

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

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

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

Cal OES 2-900

Medical Report: Suspected Child Physical Abuse and Neglect Examination

REQUIRED USE OF STANDARD STATE FORM:

Penal Code § 11171 established the use of a standard form to record findings from examinations performed for suspected child physical abuse and neglect. This form is intended to facilitate identification of child physical abuse and neglect, and as such, is not a complete medical treatment record.

SUGGESTED USE OF THE STANDARD STATE FORMS: FOLLOW LOCAL POLICY

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| Cal OES 2-900 | Medical Report: Suspected Child Physical Abuse and Neglect Examination <ul style="list-style-type: none"> • Suspected child physical abuse and neglect • Examination of children and adolescents under age 18 |
| Cal OES 925 | Forensic Medical Report: Nonacute (>72 hours) Child/Adolescent Sexual Abuse Examination <ul style="list-style-type: none"> • History of nonacute sexual assault (>72 hours) • Examination of children and adolescents under age 18 |
| Cal OES 2-930 | Forensic Medical Report: Acute (<72 hours) Child/Adolescent Sexual Abuse Examination <ul style="list-style-type: none"> • History of acute sexual assault or assault (<72 hours) • Examination of children and adolescents under age 18 |

INSTRUCTIONS FOR Cal OES 2-900

These instructions contain the recommended methods for meeting the minimum legal standards established by Penal Code § 11171 for performing examinations. Consult the California Medical Protocol for Examination of Suspected Child Physical Abuse and Neglect published by Cal OES for additional information including the knowledge, skills, and abilities necessary for health practitioners to complete the medical examination.

LIABILITY AND RELEASE OF INFORMATION

This medical report is subject to the confidentiality requirements of the Child Abuse and Neglect Reporting Act (Penal Code § 11164 or privilege), the Medical Information Act (Civil Code § 58 et seq.), the Physician-Patient Privilege (Evidence Code § 990), the Official Information Privilege (Evidence Code § 1040) and Penal Code § 11171.2. It can only be released to those involved in the investigation and prosecution of the case: a law enforcement officer, district attorney, city attorney, crime laboratory, child protective services worker, child abuse and neglect team member, county licensing agency, and coroner. Records may be released to the defense counsel only through discovery of documents in the possession of a prosecuting agency or after the appropriate court process (i.e., judicial review and a court order).

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| Complete this report in its entirety. Print legibly. Use N/A (not applicable) when appropriate to show that the examiner attended to the question. | Patient identification: This space is provided for hospitals and clinics using plastic plates for stamping identification information; or, for facilities to write in an identification number and date. |
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A. GENERAL INFORMATION

Note: If the facility patient label or registration face sheet includes the information requested in items #1-5 below, these may be used in lieu of handwritten entries. Mark the box and attach the label or registration face sheet to this form.

1. Enter the name and address of the facility where the examination was performed.
2. Enter the date and time of the exam.
3. Enter the patient's name and telephone number.
4. Enter the patient's street address, city, county, state, and zip code.
5. Enter the patient's age, date of birth (DOB), gender, and ethnicity.
6. Enter whether an interpreter was used, the language used, and who provided interpreting services.
7. Enter the name of the child's caregiver, gender, street address, city, county, state, zip code, and telephone numbers.
8. Enter the name of the child's caregiver, gender, street address, city, county, state, zip code, and telephone numbers.
9. Enter the name(s) of siblings, gender, age, and date of birth.

B. MANDATORY REPORTING FOR SUSPECTED CHILD ABUSE AND NEGLECT: Suspected Child Abuse and Neglect Form Department of Justice (DOJ) SS 8572.

1. Penal Code § 11166 requires all professional medical personnel to report suspected child abuse and neglect, defined by Penal Code § 11165, immediately by telephone and to submit a written report (DOJ SS 8572) within 36 hours to a local law enforcement agency OR a child protective services agency.
2. The Cal OES 2-900 should not replace the DOJ SS 8572 Suspected Child Abuse and Neglect Report. The SS 8572 is used by all mandated reporters to report suspected child abuse and neglect. The Cal OES 2-900 is used by medical personnel to document physical findings and is part of the medical treatment record (Penal Code § 11171.2(d).
 - Check the appropriate box to indicate that a telephone report was made to a law enforcement agency and/or Child Protective Services. Identify the person who took the report, his/her telephone number, and the date the report was made.
 - Check the appropriate box to indicate whether the written report was submitted to a law enforcement agency or to Child Protective Services.
3. See California Medical Protocol for Examination of Suspected Child Physical Abuse and Neglect for further discussion.

