|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Child Protection Medical Request Form** | | | | | | | | | | | | | | | | | |
| **Child Details** | | Index Case/Sibling (delete as applicable, complete separate form for **each** child) | | | | | | | | | | | | | | | |
| Name | |  | | | | | | | | | NHS Number | | |  | | | |
| RMS number | | |  | | | |
| Address | |  | | | | | | | | | Ethnicity | | |  | | | |
| Date of Birth | |  | | | | | | | | | Age | | |  | | | |
| Language Spoken | |  | | | | | | | | | Interpreter Required? | | | | | | |
| Location of Child | |  | | | | | | | | | | | | | | | |
| Nursery /School | |  | | | | | | | | | | | | | | | |
| **FAMILY DETAILS** | | | | | | | | | | | | | | | | | |
|  | | Name | | | | | Date of Birth | | | | | Address (if different from above) | | | | | Telephone |
| Mother | |  | | | | |  | | | | |  | | | | |  |
| Father | |  | | | | |  | | | | |  | | | | |  |
| Siblings + children living at the same address | |  | | | | |  | | | | |  | | | | |  |
| Adults living at the same address | |  | | | | |  | | | | |  | | | | |  |
| Who has parental responsibility (PR)? Mother/ Father/ Local Authority  **Full name of person with PR who will be present at the assessment:**  Relationship: | | | | | | | | | | | | | | | | | |
| RISK FACTORS | | Domestic abuse | | | | | | | | | | |  | | | | |
| Other violent offences/risks to staff | | | | | | | | | | |  | | | | |
| Parental mental/physical health problems | | | | | | | | | | |  | | | | |
| Parental substance/alcohol misuse | | | | | | | | | | |  | | | | |
| Other | | | | | | | | | | |  | | | | |
| **Special Needs YES/No** | | | **Details:** | | | | | | | | | | | | | | |
| **Safeguarding Status** | | | Looked After Child/Child Protection Plan/Child In Need/Early Help/previously known to social care/None Care order details: | | | | | | | | | | | | | | |
| **REFERRER’S DETAILS** | | | | | | | | | | | | | | | | | |
| Date of Referral | | | |  | | | | | | | Time of Referral | | | |  | | |
| Requested by (name & title) | | | |  | | | | | | | Team name (e.g. CAST no) and their tel no | | | |  | | |
| Contact numbers: **If personal mobile given please indicate so that we can redact before filing in the child’s notes.** | | | | Usual No: | | | | | | | Immediate no: | | | | After 5pm and contact name: | | |
| Referrers secure email | | | |  | | | | | | | Team secure email | | | |  | | |
| S 47 Joint/Single Investigation | | | | Court Order YES / NO Detail: | | | | | | | | | | | | | |
| Who should doctor feedback to ? \*may finish after 4pm | | | | * Referrer * Duty SW * Other | | | | | Has the child been interviewed? | | | | | | * Yes, police * Yes SW * No | | |
| **CONTACT DETAILS** | | | | | | | | | | | | | | | | | |
|  | | | Name | | | Telephone | | | | | | Base Address | | | | | |
| Social Worker | | |  | | |  | | | | | |  | | | | | |
| Police | | |  | | |  | | | | | |  | | | | | |
| GP | | |  | | |  | | | | | |  | | | | | |
| Health Visitor | | |  | | |  | | | | | |  | | | | | |
| **WHO WILL ACCOMPANY CHILD (please give name)** | | | | | | | | | |  | | | | | | | |
| Mother | | | | | | | |  | | | | | | | | | |
| Father | | | | | | | |  | | | | | | | | | |
| Social Worker | | | | | | | |  | | | | | | | | | |
| Police | | | | | | | |  | | | | | | | | | |
| Other (incl siblings and other family members) | | | | | | | |  | | | | | | | | | |
| Other | | | | | | | |  | | | | | | | | | |
| **What is the MAIN reason for requesting a child protection medical assessment?** | | | | | | | | | | | | | | | | | |
| □ | To document physical injury and give paediatric opinion about likelihood of abuse | | | | | | | | | | | | | | | | |
| □ | To look for hidden injury. | | | | | | | | | | | | | | | | |
| □ | To look for evidence of sexual abuse. | | | | | | | | | | | | | | | | |
| □ | To look for current evidence of severe neglect (i.e. physical signs that need immediate documentation) | | | | | | | | | | | | | | | | |
| □ | Other | | | | | | | | | | | | | | | | |
| **MEDICAL EXAMINATION REQUEST DETAILS** | | | | | | | | | | | | | | | | | |
| Brief details of reason for request: Include DATE and TIME of incidents. If disclosure, use child’s actual words. Include relevant background information. (If completed electronically, field will expand.). Please continue on reverse if needed. Please advise if child or caregivers may be under the influence of drugs or alcohol. | | | | | | | | | | | | | | | | | |
| **Social worker to attach or bring CHRONOLOGY** | | | | | | | | | | | | | | | | | |
| * Photographer required | | | | | | | | * CSI required | | | | | | | | | |
| OUTCOME | | | Telephone advice | | □ | | | Proceed to examination | | | | | □ | Time: | | Attended/Cancelled/WNB | |
| If the child is deemed as at risk of significant harm, **a place of safety should be identified prior to the child protection medical assessment.** Safeguarding decisions should not be based on medical findings alone. | | | | | | | | | | | | | | | | | |
| Instructions to referrers: | | | | | | | | | | | | | | | | | |
| Name of Consultant | | | | | Appointment Date & Time | | | | | | | | | | Appointment Venue | | |
|  | | | | |  | | | | | | | | | |  | | |

