Agency	Telephone	Date
Name of Person Taking Report: _____					
<input type="checkbox"/> Child Protective Services	<input type="checkbox"/> Telephone Report	<input type="checkbox"/> Written Report Submitted	Name of Agency	Telephone	Date
Name of Person Taking Report: _____					

C. RESPONDING PERSONNEL TO MEDICAL FACILITY

Name	ID Number	Agency	<input type="checkbox"/> Unknown
Child Protective Services _____			
and/or _____			
Law Enforcement Officer _____			

D. PATIENT CONSENT AND AUTHORIZATION FOR EXAMINATION (See instructions)

Law Enforcement Authorized CPS Authorized Placed in protective custody Physician authority pursuant to state law Parent/Guardian consent

E. DISTRIBUTION OF Cal OES 2-900 (Check all that apply)

<input type="checkbox"/> Law Enforcement Agency (original)	<input type="checkbox"/> Hand Delivered	<input type="checkbox"/> Mailed	<input type="checkbox"/> Faxed	<input type="checkbox"/> Child Protective Services (copy)	<input type="checkbox"/> Hand Delivered	<input type="checkbox"/> Mailed	<input type="checkbox"/> Faxed
<input type="checkbox"/> Crime Laboratory (copy included with evidence)				<input type="checkbox"/> Medical Facility Records (copy)			

J. GENERAL PHYSICAL EXAMINATION

1. Temperature		Pulse		Respiration		Blood Pressure	
2. Height (cm or in)	(%)	Weight (kg or lb)	(%)	Children under 2: (HC)		(%)	

3. General physical appearance, demeanor, and level of physical discomfort/pain. Provide brief handwritten summary even if dictating. See dictation for additional information. N/A

Patient Identification

4. Record results of physical examination.

	WNL	ABN	Not Examined	See Body Diagram	Describe Abnormal Findings. <input type="checkbox"/> N/A <input type="checkbox"/> See dictation for additional information
Skin					
Head					
Eyes					
Ears					
Nose					
Mouth/Pharynx					
Teeth					
Neck					
Lungs					
Chest					
Heart					
Abdomen					
Back					
Buttocks					
Extremities					
Neurological					
Genitalia					

5. If genital injuries are sustained, use copies of page(s) 6 and 7 (if applicable) from Cal OES 2-930 Forensic Medical Report: Acute (<72 hours) Child/Adolescent Sexual Abuse Examination Form or Cal OES 2-925 Forensic Medical Report: NonAcute (>72 hours) Child/Adolescent Sexual Abuse Examination to document findings and attach to this form.

