



Child Protection Paediatric Examination Proforma

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

The sections with this symbol  contain data required for national MCN and Public Health Scotland.

 1. Child Details
Name of child
Date of birth: CHI number:
Address and postcode
Age Sex* Female <input type="checkbox"/> Male <input type="checkbox"/> (*see over for CSA cases)
School / Nursery attended
Ethnicity
Main Language
Known Vulnerabilities: Neurological Condition <input type="checkbox"/> Significant Learning Disability <input type="checkbox"/> Autistic Spectrum Disorder <input type="checkbox"/> ADHD <input type="checkbox"/> Mental Health Issues <input type="checkbox"/> Drugs/Alcohol <input type="checkbox"/> Previous LAAC <input type="checkbox"/>
Child Protection Registration Is the child on/ever been on CPR: No <input type="checkbox"/> Yes <input type="checkbox"/> Details:
Current Experience Seeking Asylum <input type="checkbox"/> Child Exploitation <input type="checkbox"/> Residential Care <input type="checkbox"/> LAC -home <input type="checkbox"/> LAAC- foster care <input type="checkbox"/>
Names and DOB of Parent(s) / Carer(s) attending:

 2. Examination details				
Date of examination:				
Time of examination:				
Out of Hours or weekend	Yes		No	
Location of examination:				
Type of examination: Acute Joint Paediatric Forensic – sexual (≤ 7 days) <input type="checkbox"/> Elective Joint Paediatric Forensic – sexual (> 7 days) <input type="checkbox"/> Joint Paediatric Forensic – physical/neglect <input type="checkbox"/> Specialist Medical (single doctor) <input type="checkbox"/> Specialist Medical – sexual (single doctor) <input type="checkbox"/> Forensic Physician Only: <input type="checkbox"/>				
Doctors Examiner 1: Designation: GMC number: Male / Female: Examiner 2: Designation: GMC number: Male/Female:				
Police Attending Officer: Investigating Officer:				
Social Work Attending Social Worker: Allocated Social Worker:				
Other relevant professionals Health Visitor: GP: Others:				

Name

CHI

Date

✓ 3. 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"/>	FGM	<input type="checkbox"/>	<input type="checkbox"/>
Sexual abuse	<input type="checkbox"/>	<input type="checkbox"/>	CSE	<input type="checkbox"/>	<input type="checkbox"/>
Emotional abuse	<input type="checkbox"/>	<input type="checkbox"/>	No clinical findings but other concerns that suggest abuse		<input type="checkbox"/>
Neglect	<input type="checkbox"/>	<input type="checkbox"/>	Not abuse		<input type="checkbox"/>
Fabricated or induced illness	<input type="checkbox"/>	<input type="checkbox"/>	Clinical findings but not conclusive of abuse		<input type="checkbox"/>

✓ 4. For CSA cases only

Source of Referral:

Date and time start of IRD:

Date and time of referral to Health:

If there was a delay, what was the reason:

Child /Family were given the opportunity to express their preference of sex of examiner(s):

Female preferred:

Male preferred:

No preference:

Not asked:

Sexual Orientation (optional if under 13)

Heterosexual

Gay

Lesbian

Bisexual

Not certain

Not disclosed

Name

CHI

Date

Consent for investigations

I give permission for:

- | | | | |
|--|-----|----|------|
| 1. Collection of specimens for laboratory tests | Yes | No | N/A |
| 2. Radiology Investigations | | | |
| -Skeletal survey | Yes | No | N/A |
| -CT head scan | Yes | No | N/A |
| -MRI head scan | Yes | No | N /A |
| -Other (please specify)..... | | | |
| | | | |
| | | | |
|
(Leaflet explaining Radiological Investigations given) | Yes | No | N/A |

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

6. Reason for referral

Briefing taken from

Names of persons present during briefing

7. 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)

8. 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	

9. 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

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

Family Tree:

11. Social History

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

Name

CHI

Date

12. Adolescent

				Description/comment
Menarche	Yes		No	e.g.. Age
LMP (date)	Frequency of periods			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	

13. Forensic Sexual Assault

				Description/comment
Time of last contact with abuser				
Has HIV risk assessment of the suspect been considered?	Yes		No	
Number of hours since last sexual intercourse	Hours			
Condom used?	Yes		No	
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	

✓ 14. Emotional Wellbeing Risk Assessment

Do they show any signs of depression/anxiety/ or behavioural problems? If so please document.	
Does the caregiver have any concerns or any anxieties following the incident?	
What positive coping strategies / support networks does the child/YP or care giver have in place?	
Have you ever self-harmed? Method used? Did you tell anyone? Did you seek medical attention?	Details:

Name

CHI

Date

15. General examination						
Name(s) of persons present						
Weight		Height		Head circumference		
kgs	centile	cm	cm	centile	cm	centile
General appearance (hygiene)						
Skin colour			Hair colour			
Demeanour/behaviour						
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"/>				
Ears	R Y <input type="checkbox"/> N <input type="checkbox"/>	R Y <input type="checkbox"/> N <input type="checkbox"/>				
	L Y <input type="checkbox"/> N <input type="checkbox"/>	L 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 Y <input type="checkbox"/> N <input type="checkbox"/>	R Y <input type="checkbox"/> N <input type="checkbox"/>				
	L Y <input type="checkbox"/> N <input type="checkbox"/>	L Y <input type="checkbox"/> N <input type="checkbox"/>				
Hands/wrists	R Y <input type="checkbox"/> N <input type="checkbox"/>	R Y <input type="checkbox"/> N <input type="checkbox"/>				
	L Y <input type="checkbox"/> N <input type="checkbox"/>	L Y <input type="checkbox"/> N <input type="checkbox"/>				
Fingers/nails note if cut/broken/false	R Y <input type="checkbox"/> N <input type="checkbox"/>	R Y <input type="checkbox"/> N <input type="checkbox"/>				
	L Y <input type="checkbox"/> N <input type="checkbox"/>	L 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 Y <input type="checkbox"/> N <input type="checkbox"/>	R Y <input type="checkbox"/> N <input type="checkbox"/>				
	L Y <input type="checkbox"/> N <input type="checkbox"/>	L Y <input type="checkbox"/> N <input type="checkbox"/>				
Feet/ankles/soles	R Y <input type="checkbox"/> N <input type="checkbox"/>	R Y <input type="checkbox"/> N <input type="checkbox"/>				
	L Y <input type="checkbox"/> N <input type="checkbox"/>	L Y <input type="checkbox"/> N <input type="checkbox"/>				

