UC Riverside, School of Medicine Policies and Procedures
Policy Title: Mandated Reporting
Policy Number: 950-02-019

Responsible Officer:	SOM Compliance and Privacy Officer
Responsible Office:	SOM Compliance Office
Origination Date:	5/2019
Date of Revision:	
Scope:	SOM and UCR Health Faculty Practice Locations

I. Policy Summary

California law designates the health care professionals of UCR Health as 'mandated reporters.' Mandated reporters have an individual duty to report known or suspected abuse or neglect relating to children, elders or dependent adults, suspicious injuries (any injury caused by firearm or assaultive abusive conduct), sexual assault/ rape, injury or conditions resulting from abuse/neglect of an individual transferred from another healthcare facility. All UCR Health Clinical faculty members, non-physician practitioners, medical assistants and clinic support staff are deemed mandated reporters.

II. Definitions

Child. Person under age 18. (Penal Code § 11165)

Elder. Person age 65 or older. (Welfare & Inst. Code § 15610.26)

Dependent Adult. Person between ages 18 and 64 with a physical or mental limitation that restricts his or her ability to carry out normal activities or protect his or her rights. Includes all people between ages 18 and 64 who have been admitted as an inpatient to a 24 hour health care facility. (Welfare & Inst. Code § 15610.23)

Mandated Reporter. Employee who is required by law to report a particular category or type of abuse to the appropriate law enforcement or social service agency.

Reasonable suspicion. Suspicion is objectively reasonable—that the facts, as known, would cause a similarly situated person, with the same information, to have a suspicion.

Abuse of an elder/dependent adult:
Physical Abuse, Neglect, Financial Abuse, Abandonment, Isolation, Abduction, or other treatment with resulting physical harm or pain, or mental suffering, or the deprivation by a custodian of care, goods or services that are necessary to avoid physical harm or mental suffering.

III. Policy Text

All employees whose positions are designated by the state as mandated reporters must understand what they are required to report, when it must be reported, and to whom.

IV. Responsibilities

UCR Health Mandated Reporters.

V. Procedures

A. Suspicious Injuries

1. A telephone report must be made immediately, or as soon as possible to the local law enforcement agency.
2. A written Suspicious Injury Report OES-2-920 (Attachment A) must be sent to the law enforcement agency within 2 working days.
3. A report must be made even if the patient dies and the death is unrelated to the suspected abuse.
4. A copy of the Suspicious Injury Report should be kept in the patient's medical record.
5. Statements made by the patient regarding domestic violence, assault, or abuse must be documented and must including names of suspected perpetrators, if known.

B. Child Abuse and Neglect

A report of any reasonably suspected abuse or neglect of a minor must be made to a designated agency immediately, or as soon as possible by telephone with a written follow-up report sent by mail, fax, or email within 36 hours. California Department of Justice Form SS 8572 (Attachment B) must be used for the written report.

1. Designated agencies:
   - Police Department (other than school district police)
   - Sherriff's Department
   - County Probation Department (if designated)
   - County Welfare Department
2. The report will include to the extent known:
   - The name, business address, phone number of the mandated reporter and the capacity with which he or she is reporting.
   - Information stating the basis for suspicion.
   - The Child's Name.
   - Names, phone numbers, and addresses of parents/ guardians.
   - Names and contact information for any individuals suspected of abuse/ neglect.

A copy of the completed Suspected Child Abuse Report form should be kept in the patient's medical record.

Practitioners must use their judgment when children are seeking care for pregnancy or sexually transmitted diseases as these are not necessarily indicators of abuse. Abuse is presumed if consensual sex occurs between a minor under thirteen years with a minor over fourteen years old.

Medical professionals who examine a child for a physical injury, or suspected abuse must also complete the form:
"Medical Report: Suspected Child Physical and Neglect Examination" – OES 2-900 (Attachment C)

Completion of California Child Abuse and Neglect Reporting Act (CANRA) training is mandated for all School of Medicine staff and faculty who will encounter/ interact with minors in the course of their employment.

C. Sexual Assault/Rape

All victims of attempted or actual sexual assault should be referred to a county-designated hospital for performance of a rape exam. This includes child molestation.

Area Hospitals with a Sexual Assault Response Team (SART):

Riverside County Regional Medical Center
26520 Cactus Avenue
Moreno Valley, CA 92555
951 486-5650 **(Emergency Room)**
951 486-5670 **(Fast Trac)**
951 486-4000 **(Operator)**

Corona Regional Medical Center
800 S. Main Street
Corona, CA 91720
951 736-6241

Rancho Springs Medical Center
2550 Medical Center Drive
Murrieta, CA 92562
951 696-6000

When a provider is seeing patients in one of these hospitals their policies and procedures regarding the treatment and reporting of sexual assault/rape victims must be followed.

D. Elder and Dependent Adults

1. A report must be made to Adult Protective Services. A telephonic/Internet report must be made as soon as possible. If telephonic, with a written follow-

up report, Form SOC 341 (Attachment D) or internet report must be sent within 2 working days.

- Patients must be notified that a report is being made, unless in the professional judgment of the provider, it would place the patient at risk of harm or if the authorized agent of the patient (person to be informed) is the one suspected of abuse/neglect.
- Verbal notification to the patient/agent is sufficient.
- Reports must be made even if the patient objects.