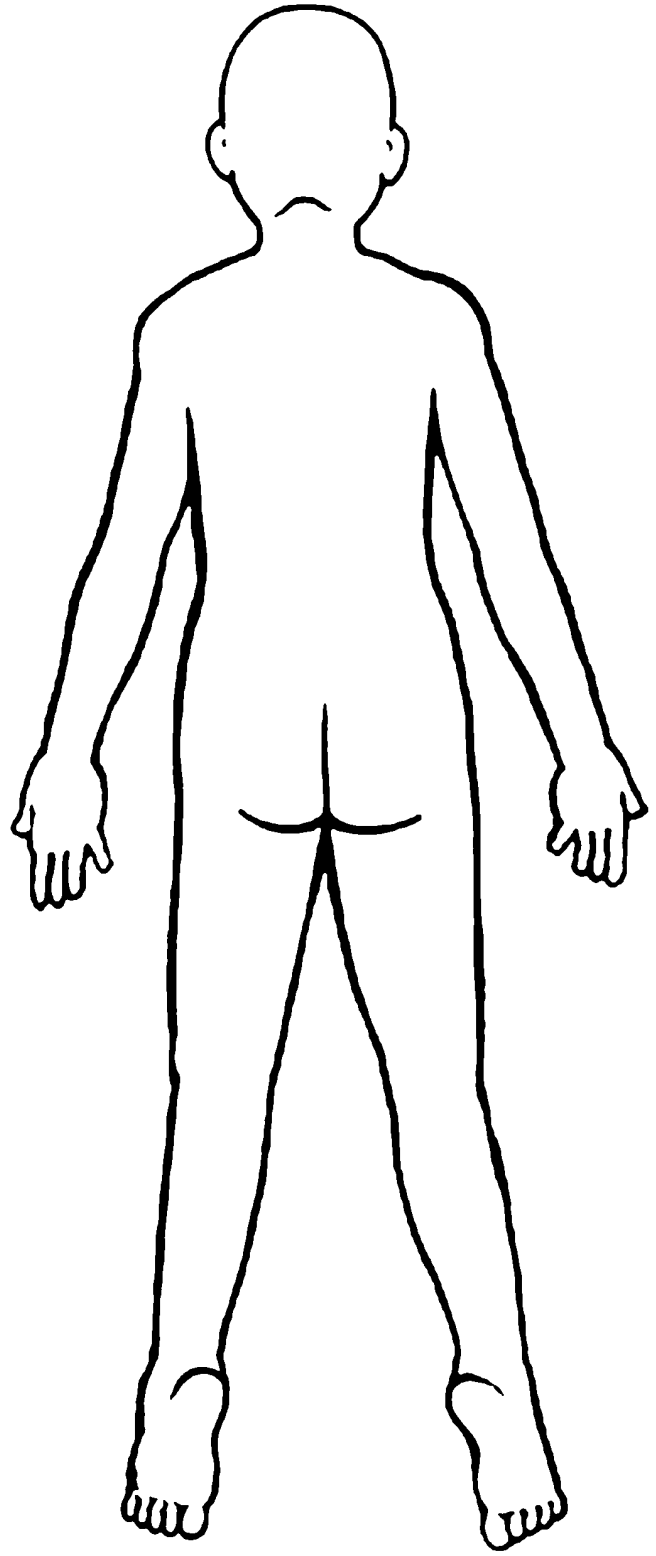
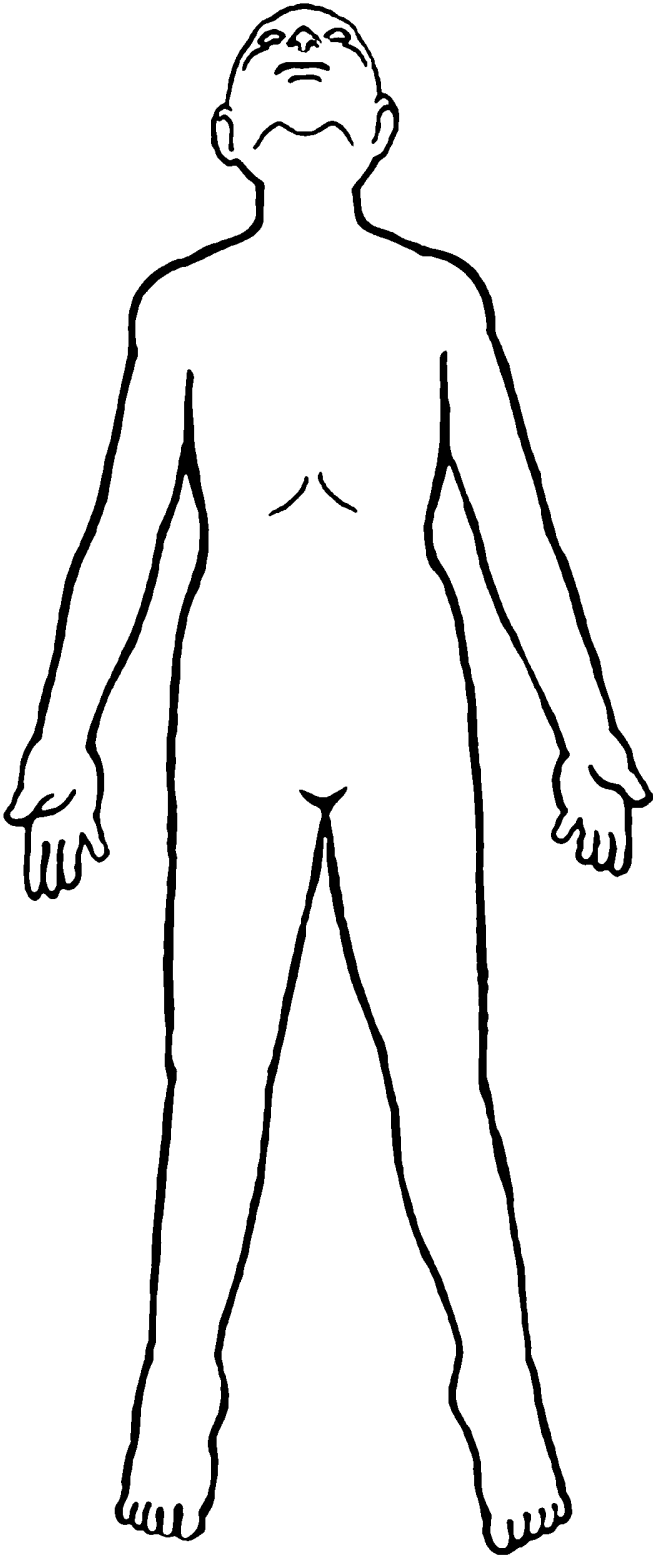
J. GENERAL PHYSICAL EXAMINATION (continued)