C. RESPONDING PERSONNEL TO MEDICAL FACILITY

1. Record name(s) of responding personnel from a law enforcement or child protective services agency and identifying information.
2. If unknown, check box.

D. PATIENT CONSENT AND AUTHORIZATION FOR EXAMINATION

1. See page 2 for information on consent and authorization for examinations.
2. Authorization by law enforcement or child protective services is not required for healthcare providers to use this form. Authorization, however, may be required if either agency is the designated payor.
3. Payment methods have not been formally established. Options to pursue include: the patient's public (Medi-Cal) or private insurance, the California Victim Compensation Program (VCP), local law enforcement agencies or Child Protective Services (CPS). Follow local policy.
4. See California Medical Protocol for Examination of Suspected Child Physical Abuse and Neglect for further discussion.

E. DISTRIBUTION OF Cal OES 2-900

Check boxes to indicate the distribution of the form.

F. PATIENT HISTORY

1. Record the name(s) of the person(s) providing the history and their relationship to the patient.
2. Record the name(s) of the person(s) accompanying the child to the facility and their relationship to the patient.
3. Record the history of present illness.
 - If dictating, provide brief 2-3 sentence handwritten summary.
 - Include date, time or timeframe of incident, place of incident, and the name, if known, of the initial reporting party.
 - If documenting specific statements made by the patient or historian, use quotation marks.
 - Document if statement(s) made by patient were spontaneous (i.e. not in response to a question or comment).
 - When interviewing verbal children, ask open-ended questions such as “What happened to you? Tell me what happened to you. How did this happen? What did he do or what did she do?” These are the easiest questions for children to answer. Avoid WHY questions or questions that require understanding abstract or complex concepts.
 - If there is an alleged accident, include details of the event. Ask where it happened, who witnessed the event, and how it happened. For example, if there is an alleged fall, ask the height of the fall and onto what surface.
 - Patient statements not heard directly by the recorder may be included, e.g. the child told his teacher that he was hit by a belt.
 - Document chronology of events leading up to medical presentation.

G. PAST MEDICAL HISTORY

1. Record past medical history, if known.
2. Record past abuse history, history of exposure to domestic violence, if known.
3. Record history of exposure to prenatal and postnatal alcohol and drug exposure, if known.
4. Obtain urine toxicology according to hospital protocol or follow local policy established by criminal justice and child protection agencies under the circumstances described below.
 - There is a reported history of child's removal from a drug manufacturing home, living in a home with significant drug exposure, or a request by law enforcement or CPS.
 - The child's clinical presentation is concerning and drug ingestion is suspected.
 - Some drugs may be detected in the urine up to 96 hours after ingestion. Collect urine in a clean container. It is important to collect the first available sample.
5. Record any cognitive, developmental, physical, or mental/emotional disabilities.
6. Record whether growth and development is within normal limits. Check WNL, if within normal limits, ABN, if abnormal, or unknown.
7. Indicate whether there are any other pertinent medical conditions, particularly if any conditions may affect the interpretation of findings (e.g. bleeding disorders, bone diseases, etc).

H. REVIEW OF SYSTEMS

Check the box “Negative except as noted below” if there are no identified medical problems. Describe, if signs and symptoms are present. Check the box if there is additional dictation in medical progress notes or another format.

I. NAME OF PERSON TAKING HISTORY

Print the name of the person taking the history, sign, date, and provide telephone number.

PATIENT CONSENT AND AUTHORIZATION FOR EXAM

Suspected child abuse: non-consenting parents

Parental consent is not required to examine, treat or collect evidence for suspected child abuse. In the absence of parental consent or in the case of parental refusal, children must be taken into protective custody by a child protective agency (e.g. law enforcement agency or county child protective services agency) in order to perform the examination. Follow local policy regarding placement of children in protective custody.