2. Abuse that occurs in a nursing home:
   - Physical Abuse with Serious Bodily Injury: A telephone report must be made to local law enforcement within 2 hours of discovery. Also a written report must be made to the local long term care Ombudsman, AND California Department of Public Health, AND local law enforcement agency within 2 hours of discovery.
   - Physical Abuse Not Resulting in Serious Bodily Injury and all other types of abuse: The reporting steps are the same though the timeframe for reporting is 24 hours instead of 2 hours.
3. Exception to Reporting Requirement must include all of the following:
   - Where an elder/dependent adult tells the reporter that they have experienced abuse AND
   - The reporter is unaware of any independent corroborating evidence AND
   - The elder/dependent adult has been diagnosed with mental illness or dementia AND
   - A physician, R.N., or psychotherapist does not believe, in his or her professional and clinical judgment that abuse has occurred.
4. Disclosure of Information and Photographs
   - Information that is otherwise protected may be disclosed if it is relevant to the elder/dependent adult abuse.
   - The information may be shared with investigators from the Public Guardian's office, Police Department, Probate Court, Department of Consumer Affairs, or other authorized agencies involved in the investigation.
   - Confidential photographs of injuries from the patient's medical record may be shared with the investigating agency. No photographs can be maintained or shared on a cell phone.

E. Injury or Condition Present in a Patient Received from a Licensed Health Facility

1. Any injury or physical condition present on a patient received from a licensed health facility, which reasonably appears to be the result of abuse or neglect must be reported. This applies to patients received from:
   - Another acute hospital
   - Community care facilities

- Skilled Nursing Facility
- Group homes/residential care facilities
- Adult day programs
- Treatment facilities
- Transitional shelters
- Outpatient surgery centers

2. UCR Health Physicians are specifically required under law to report. Other UCR Health professionals, such as nurses and social workers are permitted to report but are not obligated.
   - Both a telephonic and written report must be made to the local police and county health department within 36 hours
   - The written report will be completed by the treating physician and should describe the character and extent of the patient's injury/physical condition and must be signed by the physician.
   - Adult patients will be informed that a report has been made, unless doing so would place him or her at risk of harm.

VI. Forms/Instructions

Attachment A – OES-2-920
Attachment B – California Department of Justice Form SS 8572
Attachment C – OES 2-900
Attachment D – SOC 341

VII. Related Information

Not Applicable

VIII. Revision History

New

Approval(s):

APPROVED BY CHAIR OF COMPLIANCE COMMITTEE (4/24/2019)

PAUL HACKMAN, J.D., L.LM
CHIEF COMPLIANCE AND PRIVACY OFFICER
SCHOOL OF MEDICINE

05-13-'19
DATE

DEBORAH DEAS, M.D., M.P.H
DEAN, SCHOOL OF MEDICINE
CEO, CLINICAL AFFAIRS

5/13/19
DATE

Attachment A

SUSPICIOUS INJURY REPORT

STATE OF CALIFORNIA
California Office of Emergency Services

Cal OES 2-920

Confidential Document

Penal Code Section 11160 requires that if any health practitioner, within their scope of their employment, provides medical services for a wound or physical injury inflicted as a result of assaultive or abusive conduct, or by means of a firearm, shall make a telephone report immediately or as soon as possible. They shall also prepare and submit a written report within 2 working days of receiving the information to a local law enforcement agency. This is the official form (Cal OES 2-920) for submitting the written report.

This form is used by law enforcement only and is confidential in accordance with Section 11163.2 of the Penal Code. In no case shall the person identified as a suspect be allowed access to the injured person's whereabouts.

Part A: PATIENT WITH SUSPICIOUS INJURY

1. Name of Patient (Last, First, Middle)	2. Birth Date	3. Gender ☐ M ☐ F	4. SAFE Telephone Number ( )
5. Patient Address (Number and Street / Apt – **No P.O. Box**) City		State	Zip
6. Patient Speaks English ☐ Yes ☐ No If No, identify language spoken:_____	7. Date and Time of Injury Date: Time: ☐ am ☐ pm ☐ unknown		
8. Location / Address Where Injury Occurred, if Available. Check here if unknown: ☐			
9. Patient description of the incident. Include any identifying information about the person the patient alleges caused the injury and the names of any persons who may know about the incident. ☐ Additional Pages Attached			
10. Name of Suspect, if Identified by the Patient	11. Relationship to Patient ☐ No Relationship		
12. Suspicious Injury Description. Include a brief description of physical findings, lab tests completed or pending, and other pertinent information. ☐ Additional Pages			

Part B: REQUIRED – AGENCIES RECEIVING PHONE AND WRITTEN REPORTS

13. Law Enforcement Agency Notified By Phone (Mandated by PC 11160)	14. Date and Time Reported Date: Time: am pm	
15. Name of Person Receiving Phone Report (First and Last)	16. Title	17. Phone Number ( )
18. Law Enforcement Agency Receiving Written Report (Mandated by PC 11160)	19. Agency Incident Number	

Part C: PERSON FILING REPORT

20. Name of Health Practitioner (First and Last)	Title	Telephone
21. Employer's Name		Phone Number
22. Employer's Address (Number and Street) City	State	Zip
23. HEALTH PRACTITIONER'S SIGNATURE:		26. Date Signed:

Cal OES 2-920 (2001)

San Francisco Supplement to Health Practitioner Suspicious Injury Report

Confidential Document

Provider Instructions

1. If the patient wishes to meet with law enforcement immediately or the provider assesses that the patient has near lethal circumstances and/ or a life threatening injury, call 911.
2. For patients who do not wish to meet with law enforcement immediately or at all, and do not have near lethal circumstances and/or life threatening injury, call 415-553-9220 and speak with the Special Victims Unit representative, or follow instructions on the voicemail after hours.
3. Transmit Cal OES 2-920 and this form via fax to 415-734-3086 or via e-mail to sfpd.svumedrec@sfgov.org or via mail to San Francisco Police Department Special Victims Unit, 850 Bryant St., Room 500, San Francisco, CA 94103.

