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|  | MISSOURI DEPARTMENT OF SOCIAL SERVICESCHILDREN’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      |