Welfare and Institutions Code Section 324.5

Whenever allegations of physical or sexual abuse of a child come to the attention of a local law enforcement agency or the local child welfare department and the child is taken into protective custody, the local law enforcement agency or child welfare department may, as soon as practically possible, consult with a medical practitioner, who has specialized training in detecting and treating child abuse injuries and neglect, to determine whether a physical examination of the child is appropriate. If deemed appropriate, the local law enforcement agency, or the child welfare department, shall cause the child to undergo a physical examination performed by a medical practitioner who has specialized training in detecting and treating child abuse injuries and neglect, and whenever possible, shall ensure that this examination takes place within 72 hours of the time the child was taken into protective custody. In the event the allegations are made while the child is in custody, the physical examination shall be performed within 72 hours of the time the allegations were made.

PHOTOGRAPHS OF INJURIES

Penal Code Section 11171.2

A physician, surgeon, or dentist or their agents, and by their direction, may take skeletal x-rays of the child without the consent of the child's parent or guardian, but only for purposes of diagnosing the case as one of possible child abuse or neglect and determining the extent of the child abuse or neglect.

Penal Code Section 11171.5

If a peace officer, in the course of an investigation of child abuse or neglect, has reasonable cause to believe that the child has been the victim of physical abuse, the officer may apply to a magistrate for an order directing that the victim be x-rayed without parental consent. Any x-ray taken pursuant to this subdivision shall be administered by a physician, surgeon, or dentist or their agents.

With respect to the cost of an x-ray taken by the county coroner or at the request of the county coroner in suspected child abuse or neglect cases, the county may charge the parent or legal guardian of the child victim the costs incurred by the county for the x-ray. No person who administers an x-ray pursuant to this section shall be entitled to reimbursement from the county for an administrative cost that exceeds 5 percent of the cost of the x-ray.

J. GENERAL PHYSICAL EXAMINATION

1. Record vital signs.
2. Record height in either centimeters or inches and weight in either kilograms or pounds. Indicate percentiles, if growth charts are available. For children under age 2, record head circumference and percentile.
3. Describe the patient's general physical appearance.
 - Describe the patient's general demeanor including level of discomfort and pain.
 - Provide brief handwritten summary, even if dictating. Check box if there is additional dictation in progress notes.
 - Documentation helps the examiner recall the patient's behavior and response during the exam for future reference.
4. Record results of physical examination.
 - Record all findings and whether the general exam was within normal limits (WNL).
 - Describe abnormal findings (ABN).

Physical Findings: A physical finding includes observable or palpable tissue injuries, physiologic changes, or foreign materials.

- Be observant for erythema (redness), abrasions, bruises, swelling, lacerations, bites, and burns.
 - Note areas of tenderness, deformity, or induration.
 - Record size and appearance of injuries and other findings using the diagrams. Describe shape, size, and color of bruises or other cutaneous injuries.
 - Photograph injuries and other findings according to local policy.
 - Use proper photographic techniques.
 - > Use an appropriate light source.
 - > Use an accurate ruler or scale for size reference in the photograph.
 - > The plane of the film must be parallel to the plane of the finding.
 - > Use a 35mm camera with a macro lens and appropriate flash attachment to adequately record small or subtle injuries.
 - > Any good quality 35mm camera may be used as long as it can be focused for undistorted, close-up photographs and it provides an accurate color rendition.
5. If genital injuries are sustained, use copies of page(s) 6 and 7 from the Cal OES 2-930 Forensic Medical Report: Acute (<72 hours) Child/Adolescent Sexual Abuse Examination Form to document findings; or use that form to document all findings, if the history indicates that the patient has been sexually and physically abused.

J. PHYSICAL EXAMINATION (continued)

6. Conduct general physical examination.

- Record size and appearance of injuries and other findings using Diagrams A and B.
- Photograph injuries and other findings according to local policy.
- Use proper photographic techniques.
 - > Use an appropriate light source.
 - > Use an accurate ruler or scale for size reference in the photograph.
 - > The plane of the film must be parallel to the plane of the finding.
 - > Use a 35mm camera with a macro lens and appropriate flash attachment to adequately record small or subtle injuries.
 - > Any good quality 35mm camera may be used as long as it can be focused for undistorted, close-up photographs and it provides an accurate color rendition.