OES Form 2-920 is mandated to fulfill a health practitioner's reporting requirement under Penal Code Section 11160 et seq., whether or not the patient wishes to make a police report at the time of the initial examination. In San Francisco, we are requesting that providers complete this optional form in addition to OES Form 2-920 to improve patient care and ensure proper patient-centered follow-up

Please Note: A patient is not required to provide any information that they feel puts them at further risk.

Patient Information

Name:

Safe way(s) for police/advocate to contact the patient without the abuser/perpetrator knowing (complete all that apply):

Email:

Phone:

Alternate Contact (Friend/Family) Name and Phone:

Reason for report (check all that apply):

[ ] Firearm [ ] Assaultive or abusive conduct

a. **Does the patient desire immediate contact with law enforcement (which may result in arrest of the perpetrator)?**
[ ] Yes [ ] No

b. **Does the patient believe police involvement would increase the risk for patient?**
[ ] Yes [ ] No

c. **Did you inform the patient that police may still contact them for further information?**
[ ] Yes [ ] No

d. **Would the patient like a follow-up call from a confidential domestic violence advocate based at the Police Department?**
[ ] Yes [ ] No

e. **Did you inform the patient that a confidential domestic violence advocate will attempt to contact them even if they answered "no" to question "d" above?**
[ ] Yes [ ] No

Are there any special needs (i.e. disabilities) or other things that the patient wants the police or domestic violence advocate to be aware of:

_____

_____

*This form is not a substitute for complete documentation in the patient's medical record. **Never** attach a patient's medical record to this form. Consult your institution's Privacy Officer if you are unsure about whether to include certain information in the mandatory report.*

Date and Time Form Sent: _____

Last revised 1/9/2017

Attachment B

Print

SUSPECTED CHILD ABUSE REPORT

Reset Form

To Be Completed by **Mandated Child Abuse Reporters**
Pursuant to Penal Code Section 11166

PLEASE PRINT OR TYPE

CASE NAME: _____

CASE NUMBER: _____

A. REPORTING PARTY

NAME OF MANDATED REPORTER	TITLE		MANDATED REPORTER CATEGORY
REPORTER'S BUSINESS/AGENCY NAME AND ADDRESS Street	City	Zip	DID MANDATED REPORTER WITNESS THE INCIDENT? ☐ YES ☐ NO
REPORTER'S TELEPHONE (DAYTIME) ( )	SIGNATURE		TODAY'S DATE

B. REPORT NOTIFICATION

☐ LAW ENFORCEMENT ☐ COUNTY PROBATION ☐ COUNTY WELFARE / CPS (Child Protective Services)	AGENCY		
ADDRESS Street	City	Zip	DATE/TIME OF PHONE CALL
OFFICIAL CONTACTED - TITLE			TELEPHONE ( )

C. VICTIM
One report per victim

NAME (LAST, FIRST, MIDDLE)			BIRTHDATE OR APPROX. AGE	SEX / ETHNICITY
ADDRESS Street	City	Zip	TELEPHONE ( )	
PRESENT LOCATION OF VICTIM	SCHOOL		CLASS	GRADE
PHYSICALLY DISABLED? ☐ YES ☐ NO	DEVELOPMENTALLY DISABLED? ☐ YES ☐ NO	OTHER DISABILITY (SPECIFY)	PRIMARY LANGUAGE / SPOKEN IN HOME	
IN FOSTER CARE? ☐ YES ☐ NO	IF VICTIM WAS IN OUT-OF-HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE: ☐ DAY CARE ☐ CHILD CARE CENTER ☐ FOSTER FAMILY HOME ☐ FAMILY FRIEND ☐ GROUP HOME OR INSTITUTION ☐ RELATIVE'S HOME		TYPE OF ABUSE *(CHECK ONE OR MORE)* ☐ PHYSICAL ☐ MENTAL ☐ SEXUAL ☐ NEGLECT ☐ OTHER (SPECIFY)	
RELATIONSHIP TO SUSPECT	PHOTOS TAKEN? ☐ YES ☐ NO		DID THE INCIDENT RESULT IN THIS VICTIM'S DEATH? ☐ YES ☐ NO ☐ UNK	

D. INVOLVED PARTIES

VICTIM'S SIBLINGS

NAME	BIRTHDATE	SEX	ETHNICITY	NAME	BIRTHDATE	SEX	ETHNICITY
1.				3.			
2.				4.			

VICTIM'S PARENTS/GUARDIANS

NAME (LAST, FIRST, MIDDLE)			BIRTHDATE OR APPROX. AGE	SEX / ETHNICITY
ADDRESS Street	City	Zip	HOME PHONE ( )	BUSINESS PHONE ( )
NAME (LAST, FIRST, MIDDLE)			BIRTHDATE OR APPROX. AGE	SEX / ETHNICITY
ADDRESS Street	City	Zip	HOME PHONE ( )	BUSINESS PHONE ( )

SUSPECT

SUSPECT'S NAME (LAST, FIRST, MIDDLE)			BIRTHDATE OR APPROX. AGE	SEX / ETHNICITY
ADDRESS Street	City	Zip	TELEPHONE ( )	
OTHER RELEVANT INFORMATION				

E. INCIDENT INFORMATION

IF NECESSARY, ATTACH EXTRA SHEET(S) OR OTHER FORM(S) AND CHECK THIS BOX ☐ *IF MULTIPLE VICTIMS, INDICATE NUMBER:* _____

DATE / TIME OF INCIDENT	PLACE OF INCIDENT

NARRATIVE DESCRIPTION (What victim(s) said/what the mandated reporter observed/what person accompanying the victim(s) said/similar or past incidents involving the victim(s) or suspect)

SS 8572 (Rev. 12/02)

DEFINITIONS AND INSTRUCTIONS ON REVERSE

DO NOT submit a copy of this form to the Department of Justice (DOJ). The investigating agency is required under Penal Code Section 11169 to submit to DOJ a Child Abuse Investigation Report Form SS 8583 if (1) an active investigation was conducted and (2) the incident was determined not to be unfounded.