6. Conduct physical examination and record findings using the diagrams.

Patient Identification

A

B



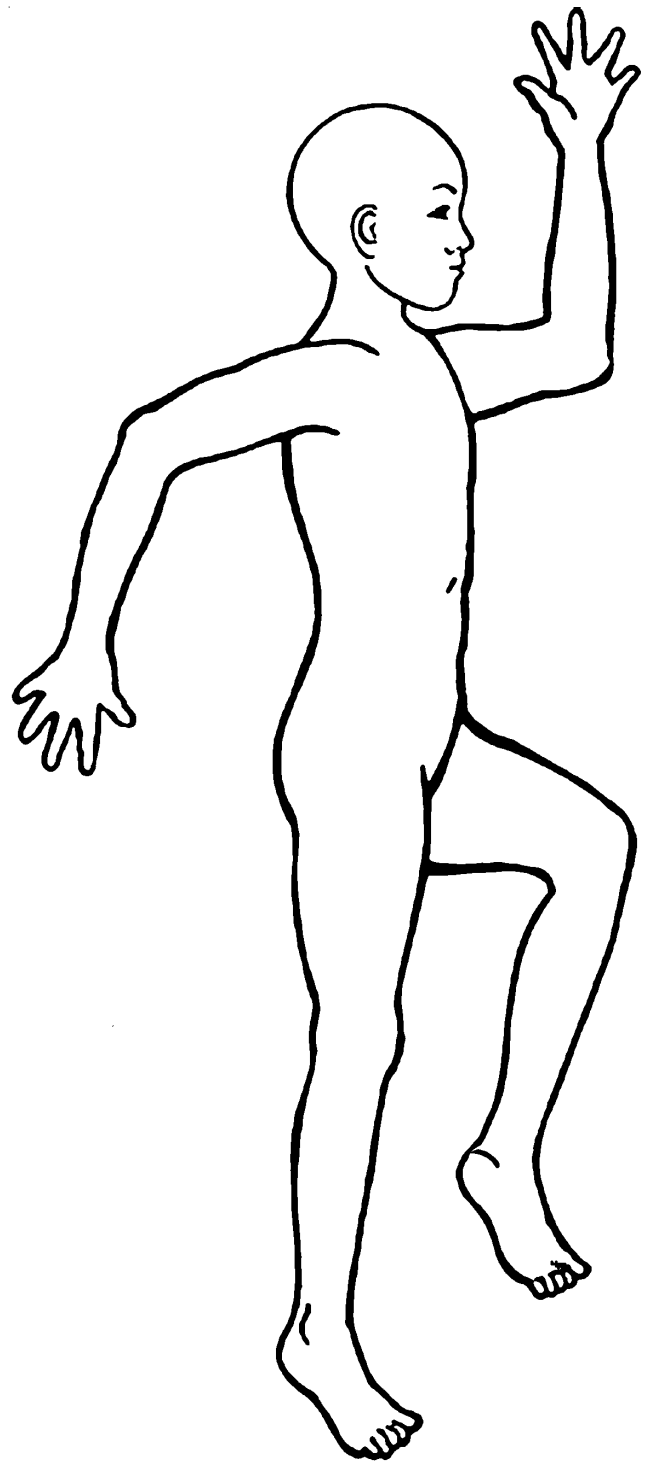
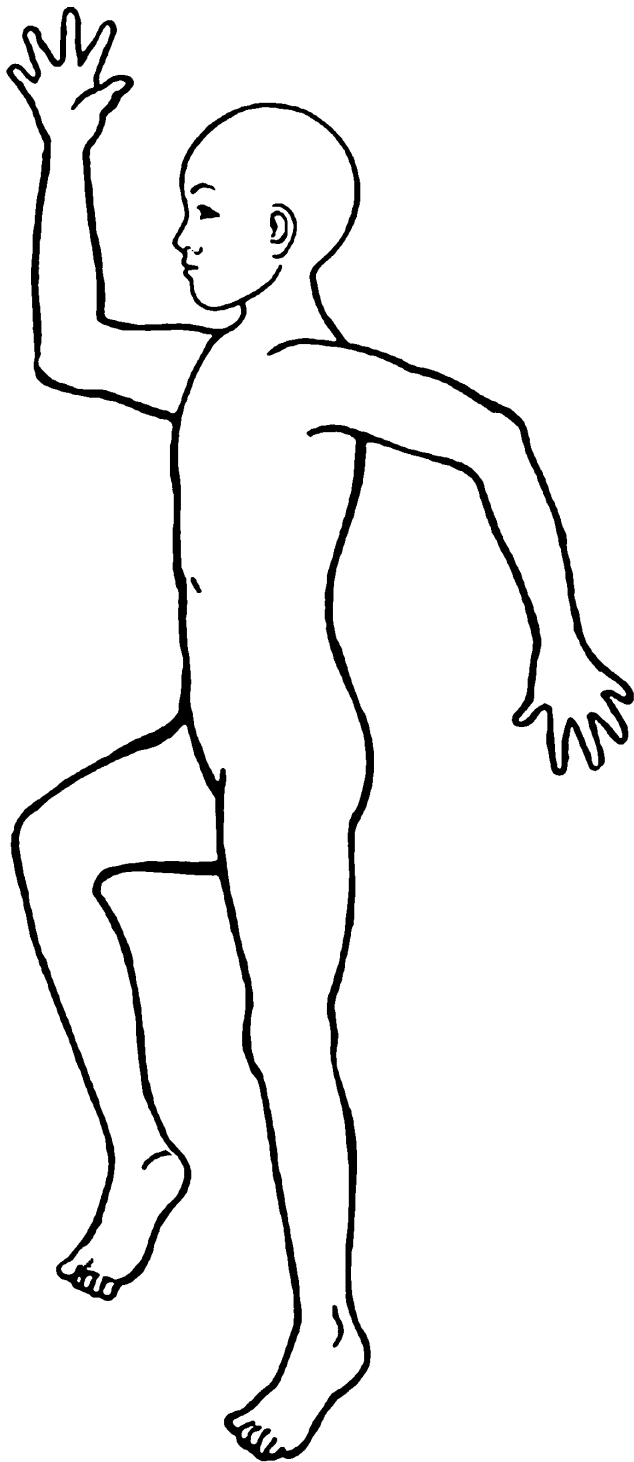
J. GENERAL PHYSICAL EXAMINATION (continued)