Name

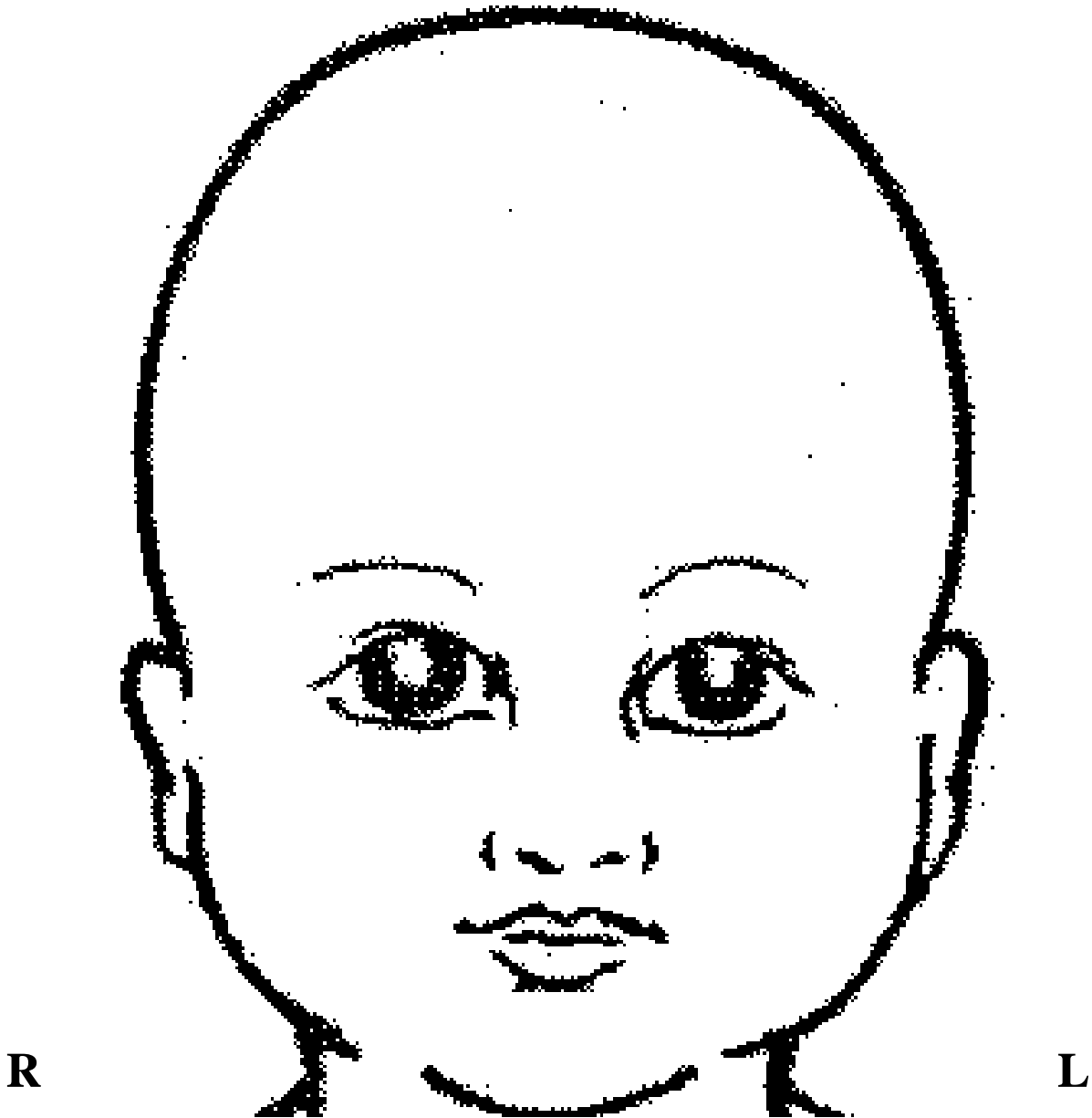
CHI

Date

Body diagrams

Injuries as pictured below

No injuries detected



Name

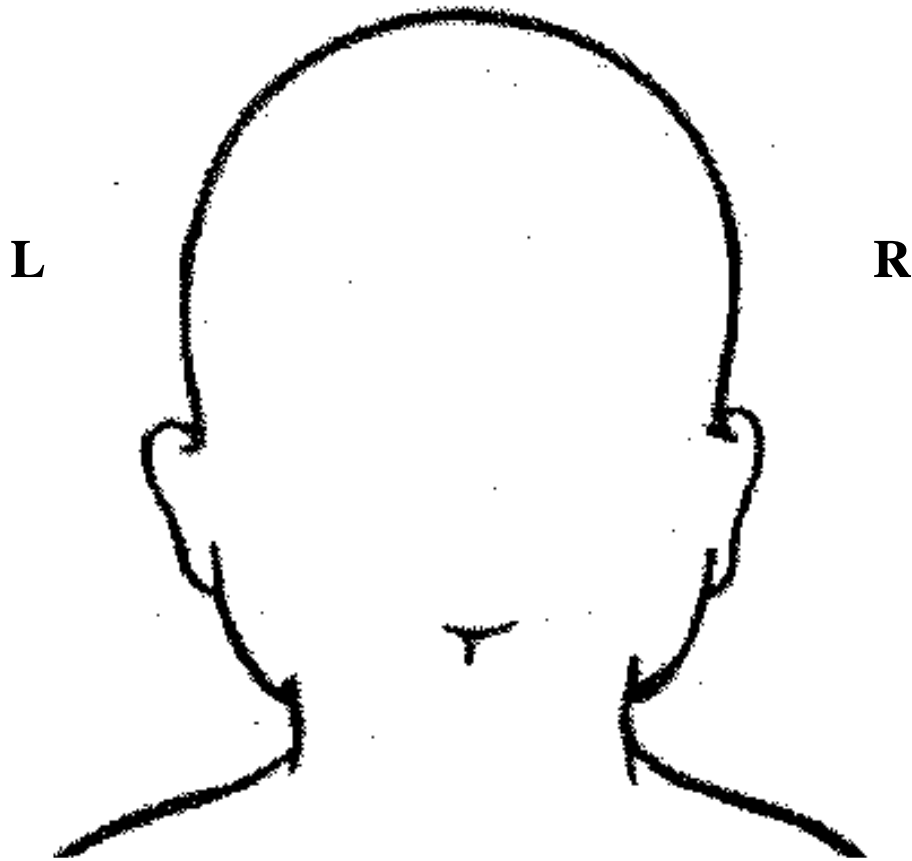
CHI

Date

Body diagrams

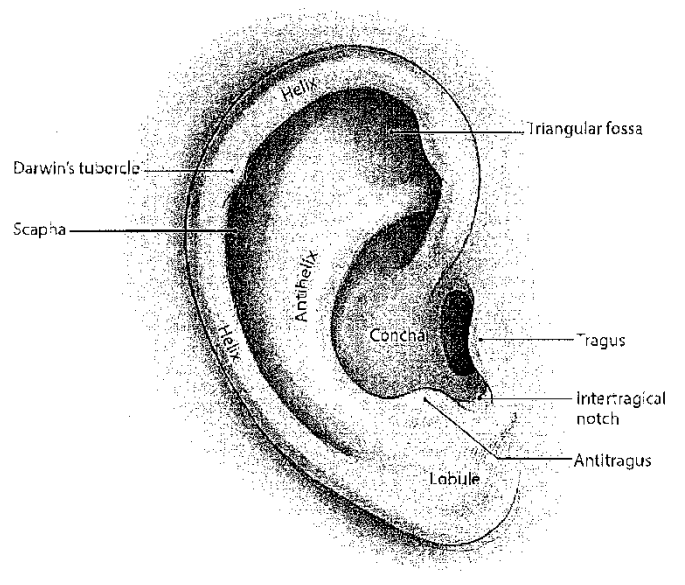
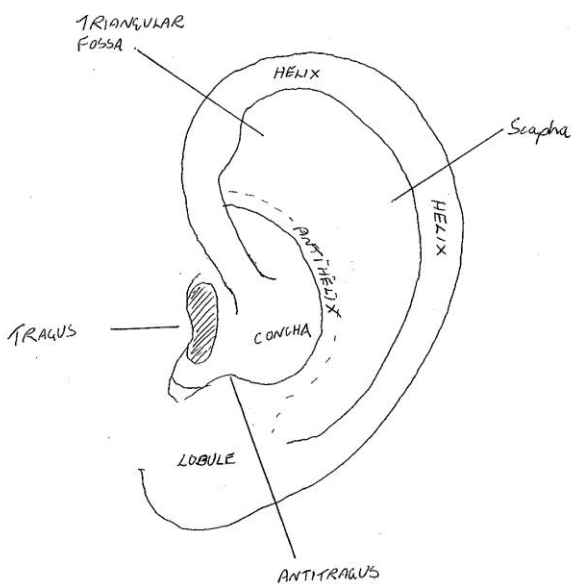
Injuries as pictured below