WHITE COPY-Police or Sheriff's Department; BLUE COPY-County Welfare or Probation Department; GREEN COPY- District Attorney's Office; YELLOW COPY-Reporting Party

Attachment C

State of California
California Emergency Management Agency

MEDICAL REPORT: SUSPECTED CHILD PHYSICAL ABUSE AND NEGLECT EXAMINATION

CalEMA 2-900

For more information or assistance in completing the CalEMA 2-900, please contact University of California, Davis California Clinical Forensic Medical Training Center at: (888) 705-4141 or www.ccfmtc.org

Available at: **www.CalEMA.ca.gov**

MEDICAL REPORT: SUSPECTED CHILD PHYSICAL ABUSE AND NEGLECT EXAMINATION
State of California
California Emergency Management Agency
CalEMA 2-900

Confidential Document: Restricted Release | **Patient Identification:** | **Date:**

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

3. Patient's Last Name	First Name	M.I.	Telephone	Cell Phone

4. Street Address	City	County	State	Zip Code

5. Age	Date of Birth	Gender ☐ Female ☐ Male	Ethnicity

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 ☐ Parent ☐ Legal Guardian ☐ Other, specify: _____	Gender ☐ Female ☐ Male	Telephone (w) (h) (c)

Street Address	City	County	State	Zip Code

8. Name of Child's Caregiver ☐ Parent ☐ Legal Guardian ☐ Other, specify: _____	Gender ☐ Female ☐ 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):

☐ Law Enforcement ☐ Telephone Report ☐ Written Report Submitted	Name of Agency	Telephone	Date
Name of Person Taking Report:			
☐ Child Protective Services ☐ Telephone Report ☐ Written Report Submitted	Name of Agency	Telephone	Date
Name of Person Taking Report:			

C. RESPONDING PERSONNEL TO MEDICAL FACILITY

Name | ID Number | Agency | ☐ 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 CalEMA 2-900 (Check all that apply)

☐ Law Enforcement Agency (original) ☐ Hand Delivered ☐ Mailed ☐ Faxed	☐ Child Protective Services (copy) ☐ Hand Delivered ☐ Mailed ☐ Faxed
☐ Crime Laboratory (copy included with evidence)	☐ Medical Facility Records (copy)

F. PATIENT HISTORY

1. Name of Person(s) Providing History	Relationship to Patient

2. Child Accompanied to Facility By	Relationship to Patient

Patient Identification: **Date:**

3. History of Present Illness ☐ See dictation for additional information. ☐ N/A

If dictating, provide brief 2-3 sentence handwritten summary. Print or write legibly. Include date, time or timeframe, place of incident, and initial reporting party. Distinguish statements made by child in quotation marks from those statements made by other historians.

G. PAST MEDICAL HISTORY

	Yes	No	Unknown	Describe
Birth History (if applicable)	☐	☐	☐	
Physical Abuse History	☐	☐	☐	
Sexual Abuse History	☐	☐	☐	
Neglect History	☐	☐	☐	
Emotional Abuse History	☐	☐	☐	
Domestic Violence Exposure	☐	☐	☐	
Alcohol/Drug Exposure	☐	☐	☐	Specify types of drugs if known, and collect urine toxicology up to 96 hours after ingestion:
☐ Prenatal ☐ Postnatal ☐ Alcohol ☐ Drug				
Hospitalization(s)	☐	☐	☐	
Surgery	☐	☐	☐	
Significant Illness/Injury	☐	☐	☐	
Any pertinent medical condition(s) that may affect the interpretation of findings?	☐	☐	☐	
Allergies	☐	☐	☐	
Medications	☐	☐	☐	
Immunizations Up To Date	☐	☐	☐	
Disabilities	☐	☐	☐	(Specify):
Growth & Development	☐	☐	☐	
☐ WNL ☐ ABN ☐ Unknown				