Bite marks

- Photograph or arrange to have bite marks photographed. Individuals can be identified by the size and shape of their bite marks.
 - > Properly taken photographs of bite marks can assist in the identification of the person who inflicted the injury.
- DNA of the person who inflicted the injury may be recovered from saliva remaining at the bitemark site. Swab the general area of trauma with a swab moistened with sterile, deionized, or distilled water. Label and air dry swab(s) prior to packaging.
- Collect a control swab by swabbing an unbroken area adjacent to the suspected saliva stain. Label, air dry, and package the control swab separately from the evidence sample.
- Casting bite marks:
 - > If the bite has perforated, broken, or left indentations in the skin, a cast of the mark may be indicated. The impressions left in the skin from a bite mark fade very quickly. If casting is indicated, it must be performed expeditiously.
 - > A forensic dentist should be consulted in these cases. The procedure for consulting such experts varies among jurisdictions. Consult with the law enforcement agency having jurisdiction over the case.
 - > Bite marks may not be obvious immediately following an assault, but may become more apparent with time. A recommendation should be made to the law enforcement agency to arrange for follow-up inspection within one to two days and to have additional photographs taken.

Bruises

- Bruises evolve and change color in an unpredictable sequence. Determination of the age of bruising can only be done in the broadest of time frames. Use caution in the identification of bruises of different ages.
- Photograph bruises to document injuries and to assist in the identification of the object that inflicted the injury.
- Deep tissue injuries may not be seen or felt initially.
- Arrange or recommend to the law enforcement agency to have follow-up photographs taken in 1-2 days after the bruising develops more fully.

J. PHYSICAL EXAMINATION (continued)

6. Conduct general physical examination.

- Record size and appearance of injuries and other findings using Diagrams C and D.
- Photograph injuries and other findings according to local policy.
- Use proper photographic techniques.
 - > Use an appropriate light source.
 - > Use an accurate ruler or scale for size reference in the photograph.
 - > The plane of the film must be parallel to the plane of the finding.
 - > Use a 35mm camera with a macro lens and appropriate flash attachment to adequately record small or subtle injuries.
 - > Any good quality 35mm camera may be used as long as it can be focused for undistorted, close-up photographs and it provides an accurate color rendition.

Bite marks

- Photograph or arrange to have bite marks photographed. Individuals can be identified by the size and shape of their bite marks.
 - > Properly taken photographs of bite marks can assist in the identification of the person who inflicted the injury.
- DNA of the person who inflicted the injury may be recovered from saliva remaining at the bitemark site. Swab the general area of trauma with a swab moistened with sterile, deionized, or distilled water. Label and air dry swab(s) prior to packaging.
- Collect a control swab by swabbing an unbroken area adjacent to the suspected saliva stain. Label, air dry, and package the control swab separately from the evidence sample.
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- Photograph bruises to document injuries and to assist in the identification of the object that inflicted the injury.
- Deep tissue injuries may not be seen or felt initially.
- Arrange or recommend to the law enforcement agency to have follow-up photographs taken in 1-2 days after the bruising develops more fully.

J. EXAMINATION OF THE HEAD, NECK, AND MOUTH

7. Examine the face, head, ears, hair, scalp, and neck for injury.

- Record injuries and other findings using the Diagrams E, F, G, and H.
- Examine mouth for injury and for missing or chipped teeth, or neglect of oral health.
 - > Signs and symptoms of dentofacial trauma may include: avulsed teeth, lip lacerations, tongue injuries, frenulum injuries, and jaw and facial fractures.
 - > Signs and symptoms of dental neglect may include: untreated rampant cavities, untreated pain, infection, bleeding, or trauma; and/or lack of continuity of care once informed that the above conditions exist.
- Photograph injuries and other findings according to local policy.
- Use proper photographic techniques.
 - > Use an appropriate light source.
 - > Use an accurate ruler or scale for size reference in the photograph.
 - > The plane of the film must be parallel to the plane of the finding.
 - > Use a 35mm camera with a macro lens and appropriate flash attachment to adequately record small or subtle injuries.
 - > Any good quality 35mm camera may be used as long as it can be focused for undistorted, close-up photographs and it provides an accurate color rendition.
- For head trauma cases:
 - > Examine head closely for evidence of scalp trauma. Record any bruises, areas of scalp swelling, or hair loss.
 - > In infants, note fullness or bulging of the anterior fontanelle or splitting of the sutures.
 - > Examine earlobes carefully for any bruising or petechiae. Record injuries using the diagrams.