No injuries detected



Left ear

Right ear



Name

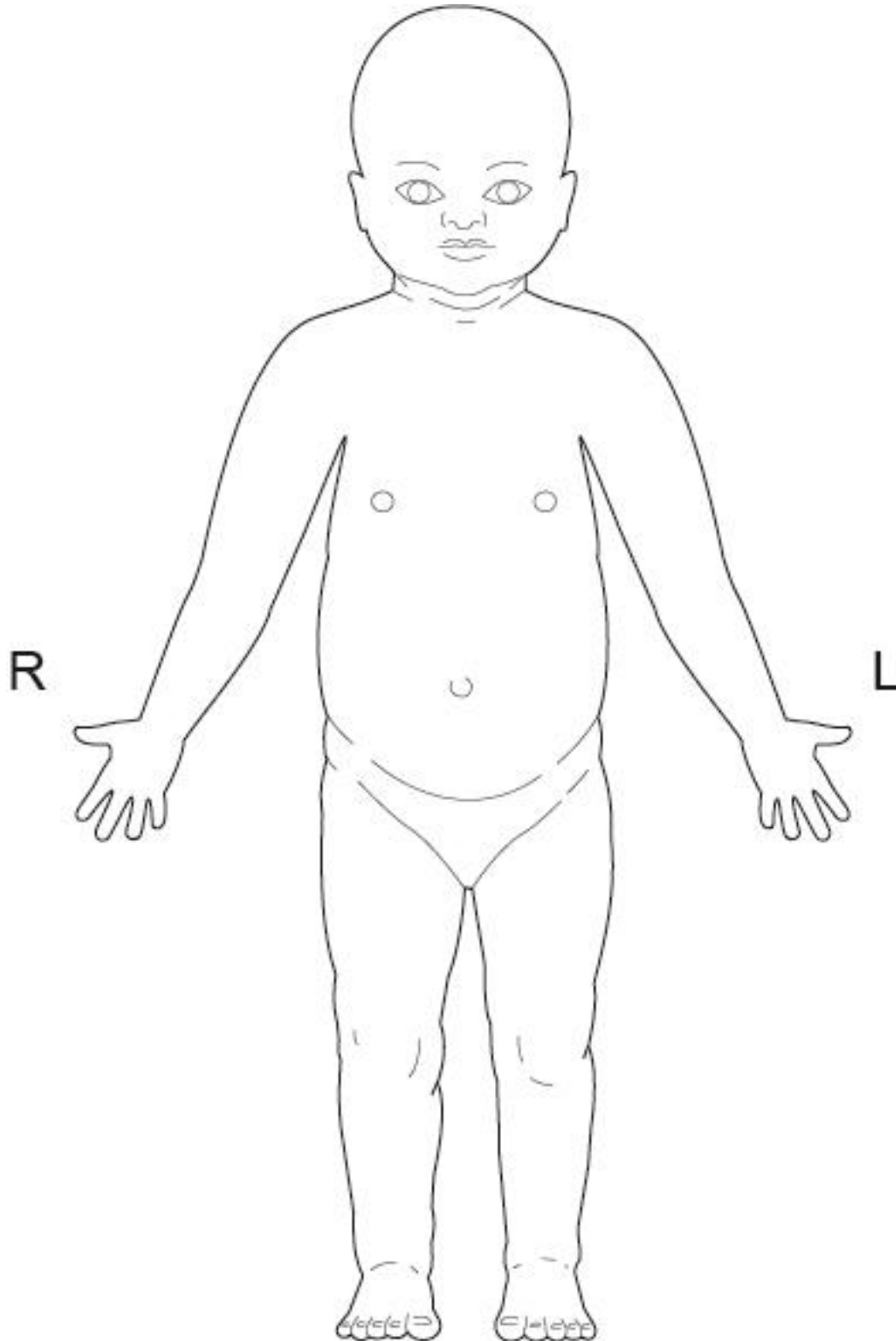
CHI

Date

Body diagrams

Injuries as pictured below

