

Child Protection Paediatric Examination Proforma

This proforma is designed to be completed as appropriate for individual cases

1. Child Details			2. Examination details		
Name of child			Date of examination		
Date of birth / CHI number			Time of examination		
Address			Day of week of examination		
Age Gender Female <input type="checkbox"/> Male <input type="checkbox"/>			Out of Hours Yes <input type="checkbox"/> No <input type="checkbox"/>		
School / Nursery attended			Location of examination:		
Ethnicity			Type of examination:		
Main Language			Joint Paediatric Forensic (JPF) <input type="checkbox"/>		
3. Doctor details			Specialist Medical <input type="checkbox"/>		
Paediatrician			4. Police details		
Forensic Physician			Attending police officer		
Other doctors (if present)			Investigating Officer		
5. Other present			6. Other relevant professionals		
Social Worker / care worker			Social worker/care worker		
Others (relationship to child)			Health visitor		
			GP		
			Others		
7. Category - tick relevant box(es) to indicate type(s) of abuse					
	At Referral	Your conclusion after assessment		At Referral	Your conclusion after assessment
Physical abuse	<input type="checkbox"/>	<input type="checkbox"/>	Fabricated or induced illness	<input type="checkbox"/>	<input type="checkbox"/>
Sexual abuse	<input type="checkbox"/>	<input type="checkbox"/>	FGM	<input type="checkbox"/>	<input type="checkbox"/>
Emotional abuse	<input type="checkbox"/>	<input type="checkbox"/>	CSE	<input type="checkbox"/>	<input type="checkbox"/>
Neglect	<input type="checkbox"/>	<input type="checkbox"/>	Not abuse		<input type="checkbox"/>
			Inconclusive		<input type="checkbox"/>
8. Child on/ever been on Child Protection Register?			No <input type="checkbox"/> Yes <input type="checkbox"/> Details:		

9. Consent to history, examination and report

Child's Name: DOB

Address: CHI No

Permission must be obtained from parent(s) or other(s) with responsibility for the child, and from the child where appropriate.

I give permission for:

- | | | | |
|---|-----|----|-----|
| 1. Medical Examination | Yes | No | N/A |
| 2. Collection of specimens for laboratory tests | Yes | No | N/A |
| 3. Photography of Clinical Findings | Yes | No | N/A |
| 4. CD/Video of Genital Findings | Yes | No | N/A |

Photographs, videos and CDs will be stored securely as part of the clinical records. They may be used to support clinical evidence of injury and may need to be shared with other doctors involved in any court proceedings.

I give permission for photographs, videos or CDs to be used to support clinical evidence in court proceeding.

Yes No N/A

Photographs, videos and CD recordings can be used for Teaching and Training of other professionals working in Child Protection proceedings. Photographs, videos and CDs used for this purpose are anonymised.

I give permission for anonymised photographs / videos / CD recordings of my child to be used for Teaching and Training

Yes No N/A

I understand that this medical examination and recorded clinical findings may be used for Peer Review with specialist doctors

**I understand the information from the medical examination will be shared with:
Social Services, Police, GP and Health Visitor/ School Nurse.**

The procedure has been fully explained to me and I understand that I have the right to withdraw my consent at any stage during the procedure.

Name Parent/Carer/Professional/Young Person

Signed: Date

Examining Doctor(s)

Signature: Date

Statement of Interpreter (where appropriate)

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe they can understand.

First Language of Parent/Carer(s):

Language used by Interpreter:

Interpreter's Name Date

Interpreter's Signature Time

10. Reason for referral

Briefing taken from

Names of persons present during briefing

History of events

10. Reason for referral (continued)

[illegible]

11. Detailed Medical History

Perinatal History

Birth Weight		Kg	Gestation:	
Place of Birth			Delivery	
Pregnancy				
Neonatal Health				
Feeding				

Immunisations: Detail

Past History

(e.g. A&E Visits, hospital admissions)

12. Symptomatology

	Description / comment
Gastrointestinal (e.g. constipation, soiling, bleeding / pain on defaecation)	
Urinary (e.g. UTI, frequency, dysuria, wetting)	
Sleep (e.g.. Night walking, nightmares)	
Behaviour (e.g.. Wetting, soiling, self-harm, sexualised behaviour)	
Medication	
Allergies	

13. Developmental History / School Progress

Comment

Gross Motor/Locomotor

Fine Motor/Manipulation

Vision and Hearing

Speech & Language Skills

Social Interactive Skills

Social self-help skills

Additional support needs

14. Family History (including any history of fractures/bruising/bleeding)

Family Tree:

15. Social History

Consider: Parental occupation(s) / Parental Health including drug / alcohol use / Domestic violence
Number of bedrooms and sleeping arrangements