K. EVIDENCE COLLECTED AND SUBMITTED TO CRIME LABORATORY

All swabs and slides must be air dried prior to packaging (Penal Code § 13823.11). Air dry in a stream of cool air for 60 minutes. Place samples from one patient at a time in the swab drying box. Wipe or spray the swab drying box with 10 percent bleach before each use.

Labeling requirements: Swabs, bindles, and small containers must be individually labeled with the patient's name and sample source. Containers for these individual items must be labeled with the name of the patient, date of collection, description of the evidence including location from which it was taken, and signature or initials of the person who collected the evidence. All containers must be labeled and sealed. Record all evidence transfers, also known as the chain of custody.

1. **Record whether clothing was collected, the items collected, and whether they were placed in an evidence kit or a paper bag. If not, check N/A.**
 - Collect outer and under clothing, if applicable. Coordinate with the law enforcement officer or child protective services worker regarding clothing to be collected. Clothing with bloodstains, tears, and burn holes can be related to physical abuse. Soiled, unkempt clothing can be related to neglect.
 - Wear gloves while collecting clothing. Have the patient disrobe on two large sheets of paper, placed one on top of the other, on the floor. Remove child's shoes before stepping on to the paper. Package each garment in an individual paper bag, label, and seal. Wet stains or garments require special handling. Consult local policy.
2. **Record all foreign materials collected and the name of the person who collected them. If none were collected, check N/A. Foreign materials (soil, vegetation) should be placed in bindles and/or envelopes. Use a separate bindle or envelope for materials collected from different locations. Label and seal.**
3. **Record whether saliva swabs from bite marks were obtained. Record whether a control swab was obtained from an unbiten atraumatic area. Swabs must be labeled with the patient's name and sample source.**

L. TOXICOLOGY SAMPLES

Record whether a urine toxicology sample was obtained. Up to 96 hours after suspected ingestion of drugs, collect a urine specimen in a clean container. It is important to collect the first available sample.

M. REFERENCE SAMPLES

1. **Record whether a DNA reference sample was collected.**
 - Policies pertaining to the collection of reference samples at the time of exam or later vary by jurisdiction. If collected at the time of the exam, ALWAYS collect after the evidence samples. A buccal (inner cheek) swab is less invasive and may be easier to obtain than a blood sample via venipuncture. Consult your local crime laboratory.
2. **Buccal swabs**
 - Rub two swabs gently but firmly along the inside of the cheek in a rotating motion to ensure even sampling. Air dry, package, label, and seal.
3. **Blood**
 - Collect blood sample in lavender stoppered evacuated vial. A blood card is optional in some jurisdictions. Label the vial, place into an envelope, and seal.

N. DIAGNOSTIC STUDIES

1. **Record the types of laboratory work ordered, results, if known, and whether results are pending.**

| | |
|-----------|--------------------------------|
| CBC | Complete Blood Count |
| INR | International Normalized Ratio |
| PTT | Partial Thromboplastin Time |
| PT | Prothrombin Time |
| SGOT/SGPT | Liver Enzymes |

2. **Record diagnostic imaging studies ordered, results, if known, and whether results are pending.**

| | |
|-----------------|---|
| Skeletal Survey | Series of radiographic images which encompass the entire skeleton |
| CT Scan | Computed Tomography Imaging |
| MRI | Magnetic Resonance Imaging |

3. **Record whether patient was referred for evaluation by an ophthalmologist.**

O. PHOTO DOCUMENTATION

Record whether photographs were taken, type of camera used, and whether film was retained or released to a law enforcement agency.

P. REQUIRED SUMMARY AND INTERPRETATION OF HISTORY, EXAMINATION, AND DIAGNOSTIC STUDIES

Provide interpretation and medical impression of history, examination, and diagnostic studies. Findings and interpretations are based on both the patient history available and the medical examination. Check the box if there is additional dictation in medical progress notes or another format and record dictation reference number.

Q. DISTRIBUTION OF EVIDENCE

List to whom the evidence was released. Check N/A if not applicable.

R. PERSONNEL INVOLVED

1. **Document who performed the examination by printing the examiner's name. The examiner must sign, date, and provide license and telephone number.**
2. **Document whether another healthcare provider assisted with the examination or evidence collection and handling. If so, print name, sign, date, and provide license and telephone number.**

S. PATIENT DISPOSITION

Indicate disposition and whether a follow-up exam is needed.