No injuries detected



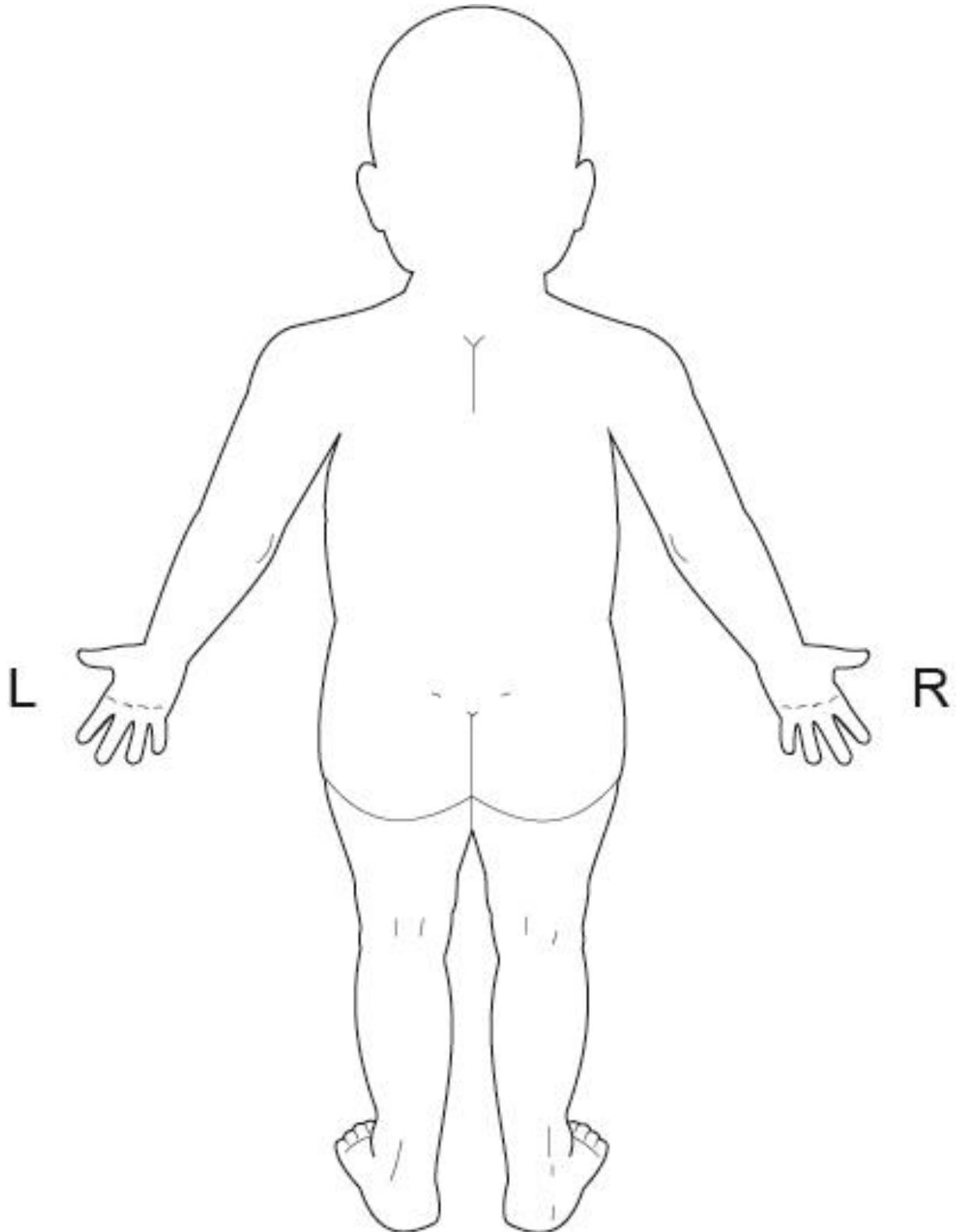
Name

CHI

Date

Injuries as pictured below

No injuries detected