H. REVIEW OF SYSTEMS ☐ Negative except as noted below

☐ See dictation for additional information ☐ N/A

I. NAME OF PERSON TAKING HISTORY (Print Name)	Signature	Telephone	Date

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: **Date:**

4. Record results of physical examination.

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

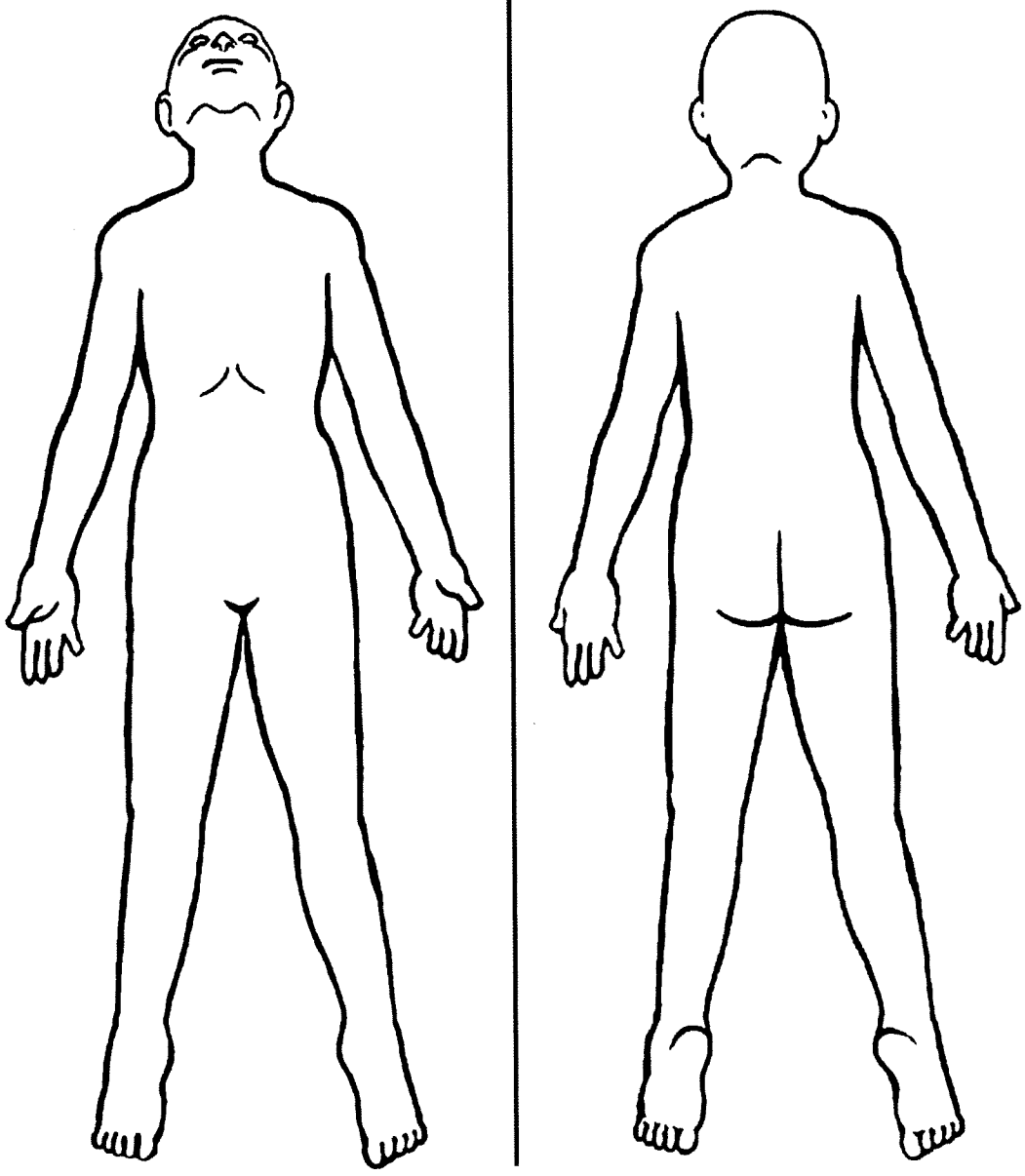
5. If genital injuries are sustained, use copies of page(s) 6 and 7 (if applicable) from CalEMA 930 Forensic Medical Report: Acute (<72 hours) Child/Adolescent Sexual Abuse Examination Form or CalEMA 925 Forensic Medical Report: NonAcute (>72 hours) Child/Adolescent Sexual Abuse Examination to document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

J. GENERAL PHYSICAL EXAMINATION (continued)

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

Patient Identification: Date:

A B

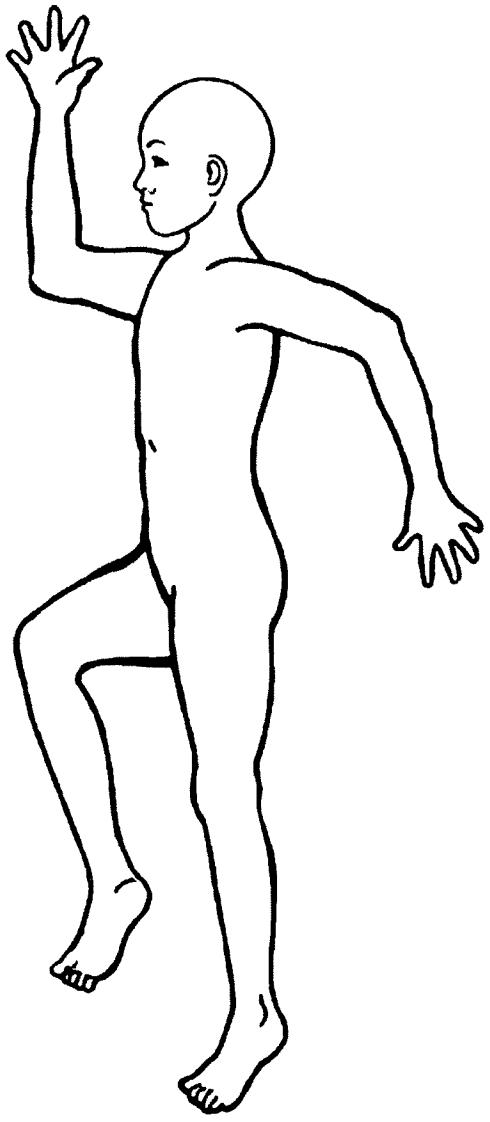


J. GENERAL PHYSICAL EXAMINATION (continued)

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

Patient Identification: **Date:**

C



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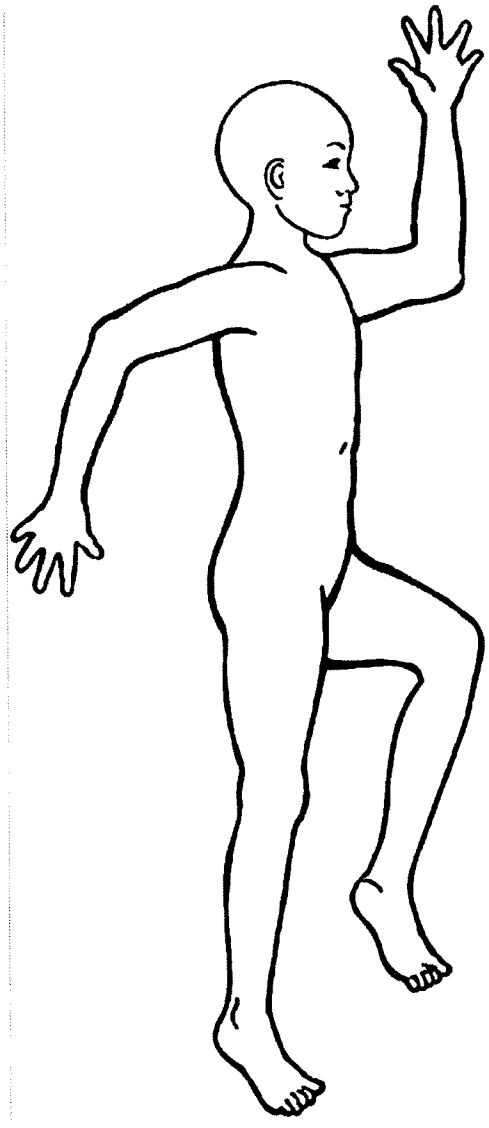
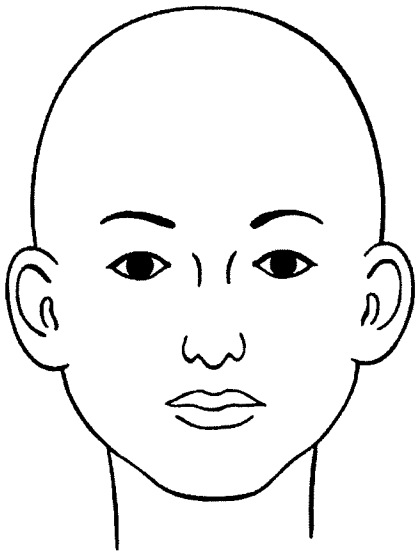


J. GENERAL PHYSICAL EXAMINATION (continued)

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

Patient Identification: **Date:**

E



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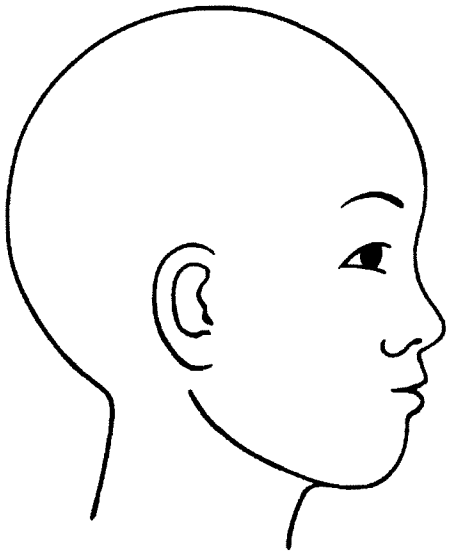

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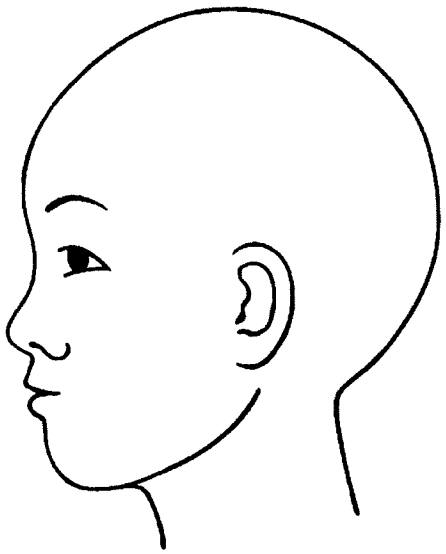

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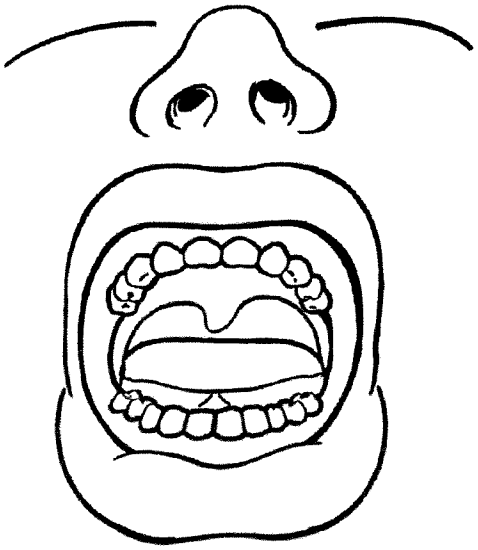