6. Conduct physical examination and record findings using the diagrams.

Patient Identification

C

D

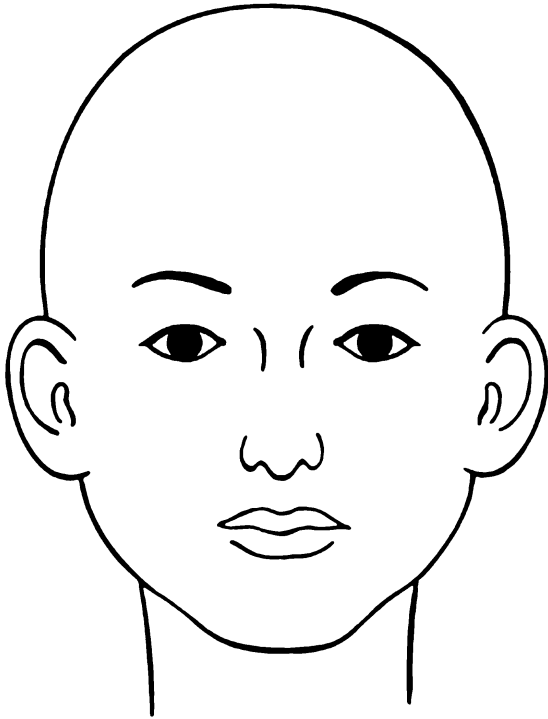


J. GENERAL PHYSICAL EXAMINATION (continued)

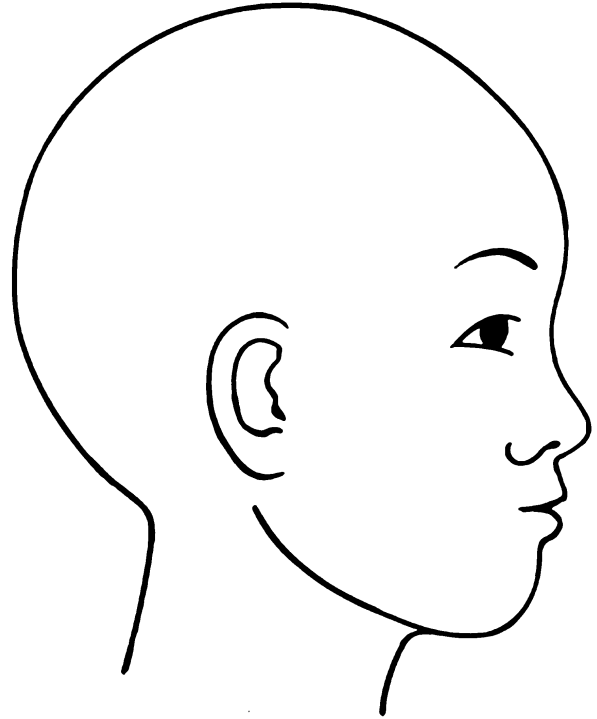
7. Examine the face, head, ears, hair, scalp, neck, and mouth for injury. Record findings using the diagrams.

Patient Identification

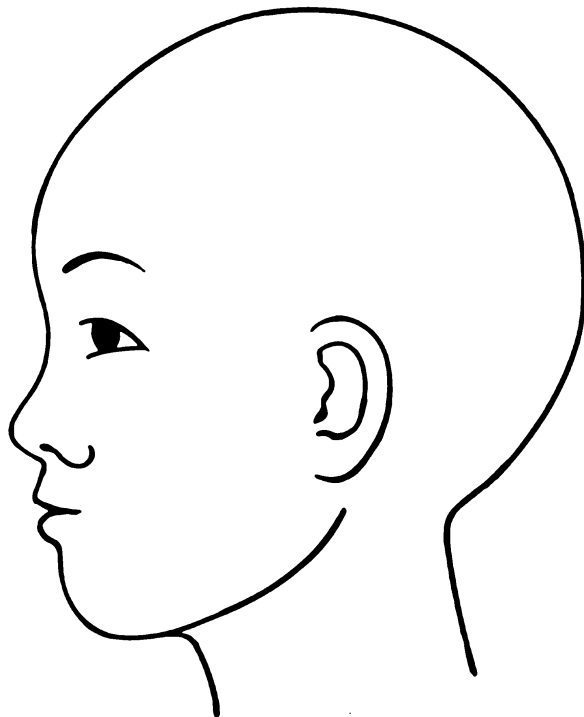
E



F



G



H