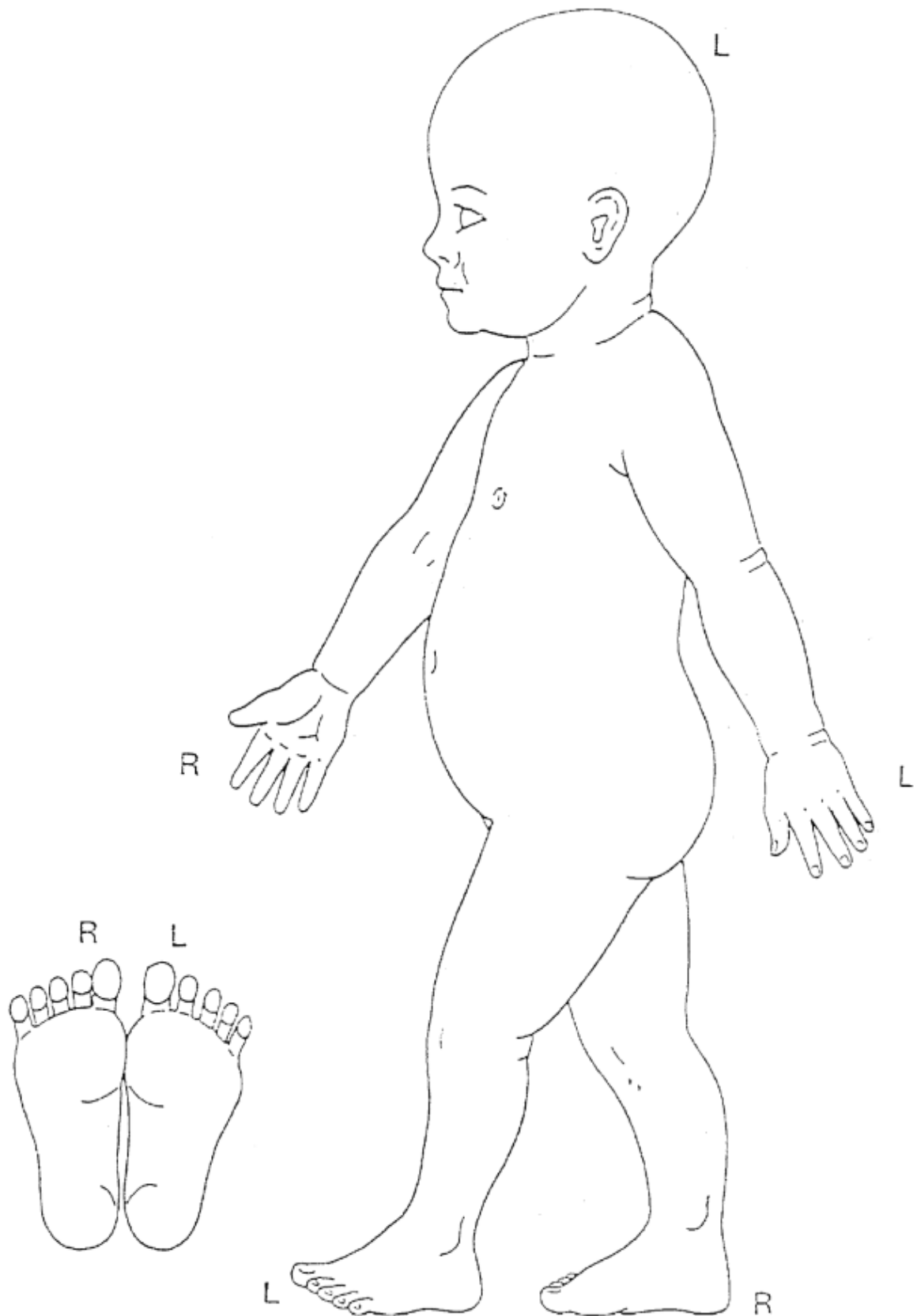
Name

CHI

Date

Injuries as pictured below

No injuries detected



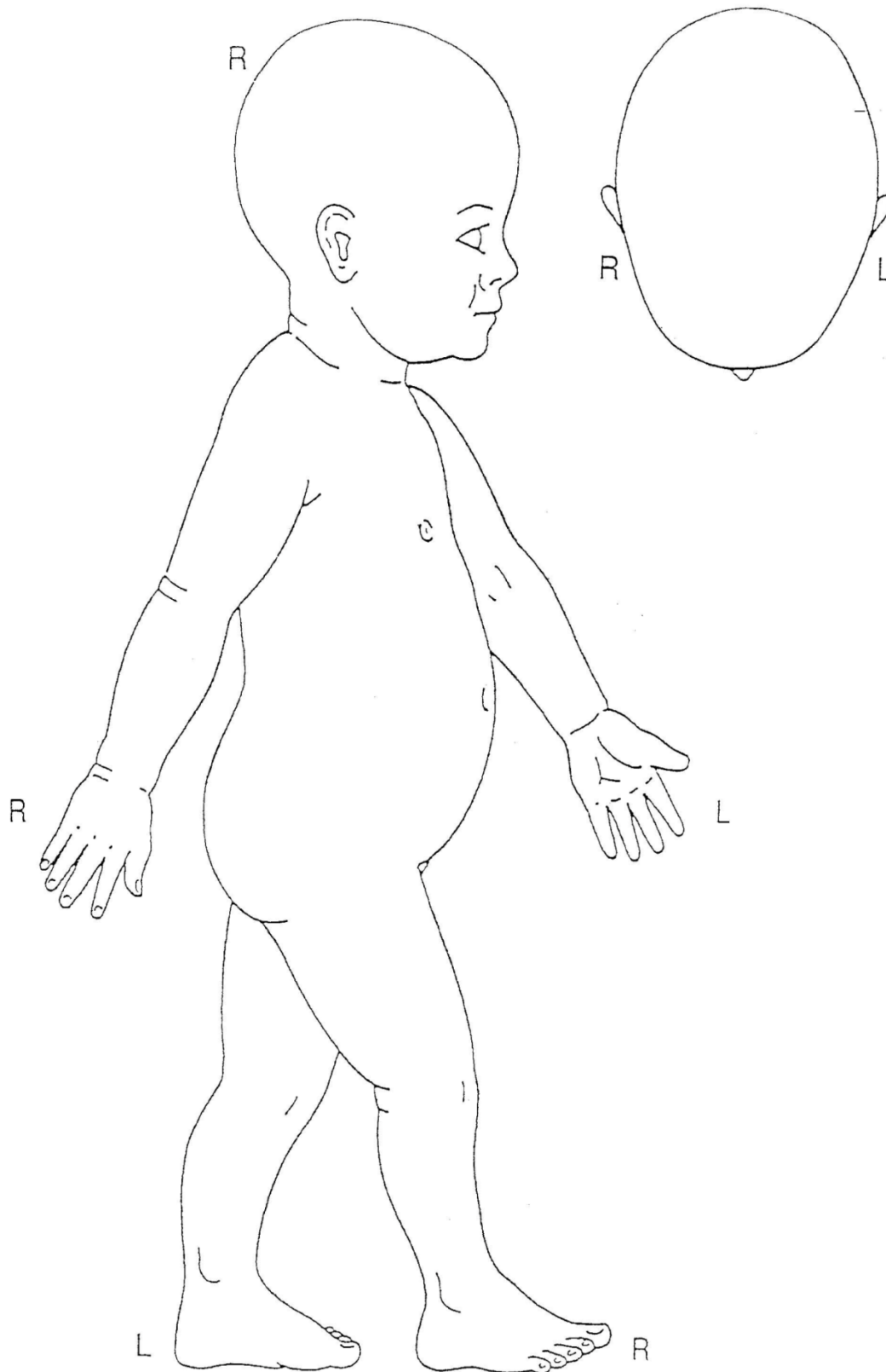
Name

CHI