K. EVIDENCE COLLECTED AND SUBMITTED TO CRIME LAB

1. Clothing Collected ☐ No ☐ Yes ☐ N/A

Clothing Placed in Evidence Kit	Clothing Placed in Paper Bag

2. Foreign Materials Collected

	N/A	No	Yes	Collected by:
Swabs/suspected blood	☐	☐	☐	
Dried secretions	☐	☐	☐	
Fiber/loose hairs	☐	☐	☐	
Soil/debris/vegetation	☐	☐	☐	
Swabs/suspected saliva	☐	☐	☐	
Foreign body	☐	☐	☐	
Control swabs	☐	☐	☐	
Fingernail scrapings	☐	☐	☐	
Matted hair cuttings	☐	☐	☐	

Other types, describe:

L. TOXICOLOGY SAMPLES

	N/A	No	Yes	Time	Collected by:
Blood Alcohol / Toxicology	☐	☐	☐		
Urine Toxicology	☐	☐	☐		

M. REFERENCE SAMPLES

	N/A	No	Yes	Time	Collected by:
Blood (lavender top tube)	☐	☐	☐		
Blood card (optional)	☐	☐	☐		
Buccal swabs (optional)	☐	☐	☐		
Saliva swabs	☐	☐	☐		

N. DIAGNOSTIC STUDIES ☐ Refer to dictation

1. Laboratory:

	WNL	ABN	N/A	Pending	Results
☐ CBC	☐	☐	☐	☐	
☐ Platelets	☐	☐	☐	☐	
☐ INR, PTT, PT	☐	☐	☐	☐	
☐ SGOT, SGPT	☐	☐	☐	☐	
☐ Urinalysis	☐	☐	☐	☐	
☐ Toxicology Screen	☐	☐	☐	☐	
☐ Other	☐	☐	☐	☐	

2. Diagnostic Imaging

	WNL	ABN	N/A	Preliminary Reading	Final Report
☐ Skeletal Survey	☐	☐	☐	☐	☐
☐ CT Scan	☐	☐	☐	☐	☐
☐ M R I	☐	☐	☐	☐	☐
☐ Other	☐	☐	☐	☐	☐

Describe:

3. Exam Performed by Ophthalmologist:
☐ N/A ☐ No ☐ Yes ☐ Pending ☐ See Medical Record for Report

Name of Ophthalmologist:

Photographs Taken By:

O. PHOTO DOCUMENTATION

☐ No ☐ Yes ☐ N/A ☐ Film Retained

☐ Film Released to:

Photographs taken by:

35mm	Digital	Instant	Other
☐	☐	☐	☐

Recommend follow-up photographs be taken in 1-2 days
☐ No ☐ Yes ☐ N/A

Patient Identification: **Date:**

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

Describe:

☐ Neglect
☐ Physical abuse
☐ Evaluation suspicious for physical abuse. Further information needed.
☐ Indeterminate cause
☐ Evaluation indicates non-abusive cause of medical findings.

☐ See Additional Dictation Dictation Reference Number:

Q. DISTRIBUTION OF EVIDENCE

	Released To
Clothing (items not placed in evidence kit) ☐ N/A	
Evidence Kit ☐ N/A	
Reference samples ☐ N/A	
Toxicology samples ☐ N/A	

R. PERSONNEL INVOLVED

Examination Performed By: (Print)	Signature of Examiner	
License No.	Telephone	Date
Examination Assisted By: (Print)	Signature	
License No.	Telephone	Date
Specimen labeled and sealed by:	Signature	
License No.	Telephone	Date

S. PATIENT DISPOSITION

☐ Admitted ☐ Home ☐ Protective Custody
☐ Follow Up Exam Needed (specify reason):

Attachment D

STATE OF CALIFORNIA-HEALTH AND HUMAN SERVICES AGENCY — CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

CONFIDENTIAL REPORT-
NOT SUBJECT TO PUBLIC DISCLOSURE

DATE COMPLETED:

REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE

TO BE COMPLETED BY REPORTING PARTY. PLEASE PRINT OR TYPE. SEE GENERAL INSTRUCTIONS.

A. VICTIM ☐ Check this box if victim consents to disclosure of information [*Ombudsman use only* WIC 15636(a)]

*NAME (LAST NAME FIRST)	*AGE	DATE OF BIRTH	SSN	GENDER	ETHNICITY	LANGUAGE (✓ CHECK ONE)
				☐ M ☐ F		☐ NON-VERBAL ☐ ENGLISH ☐ OTHER (SPECIFY)

*ADDRESS (IF FACILITY, INCLUDE NAME AND NOTIFY OMBUDSMAN)	*CITY	*ZIP CODE	*TELEPHONE
			( )
*PRESENT LOCATION (IF DIFFERENT FROM ABOVE)	*CITY	*ZIP CODE	*TELEPHONE
			( )

☐ ELDERLY (65+) ☐ DEVELOPMENTALLY DISABLED ☐ MENTALLY ILL/DISABLED ☐ PHYSICALLY DISABLED ☐ UNKNOWN/OTHER ☐ LIVES ALONE ☐ LIVES WITH OTHERS

B. SUSPECTED ABUSER ✓ *Check if* ☐ *Self-Neglect*

NAME OF SUSPECTED ABUSER — ☐ CARE CUSTODIAN (type) ____ ☐ HEALTH PRACTITIONER (type) ____ ☐ PARENT ☐ SPOUSE ☐ SON/DAUGHTER ☐ OTHER RELATIONSHIP ☐ OTHER ____

ADDRESS	*ZIP CODE	TELEPHONE	GENDER	ETHNICITY	AGE	D.O.B.	HEIGHT	WEIGHT	EYES	HAIR
			☐ M ☐ F							

C. REPORTING PARTY: *Check appropriate box if reporting party waives confidentiality to:* ☐ ✓ All ☐ ✓ All but victim ☐ ✓ All but perpetrator