16. Adolescent

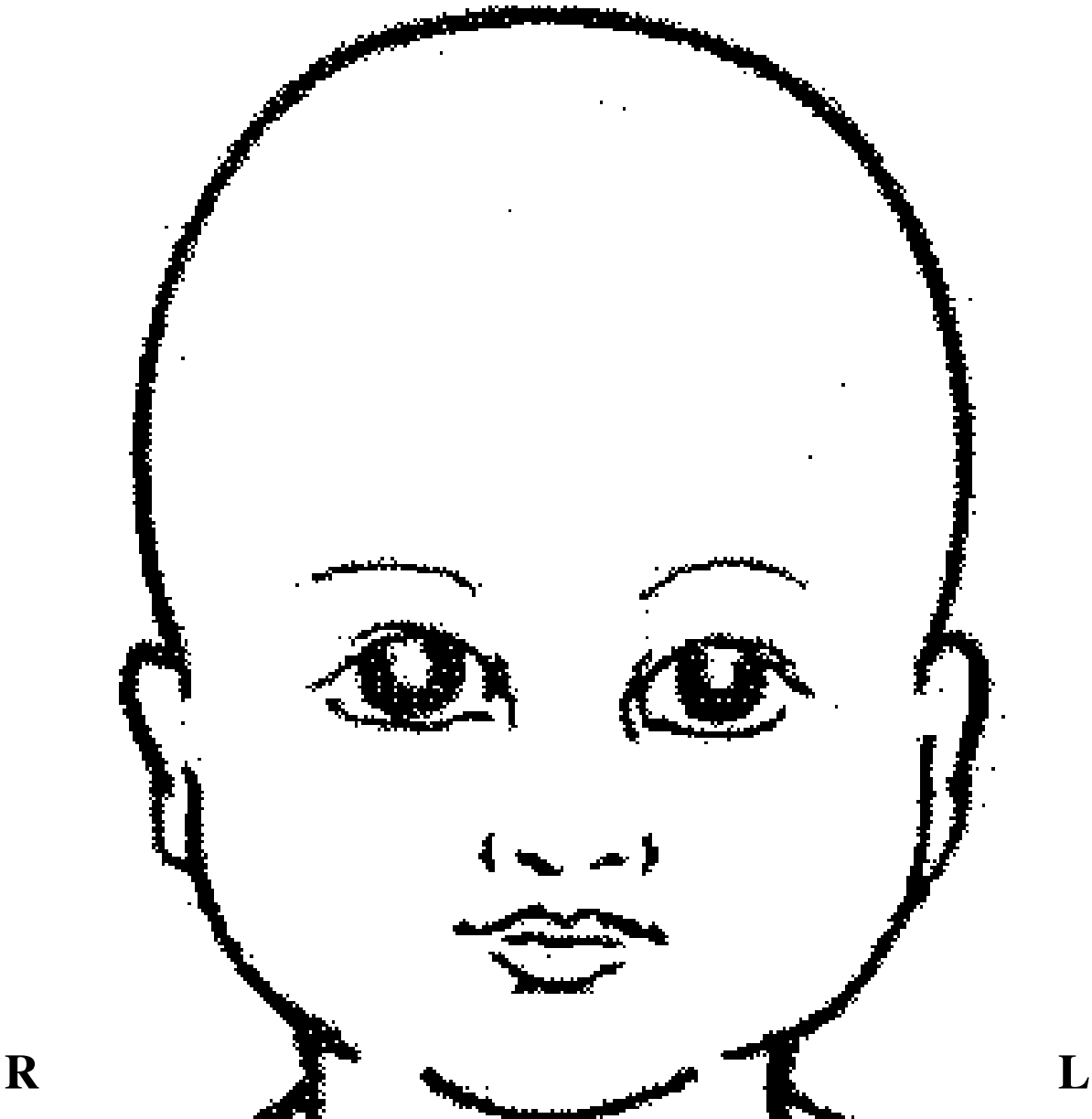
					Description/comment
Menarche	Yes		No		e.g.. Age
LMP (date)					
Frequency				Duration	
Tampons	Yes		No		
Pads	Yes		No		
Vaginal Discharge	Yes		No		
Irritation	Yes		No		
Bleeding	Yes		No		
Smell	Yes		No		
Dysuria	Yes		No		
Sexual experience	Yes		No		
No. of consensual partners				Date last sexual intercourse	
Contraception (and type)	Yes		No		
Smoking	Yes		No		
Alcohol	Yes		No		
Drugs	Yes		No		

17. Forensic Sexual Assault

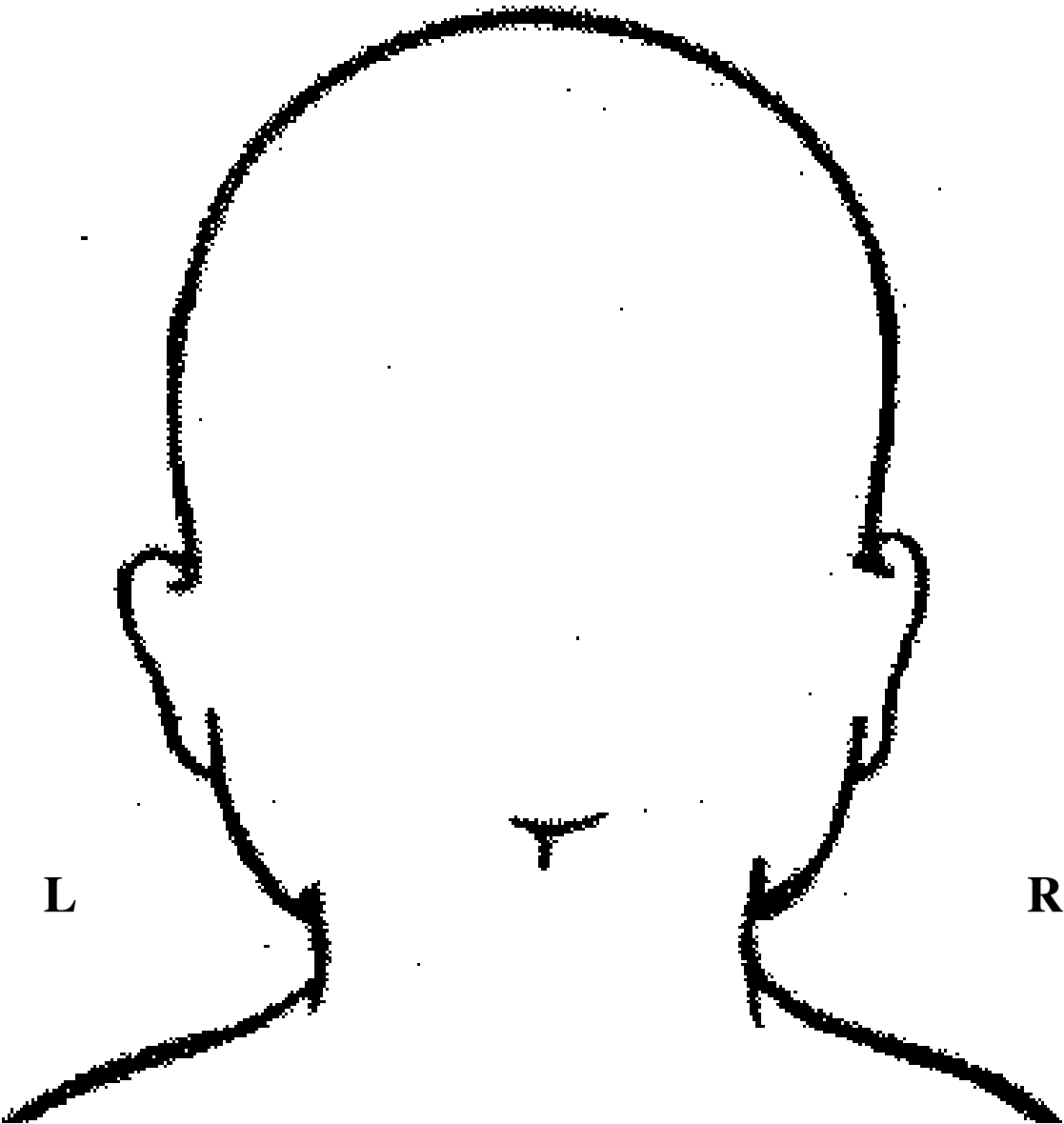
					Description/comment
Time of last contact with abuser					
Number of hours since last episode of unprotected sex					
Drugs/alcohol taken during event	Yes		No		
Bowels opened since event	Yes		No		
Passed urine since event	Yes		No		
Washing/bathing since event	Yes		No		
Teeth brushed since event	Yes		No		
Eating/drinking since event	Yes		No		
Changed clothes	Yes		No		
Complaints of pain, bleeding	Yes		No		
Self-Harm sites	Yes		No		