Date

Injuries as pictured below

No injuries detected



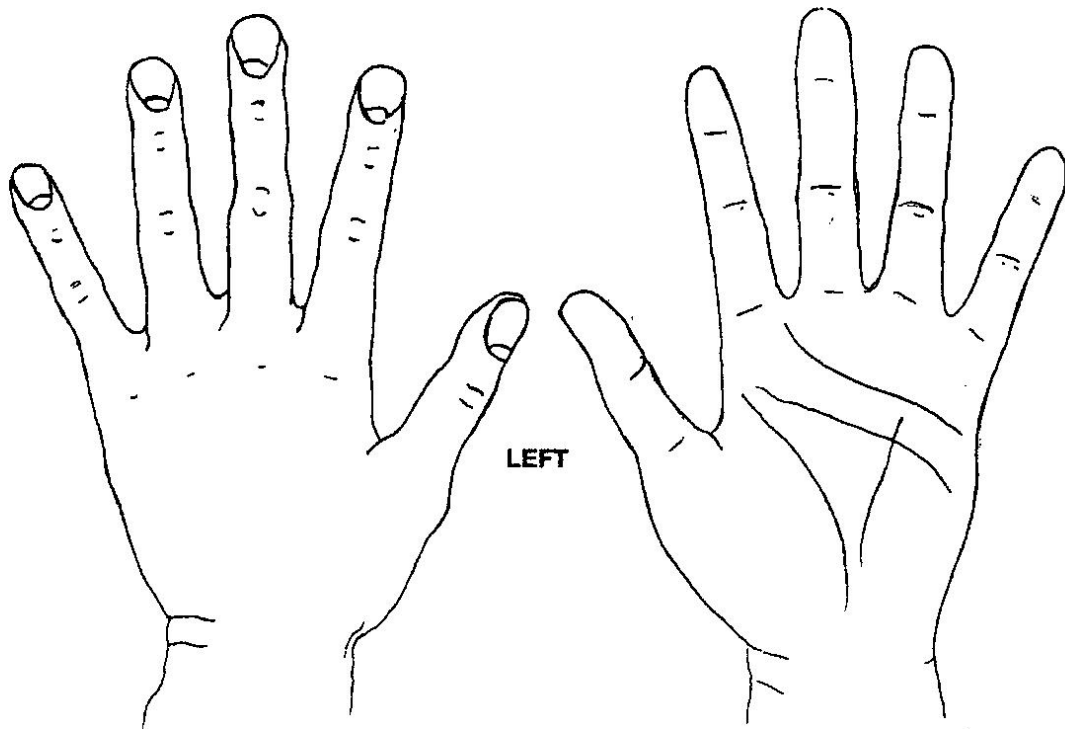
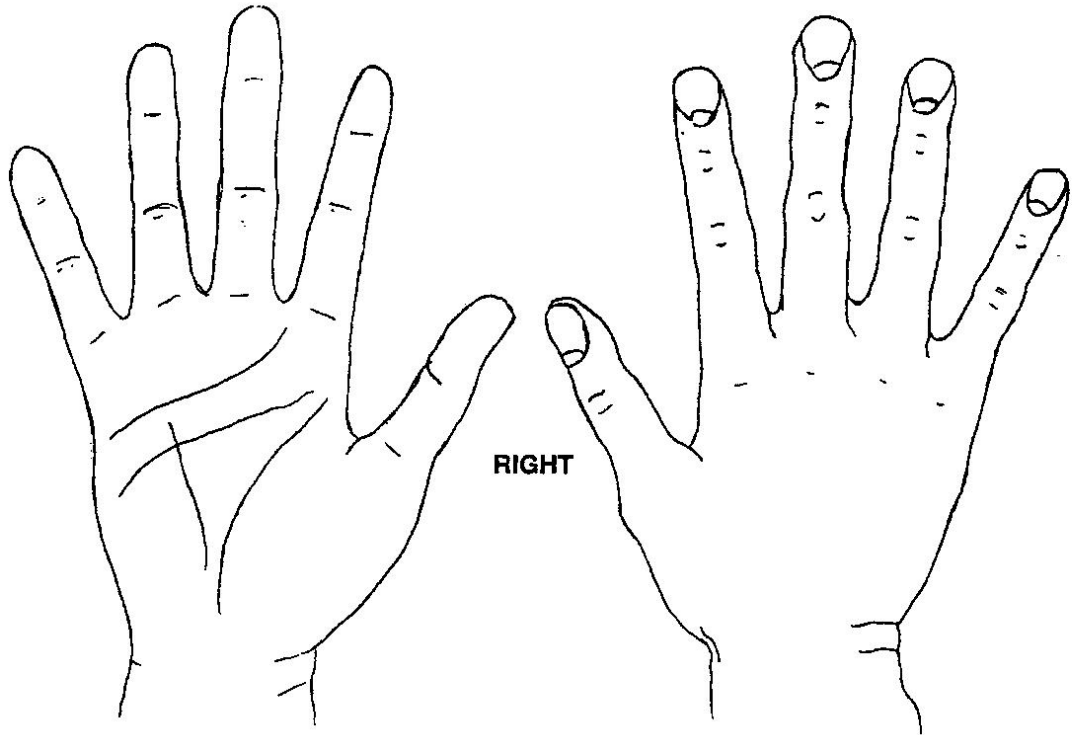
Name