*NAME (PRINT)	SIGNATURE	OCCUPATION	AGENCY/NAME OF BUSINESS

RELATION TO VICTIM/HOW KNOWS OF ABUSE (STREET) (CITY) (ZIP CODE) (E-MAIL ADDRESS) TELEPHONE ( )

D. INCIDENT INFORMATION – Address where incident occurred:

*DATE/TIME OF INCIDENT(S)

PLACE OF INCIDENT (✓ CHECK ONE)
☐ OWN HOME ☐ HOME OF ANOTHER ☐ COMMUNITY CARE FACILITY ☐ NURSING FACILITY/SWING BED ☐ HOSPITAL/ACUTE CARE HOSPITAL ☐ OTHER (Specify)

E REPORTED TYPES OF ABUSE (✓ CHECK ALL THAT APPLY).

1. PERPETRATED BY OTHERS (WIC 15610.07 & 15610.63)

a. PHYSICAL
☐ ASSAULT/BATTERY
☐ CONSTRAINT OR DEPRIVATION
☐ SEXUAL ASSAULT
☐ CHEMICAL RESTRAINT
☐ OVER OR UNDER MEDICATION

b. ☐ NEGLECT
c. ☐ FINANCIAL
d. ☐ ABANDONMENT
e ☐ ISOLATION
f. ☐ ABDUCTION
g. ☐ OTHER (Non-Mandated: e.g., deprivation of goods and services: psychological/mental)

2. SELF-NEGLECT (WIC 15610.57 (b)(5))

a. ☐ PHYSICAL CARE (e.g., personal hygiene, food, clothing, shelter)
b. ☐ MEDICAL CARE (e.g., physical and mental health needs)
c. ☐ HEALTH and SAFETY HAZARDS
d. ☐ MALNUTRITION/DEHYDRATION
e. ☐ OTHER (Non-Mandated e.g., financial)

ABUSE RESULTED IN (✓ CHECK ALL THAT APPLY) ☐ NO PHYSICAL INJURY ☐ MINOR MEDICAL CARE ☐ HOSPITALIZATION ☐ CARE PROVIDER REQUIRED ☐ DEATH ☐ MENTAL SUFFERING ☐ OTHER (SPECIFY) ☐ UNKNOWN

F. REPORTER'S OBSERVATIONS, BELIEFS, AND STATEMENTS BY VICTIM IF AVAILABLE. DOES ALLEGED PERPETRATOR STILL HAVE ACCESS TO THE VICTIM? PROVIDE ANY KNOWN TIME FRAME (2 days, 1 week, ongoing, etc.) ***LIST ANY POTENTIAL DANGER FOR INVESTIGATOR (animals, weapons, communicable diseases, etc.).*** ☐ ✓ CHECK IF MEDICAL, FINANCIAL, PHOTOGRAPHS OR OTHER SUPPLEMENTAL INFORMATION IS ATTACHED).

G. TARGETED ACCOUNT

ACCOUNT NUMBER (LAST 4 DIGITS):	TYPE OF ACCOUNT: ☐ DEPOSIT ☐ CREDIT ☐ OTHER	TRUST ACCOUNT: ☐ YES ☐ NO
POWER OF ATTORNEY: ☐ YES ☐ NO	DIRECT DEPOSIT: ☐ YES ☐ NO	OTHER ACCOUNTS: ☐ YES ☐ NO

H. OTHER PERSON BELIEVED TO HAVE KNOWLEDGE OF ABUSE. *(family, significant others, neighbors, medical providers and agencies involved, etc.)*

NAME	ADDRESS	TELEPHONE NO ( )	RELATIONSHIP

I. FAMILY MEMBER OR OTHER PERSON RESPONSIBLE FOR VICTIM'S CARE. *(If unknown, list contact person).*

*NAME	IF CONTACT PERSON ONLY ✓ CHECK ☐	*RELATIONSHIP
*ADDRESS	*CITY *ZIP CODE	*TELEPHONE ( )

J. TELEPHONE REPORT MADE TO: ☐ Local APS ☐ Local Law Enforcement ☐ Local Ombudsman ☐ Calif. Dept. of Mental Health ☐ Calif. Dept. of Developmental Services

NAME OF OFFICIAL CONTACTED BY PHONE	*TELEPHONE ( )	DATE/TIME

K. WRITTEN REPORT Enter information about the agency receiving this report. Do not submit report to California Department of Social Services Adult Programs Bureau.

AGENCY NAME	ADDRESS OR FAX #	☐ DATE MAILED:	☐ DATE FAXED:

L. RECEIVING AGENCY USE ONLY ☐ Telephone Report ☐ Written Report

1. Report Received by: Date/Time:
2. Assigned ☐ Immediate Response ☐ Ten-day Response ☐ No Initial Face-To-Face Required ☐ Not APS ☐ Not Ombudsman
   Approved by: Assigned to (optional):
3. Cross-Reported to: ☐ CDHS, Licensing & Cert.; ☐ CDSS-CCL; ☐ CDA Ombudsman; ☐ Bureau of Medi-Cal Fraud & Elder Abuse; ☐ Mental Health; ☐ Law Enforcement; ☐ Professional Board; ☐ Developmental Services; ☐ APS; ☐ Other (Specify) Date of Cross-Report:
4. APS/Ombudsman/Law Enforcement Case File Number: ____

SOC 341 (rev. 12/06)