18. General examination					
Name(s) of persons present					
Weight		Height		Head circumference	
kgs	centile	cm	centile	cm	centile
General appearance (hygiene)					
Skin colour			Hair colour		
Demeanour/behaviour					
Pre-existing physical problems (note type)					
Cardiovascular System			Central Nervous System		
Pulse		BP	Tone/Power		
Heart sounds			Reflexes/Coordination		
Respiratory System			Abdomen		
Trachea/air entry/percussion note etc.			Tenderness/masses/L.K.K.S		
Breath sounds			Bowel sounds		
Head to Toe Survey inc. measurements, colour, shape, site, type of injury etc.					
	Examined	Injuries		See body chart	
Scalp/hair	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>			
Face	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>			
Inside mouth/palate	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>			
Teeth	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>			
Neck	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>			
Back	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>			
Buttocks	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>			
Arms	R L Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/>			
Hands/wrists	R L Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/>			
Fingers/nails note if cut/broken/false	R L Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/>			
Front of chest	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>			
Breasts (Tanner stage)	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>			
Abdomen	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>			
Legs	R L Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/>			
Feet/ankles/soles	R L Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/>			

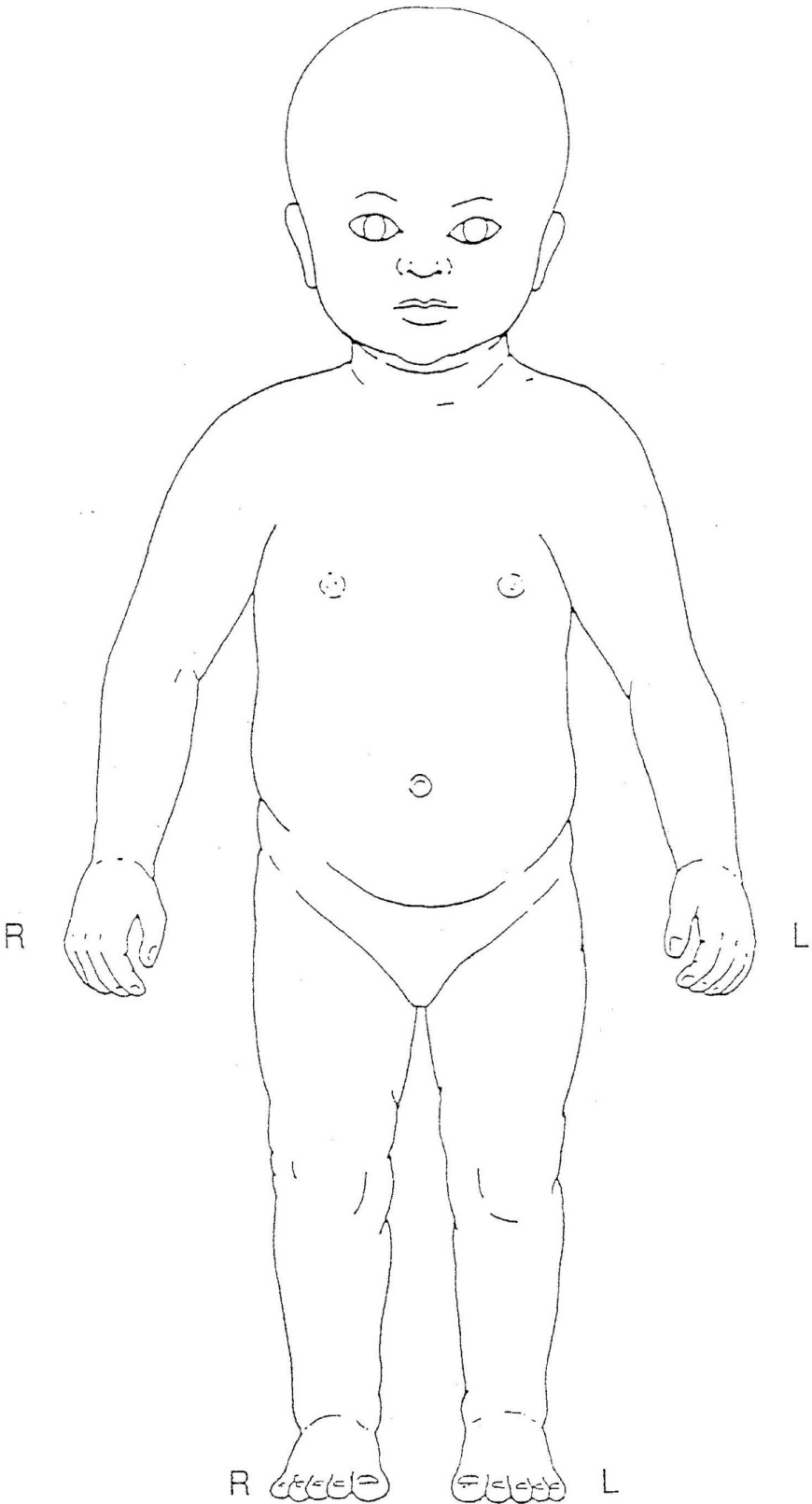
Body diagrams	
Injuries as pictured below <input type="checkbox"/>	No injuries detected <input type="checkbox"/>



Body diagrams	
Injuries as pictured below <input type="checkbox"/>	No injuries detected <input type="checkbox"/>



Body diagrams	
Injuries as pictured below <input type="checkbox"/>	No injuries detected <input type="checkbox"/>

