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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | MISSOURI DEPARTMENT OF SOCIAL SERVICES  CHILDREN’S DIVISION  **SAFE-CARE Provider Evaluation Referral** | | | | | |  | | | |  | |
| Report Date: | | | | | |
| Incident Number: | | | | | |
| Date of Referral: | | | | | |
| **CASE DATA** | | | | | | | | | | | | |
| **CHILD** | | | | | | | | | | | | |
| CHILD’S NAME | | | | | DATE OF BIRTH | | | AGE | | | | GENDER |
| **ALLEGED PERPETRATOR(S)**  **UNKNOWN** | | | | | | | | | | | | |
| NAME | | | | RELATIONSHIP | | | | | | | | |
| NAME | | | | RELATIONSHIP | | | | | | | | |
| **WORKER** | | | | | | | | | | | | |
| WORKER NAME | | PHONE NUMBER | | | | | | | | COUNTY | | |
| WORKER’S EMAIL ADDRESS | | | SUPERVISOR’S EMAIL | | | | | | | | | |
| **ALLEGATIONS** | | | | | | | | | | | | |
| **CATEGORY OF ABUSE/NEGLECT** (Check all that apply)  PHYSICAL ABUSE  SEXUAL ABUSE  EMOTIONAL ABUSE  NEGLECT | | | | | | | | | | | | |
| **REPORTED CONCERN** | | | | | | | | | | | | |
| **ADDITIONAL INFORMATION OBTAINED FROM CONTACTS** | | | | | | | | | | | | |
| **MEDICAL INFORMATION** | | | | | | | | | | | | |
| Has the child received medical attention for these allegations?  Yes  No | | | | | | | | | | | | |
| If yes, treating physician’s information: | | | | | | | | | | | | |
| Name: | | Phone Number | | | | Hospital: | | | | | | |
| Does The Child Have An Injury?  Yes  No  Unknown | | | | | | | | | | | | |
| Do You Have Any Medical Records For This Incident Yet?  Yes (Attach To Referral)  No | | | | | | | | | | | | |
| Explain/describe any injuries or suspicion of injury, **including** location and any possible mechanism of injury. If there are no concerns of injury, are there any other medical concerns related to the allegation? | | | | | | | | | | | | |
| **RECOMMENDATIONS FOR FOLLOW UP MEDICAL EVALUATION (TO BE COMPLETED BY PHYSICIAN)** | | | | | | | | | | | | |
| no medical/forensic evaluation required based on information provided above  medical exam by general practitioner  medical examination by a safe-care provider needed  medical examination by a board certified child abuse pediatrician needed  case review by a safe-care provider needed | | | | | | | | | | | | |
| Further recommendations for medical treatment: | | | | | | | | | | | | |
| SIGNATURE OF PHYSICIAN | | | | | | | | | DATE | | | |