



CHILD PHYSICAL ABUSE CPG

Alleged or Suspected

Enter patient < 18 years (or 21 years if mentally or physically handicapped) with known or potential physical abuse.

Consult social worker. (If no social worker is available on-site, nurse is to complete this section.) Regardless, check order for social work consult and notify on-call social worker after history and physical is obtained.

OBTAIN HISTORY — SOCIAL WORKER (OR NURSE OR PHYSICIAN)

Consult Social Worker Social worker present in ED

Telephone call to social worker Name of social worker: _____

Patient age: _____ Gender: _____ Who is giving Hx: _____

Date, time and place of injury (if known): _____

Accompanied by: _____ Via: _____

Detail of injury, including who was involved / where it occurred — for each injury: _____

FAMILY / SOCIAL HISTORY: _____

Any history of domestic violence: Yes No If yes, details: _____

Previous injury: Yes No _____

Previous allegation of abuse: Yes No _____

Previous / Current involvement of social agencies or law enforcement: Yes No _____

Signature: _____

PHYSICIAN HISTORY

History obtained by: _____

Developmental history: _____

Family history, i.e., bone / bleeding disorders: _____

Previous ED visits / hospitalizations for injury or poisoning: _____

Other past medical history: _____

Medications: _____

Allergies: _____

Last tetanus / immunization status: _____

Child's demeanor during exam: _____



NURSING DATA

Vital Signs: T: _____ Pulse: _____ Resp: _____ BP: _____

Weight: _____ Length / Height: _____ Head circumference for < 2 yrs. of age: _____

Signature: _____

PHYSICIAN: PERFORM PHYSICAL EXAM
(Remove all clothes and provide hospital gown for surface inspection)

General Appearance: _____

WNL: _____

HEENT: WNL: _____ FUNDI: _____

LUNGS: WNL: _____

HEART: WNL: _____

ABDOMEN: WNL: _____

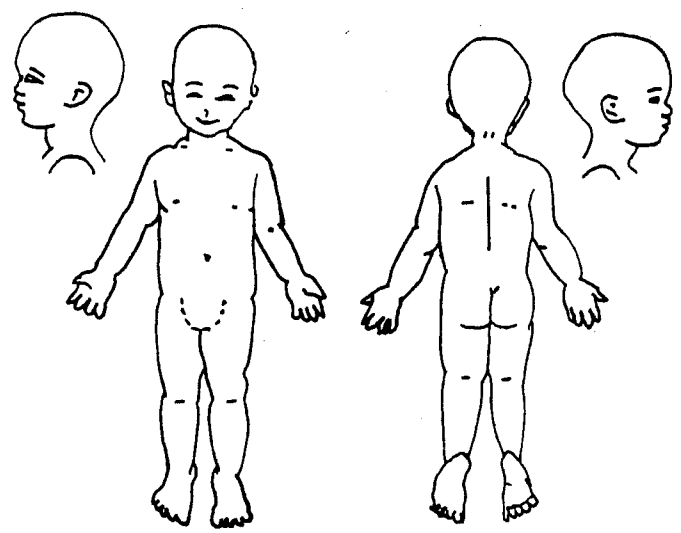
GENITALIA: WNL: _____

EXTREMITIES: WNL: _____

NEURO: WNL: _____

SKIN: WNL: _____

PHYSICIAN: DESCRIBE INJURIES — USE GRAPHIC CHART TO MARK INJURY SITES, INCLUDE NARRATION OF SIZE, SHAPE, TYPE, COLOR FOR EACH INJURY



Sketch findings and label with number at left.

PERFORM LABS / RADIOLOGIC EXAMS / PHOTOS IF INDICATED

RECORD RESULTS HERE

LAB TESTS RESULTS PENDING

COAGULATION SCREENING (Consider with unexplained, abnormal bruising, intracranial or retinal hemorrhage)

- PT / PTT: _____
- CBC with differential / platelets: _____
- VON WILLEBRAND PANEL: _____
- FACTOR XIII: _____
- Thrombin time: _____
- Fibrinogen: _____

Other tests if indicated:

- UA: _____
- LFT (AST / ALT): _____
- AMYLASE: _____
- Other: _____

RADIOLOGY RESULTS PENDING

- SKELETAL SURVEY (Consider for unexplained / suspicious injury / bruising or fracture in < 2 yrs of age or individually for developmentally delayed older child.) _____

OTHER X-RAYS IF WARRANTED: RESULTS PENDING

- CT SCAN OF HEAD: (Consider with unexplained neurological deficit or for infant with bruising on head) _____
- CT ABDOMEN: (Consider in child with abdomen / flank bruising, hematuria or positive CT of head) _____
- BONE SCAN: _____
- MRI: (Consider if CNS symptoms with negative CT of head / extra-axial fluid) _____

Photographs Time: _____ Taken by: _____



OTHER CONSULTS

CONSIDER

NAME

TIME CONTACTED

| | | | |
|--|--------------------------|-------|-------|
| Ophthalmology | <input type="checkbox"/> | _____ | _____ |
| (Consider for evaluation of retinal hemorrhages) | | | |
| Psychology | <input type="checkbox"/> | _____ | _____ |
| Surgery | <input type="checkbox"/> | _____ | _____ |
| Orthopedics | <input type="checkbox"/> | _____ | _____ |
| Neurosurgery | <input type="checkbox"/> | _____ | _____ |
| Other | <input type="checkbox"/> | _____ | _____ |



TREAT INJURY: LIST PROCEDURES PERFORMED

Assessment _____

MEDICAL DECISION MAKING

FINAL IMPRESSION

Unexplained injury or injuries, suspicious for child physical abuse

History of physical abuse and injuries consistent with the history

No history of physical abuse and physical examination is normal

Parental concerns regarding child physical abuse

History of child physical abuse, physical examination this date is normal

REPORT SUSPICION OF ABUSE TO:

_____ County CPS. Contact name: _____

Date and time reported: _____

Police jurisdiction: _____

Coroner (in case of fatality): _____ Time notified: _____

DISPOSITION

Discharge to Children Service Emergency Care (CPS)

Discharge to alternate family arrangement

Name: _____

Admit: _____

(Specify unit level of service)

Discharge home To whom: _____

DISCHARGE FOLLOW-UP

Sibling / Follow-up: _____

See additional documentation by dictation.

Physician signature: _____ Date: _____

Resident signature: _____ Date: _____

Note: This guideline represents current clinical recommendations. The physician may choose to vary from the pathway if clinical conditions warrant.