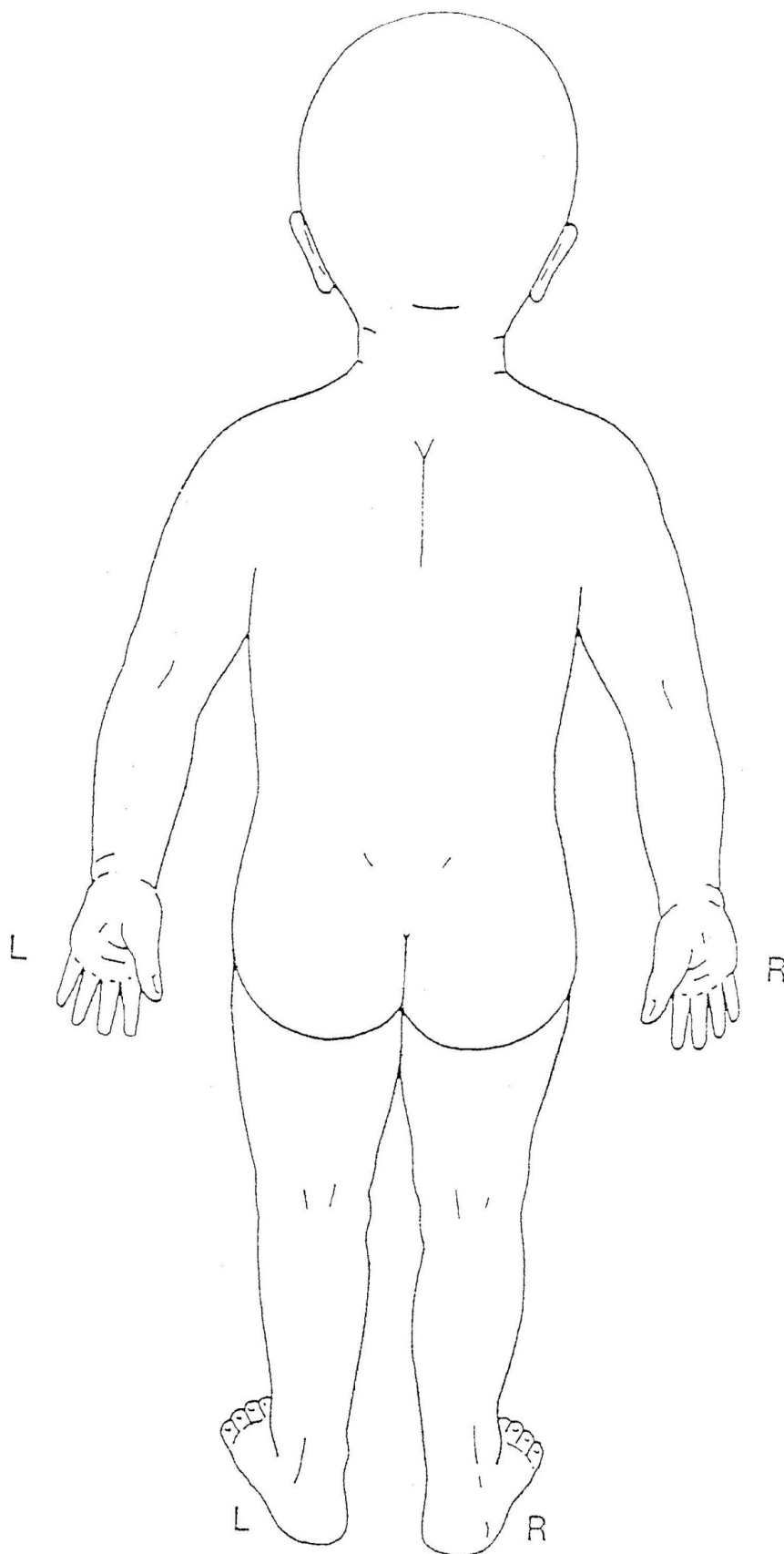


Child's Name:

CHI No

Injuries as pictured below ☐

No injuries detected ☐

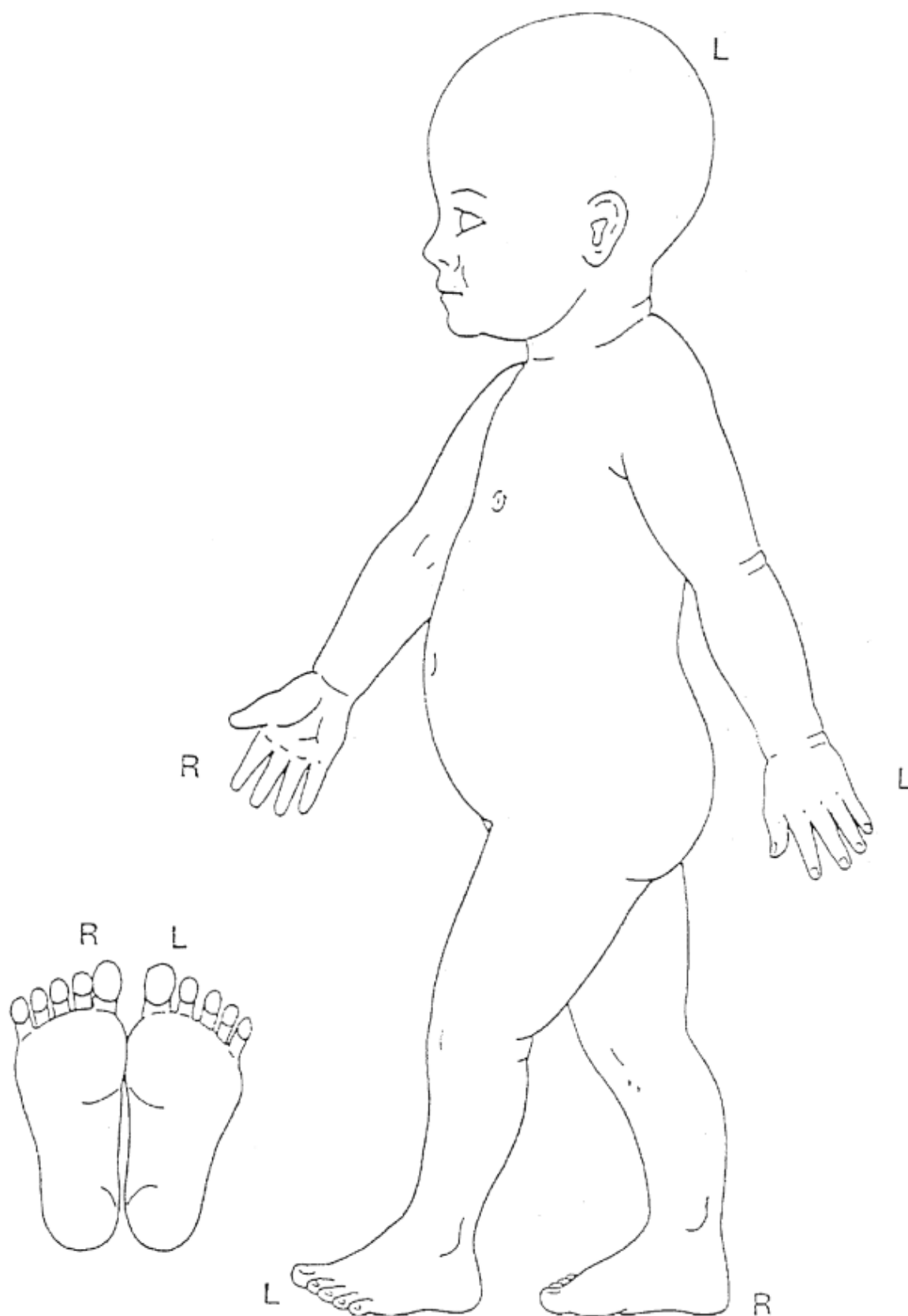


Child's Name:

CHI No

Injuries as pictured below ☐

No injuries detected ☐

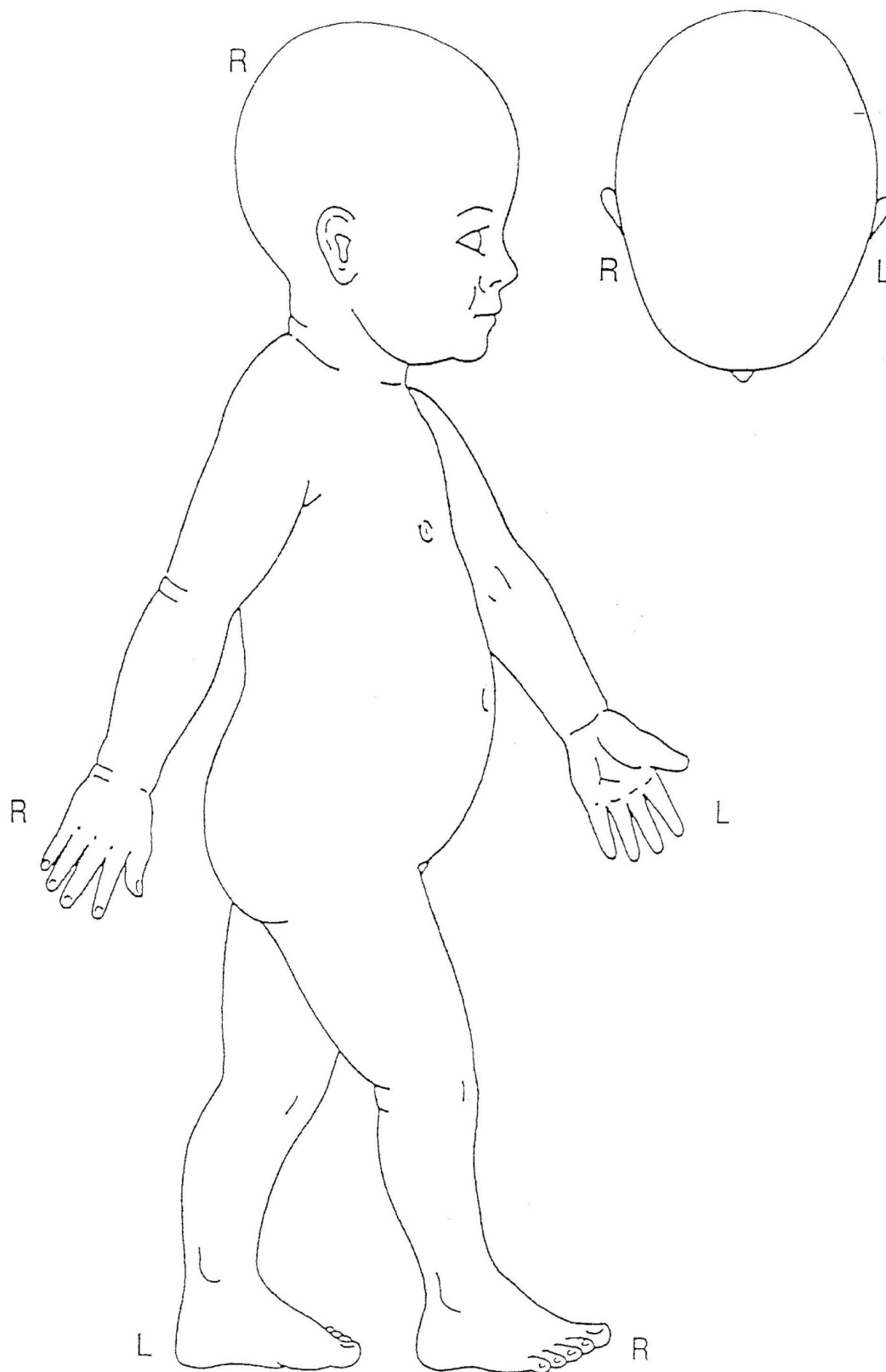


Child's Name::