**IN HOURS- all referrals must be made by telephone to the appropriate medical team, with appointment times agreed. In addition this form should sent by email. Please note that emails may not be accessed routinely.**

|  |  |  |
| --- | --- | --- |
|  | **TELEPHONE** | **EMAIL** |
| Hampshire Hospitals NHS Foundation Trust | 01256 313687 | [childprotectionmedicals@hhft.nhs.uk](mailto:childprotectionmedicals@hhft.nhs.uk) |
| St Mary’s Hospital, Isle of Wight (for child sexual abuse referrals, please contact the Portsmouth and SEH service below) | 01983 822099  Hospital consultant  07833 124838  Safeguarding Nurses Team Ext 5412 |  |
| Portsmouth and SE Hants Solent NHS trust | 0300 300 2013  (please phone first to discuss case details and book appointment) | [childprotectioneast@solent.nhs.uk](mailto:childprotectioneast@solent.nhs.uk) |
| Southampton and SW Hants Solent NHS trust | 0300 123 6662 | [snhs.childprotectionadmin@nhs.net](mailto:snhs.childprotectionadmin@nhs.net) |
| Frimley Park (NE Hants)area  NOTE – CP Medicals service now led by Children and Family Health Surrey not FP Hospital | 07717 426704  (Landline 01483 794879 -monitored answer machine) |  |

**OUT OF HOURS**

|  |  |
| --- | --- |
|  | **TELEPHONE** |
| **All HIPS areas: suspected child sexual abuse where forensic samples might be indicated** | Sexual Assault referral Centre (SARC) 0300 123 6616. SARC will contact the paediatrician and/or sexual offences examiner on call. If forensic samples not needed telephone in- hours services as above, **asap** the next working day |
| **Suspected physical abuse** |  |
| Hampshire Hospitals NHS Foundation Trust | Royal Hampshire County Hospital Winchester 01962 863535  Basingstoke & North Hampshire Hospital 01256 473202  Ask for the ‘paediatric consultant on call’  Please bring a hardcopy of this form for the paediatrician and send a copy to  [childprotectionmedicals@hhft.nhs.uk](mailto:childprotectionmedicals@hhft.nhs.uk) |
| St Mary’s Hospital, IOW | As per in-hours. |
| Queen Alexandra Hospital, Portsmouth | 02392 286000 ask for the ‘duty consultant paediatrician’ they will advise the email address to send this request form to.  Please send a copy to safeguarding team by email  [pho-tr.safeguardingchildrenteam@nhs.net](https://mail.win.hhft.nhs.uk/owa/redir.aspx?C=OL_OMuqP8c4vwxQzlgM8sHbD1r8gxIfubVyzvlAY-cHnee5VFNfXCA..&URL=mailto%3apho-tr.safeguardingchildrenteam%40nhs.net) |
| University Hospital Southampton NHS Foundation Trust | 02380 777 222. Ask for the ‘paediatric consultant on call’ |