CHI No

Injuries as pictured below ☐

No injuries detected ☐

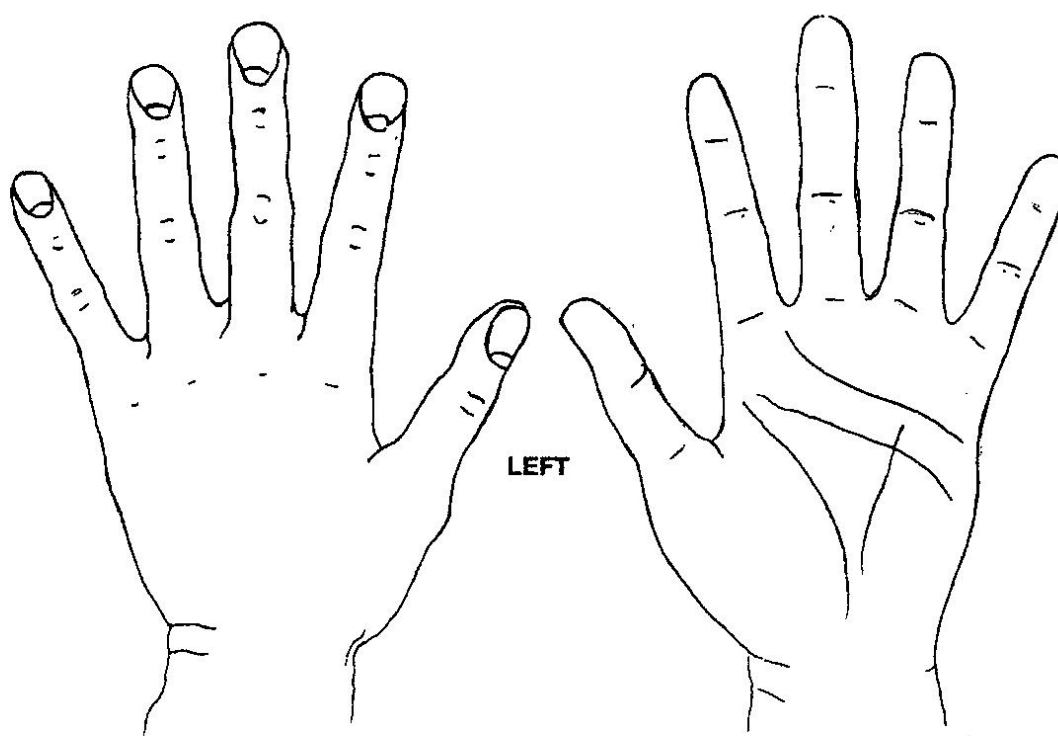
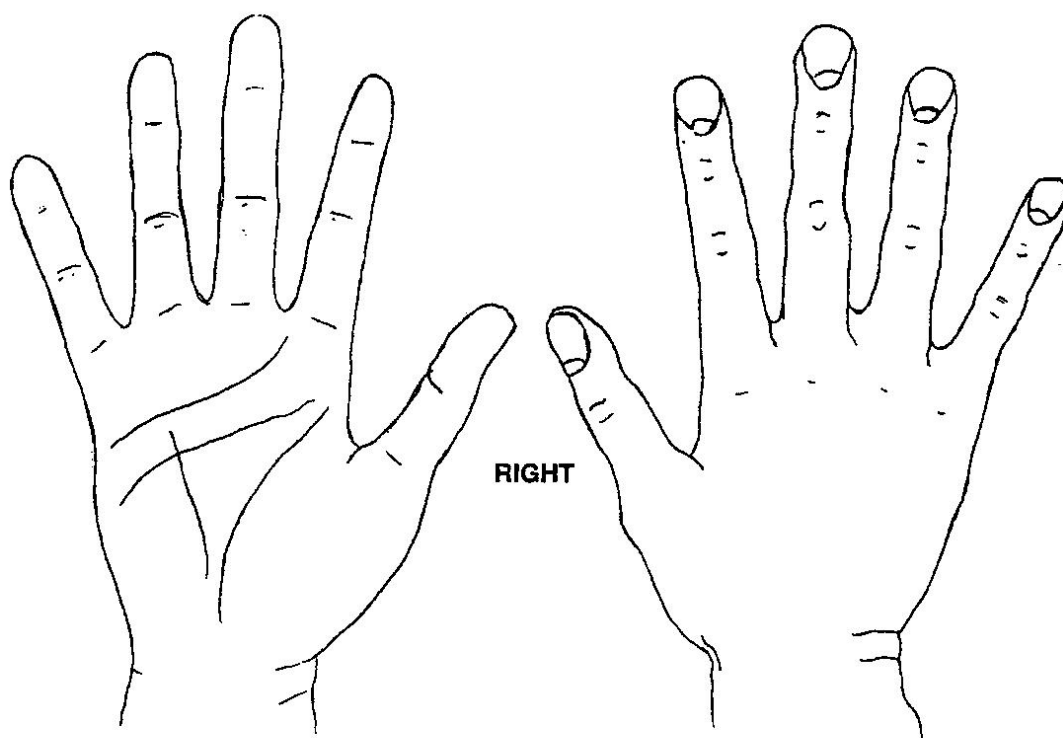


Child's Name::

CHI No

Injuries as pictured below ☐

No injuries detected ☐



Child's Name:..... CHI No.....

19. Genital examination - Female

Tanner stage: Breast 1 2 3 4 5 Pubic hair 1 2 3 4 5

	Yes	No	Reason not used
Colposcope used			
Digital Recording			
Photographs taken			

Exam position used:	Supine		Prone knee chest		Left lateral	
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Method of Exam of Hymen	Separation		Traction		Water	
	Swab		Catheter			

Type of Hymen	Annular		Crescentic		Fimbriated	
	Sleeve		Septate		Other	
Describe Other						

Findings – Genitalia:	Normal		Non specific		Abnormal	
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External Genitalia

	Yes	No	Describe location & extent
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Reddening			
Abrasion			
Oedema			
Bruising			
Laceration			
Labial fusion			
Discharge			
Bleeding			

Internal Genitalia

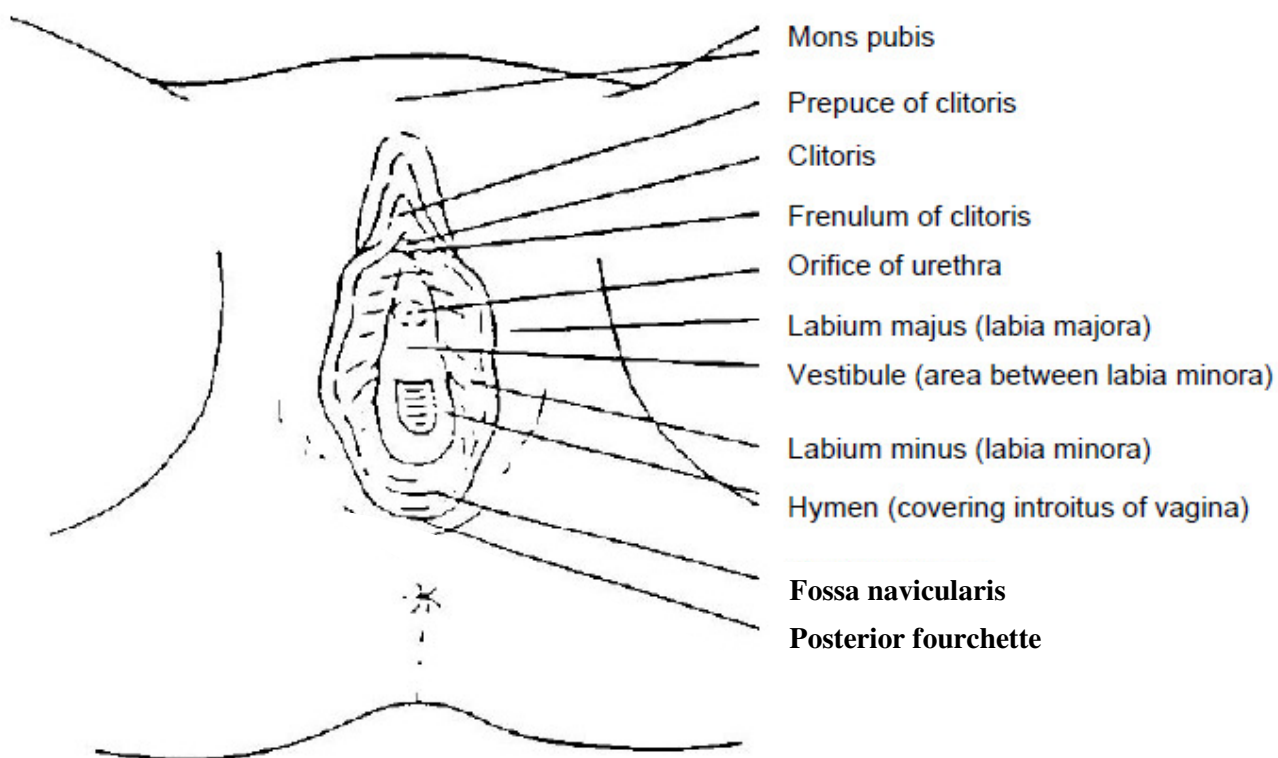
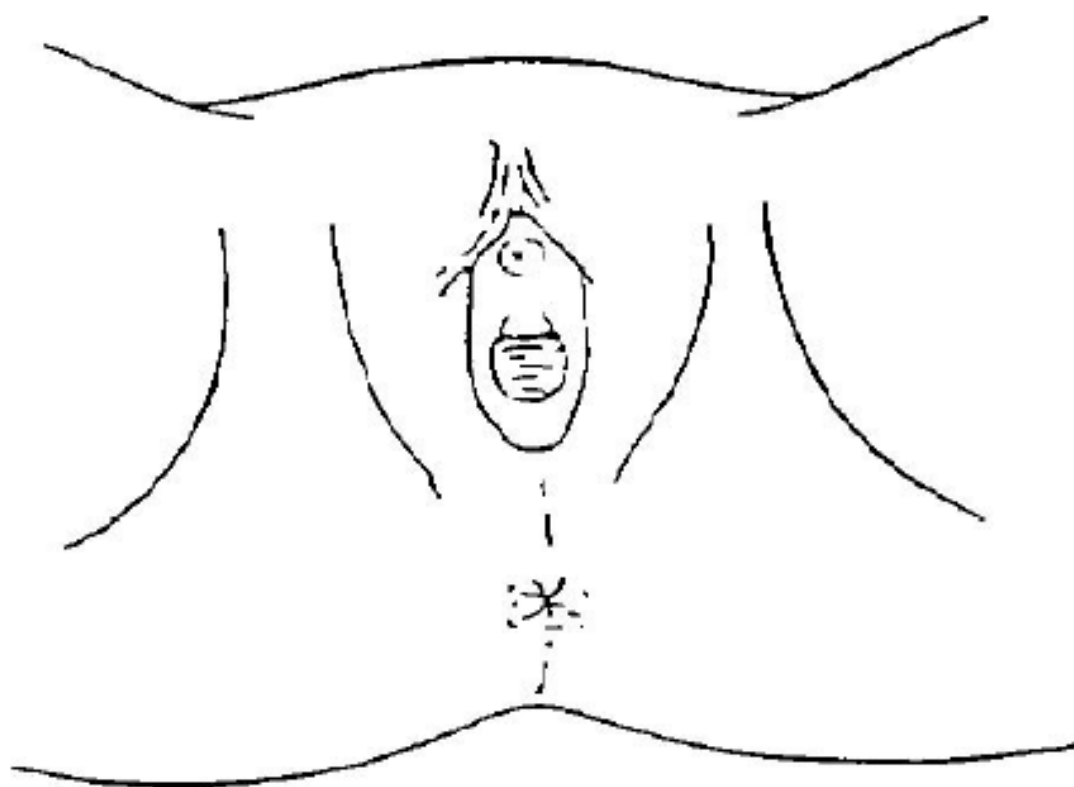
Vestibule

	Yes	No	Describe location & extent
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Reddening			
Abrasion			
Oedema			

Hymen (use the clock face to describe sites)

	Yes	No				
Reddening						
Abrasion						
Oedema						
Bruising						
Laceration			Partial		Complete	
Site of Laceration						
Transection			Site			
Notch			Site		Superficial	Deep
Narrow rim						
Posterior fourchette	Normal		Abnormal			
Vagina	Normal		Abnormal		Not Seen	
Other Findings						



Child's Name:..... CHI No.....

20. Genital examination - Male

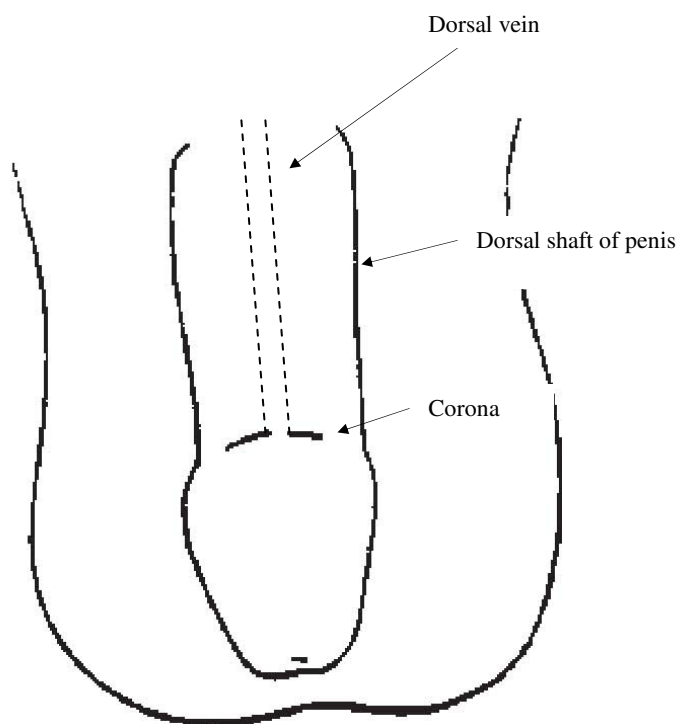
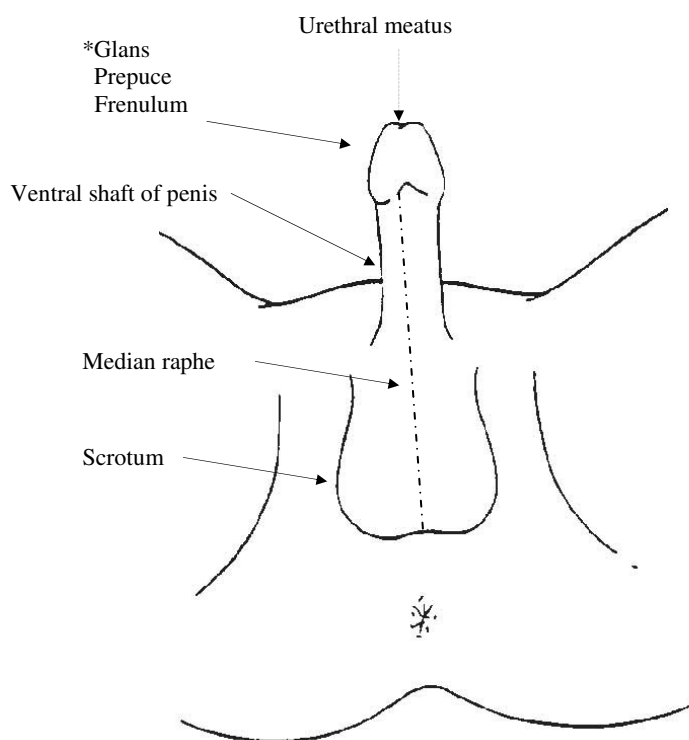
Tanner stage: Genitalia 1 2 3 4 5 Pubic hair 1 2 3 4 5

	Yes	No	Reason not used
Colposcope used			
Digital Recording			
Photographs taken			

Penis circumcised			
Foreskin retractable			
Frenulum intact			

Testes	
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Findings - genitalia	Normal		Non Specific		Abnormal	
Describe abnormalities						



* Glans – the conic expansion that forms the head of the penis

Prepuce - the free fold of skin that covers, more or less completely, the glans penis in the uncircumcised male.

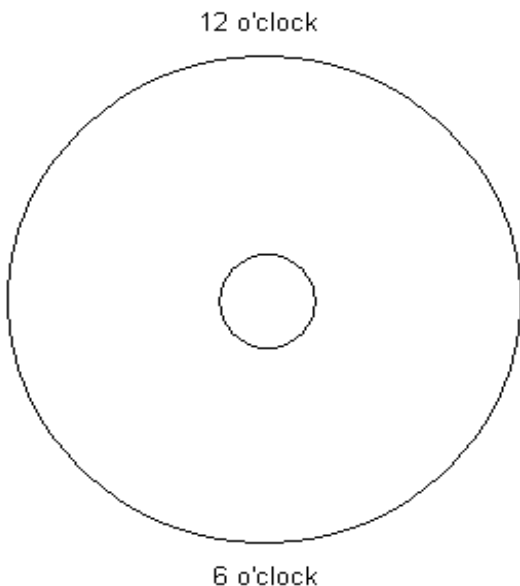
Frenulum – small fold of skin that attaches the prepuce to the ventral surface of the penis

Child's Name::..... CHI No.....

21. Anal examination – Male and Female

	Yes	No	Reason not used
Colposcope used			
Digital Recording			
Photographs taken			

Exam position used	Supine knee chest			Left lateral	
Findings – Anus	Normal		Non Specific	Abnormal	

Details of anal findings				
	Yes	No		
Anal / perianal erythema				
Perianal venous congestion				
Anal / perianal bruising				
Immediate anal dilatation (present as buttocks parted and no change over 30 seconds) Note if stool present				
Dynamic anal dilatation (not present as buttocks parted but occurs within 30 seconds) Note if stool present				
Warts				
Burns				
Other				
Anal Lacerations			Superficial	
			Deep or extensive	
			Number	
Scars			Site Number	
Tags			Site Number	

Child's Name:..... CHI No.....

22. Investigations

	Investigation	Date Requested	Result or Why not done				
Radiology	CT Head						
	MRI Brain and spine						
	Skeletal Survey						
	Follow up skeletal survey views (i.e. repeat CXR 10-14days)						
	Retinal Examination						
	Abdominal CT should be considered if serious history of trauma / abnormal LFTs						
Bloods	FBC						
	Coagulation screen						
	Blood Culture / CRP/ septic screen						
	Extended NAI Coagulation Screen						
	Renal and liver function						
	Ca, Mg, Phosphate, Alkaline Phosphatase						
	Vit D, PTH						
	Copper, zinc						
	Further metabolic tests if indicated (AA if large head for instance)						
Blood Borne Virus Screen	VDRL HIV Hep B Hep C						
Urine	MSU						
	Toxicology						
	Pregnancy test						
Swabs taken:							
	Vulval	HVS	Cervix	Anal	Oral	Date	Result
Universal							
Gonococcal PCR							
Chlamydia PCR							
Trichomonas							
HSV and syphilis PCR							
Photography	Taken by:				Sites:		

Child's Name:..... CHI No.....

23. Conclusions/advice given to police/social care services

[illegible]

Remember to complete section 7 - categorise type(s) of abuse after assessment for data collection

24. Action Plan

Referrals		Details
Referral to GP	YES <input type="checkbox"/> NO <input type="checkbox"/>	
Referral to general paediatrician	YES <input type="checkbox"/> NO <input type="checkbox"/>	
Referral to specialist	YES <input type="checkbox"/> NO <input type="checkbox"/>	
Referral to ophthalmologist	YES <input type="checkbox"/> NO <input type="checkbox"/>	
STI screening referral	YES <input type="checkbox"/> NO <input type="checkbox"/>	
Referral for Hep B /PEP	YES <input type="checkbox"/> NO <input type="checkbox"/>	
Referral to CAMHS	YES <input type="checkbox"/> NO <input type="checkbox"/>	
Referral to other support service	YES <input type="checkbox"/> NO <input type="checkbox"/>	
Medication		
Emergency contraception given	YES <input type="checkbox"/> NO <input type="checkbox"/>	Type:
Follow up advice given:	YES <input type="checkbox"/> NO <input type="checkbox"/>	Expiry date:
		Batch number:
Antibiotics given	YES <input type="checkbox"/> NO <input type="checkbox"/>	
Other medication given	YES <input type="checkbox"/> NO <input type="checkbox"/>	Details

Child's Name:..... CHI no:.....

Action Plan - continued	
Advice	
Post sexual assault leaflet given YES <input type="checkbox"/> NO <input type="checkbox"/>	
Advice given to patient &/carer YES <input type="checkbox"/> NO <input type="checkbox"/>	
Reports	
Interim Report to SW/Police/GP <input type="checkbox"/>	Soul /Conscience Report <input type="checkbox"/>
Other Actions	
Admit to hospital <input type="checkbox"/>	Consider CPO / CAO <input type="checkbox"/>
Case Conference requested <input type="checkbox"/>	Other <input type="checkbox"/>

Name / Title of examining doctor(s)	Signature of examining doctor(s)
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Date / time completed:

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