CHI

Date

Injuries as pictured below

No injuries detected



Name

CHI

Date

16. 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
Method of Exam of Hymen	Separation		Traction
	Swab		Catheter
Type of Hymen	Annular		Crescentic
	Sleeve		Septate
Describe Other			Fimbriated
			Other
Findings – Genitalia:	Normal		Non specific
			Abnormal

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

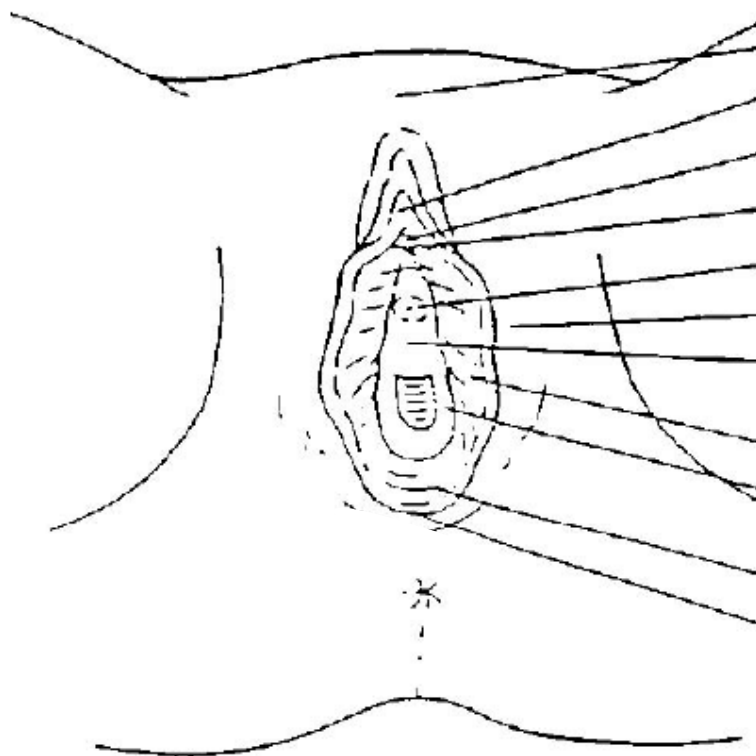
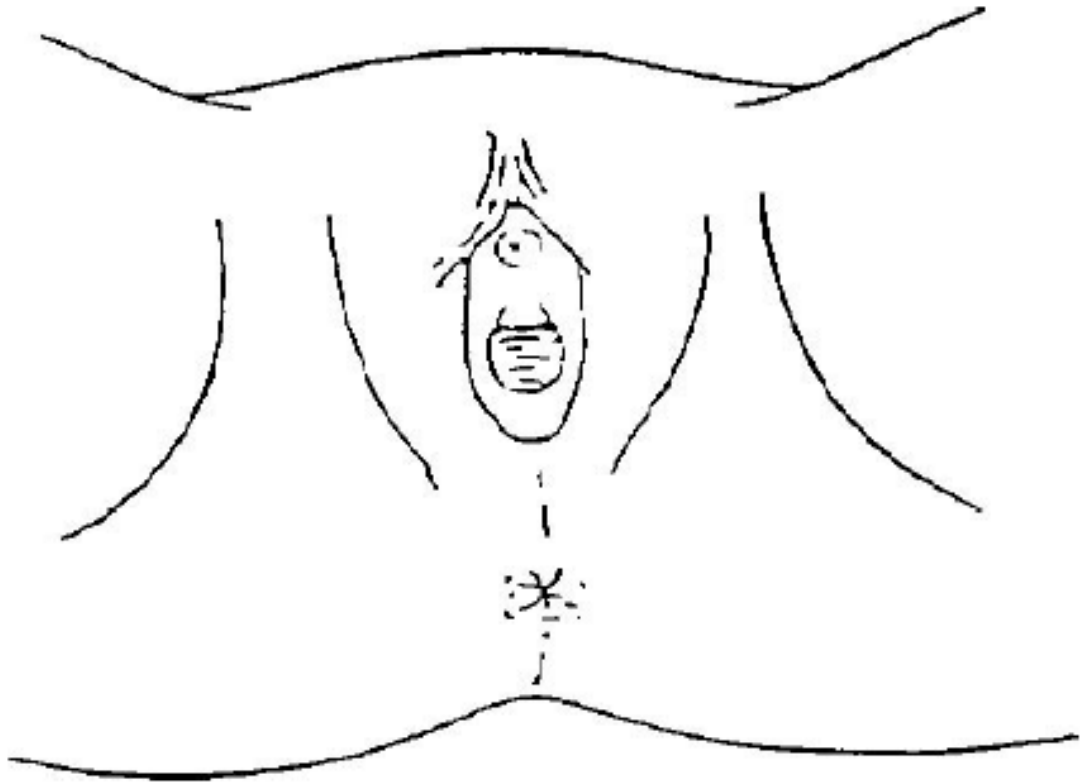
Urethra, Vestibule and Fossa navicularis	Yes	No	Describe location & extent
Reddening			
Abrasion			
Oedema			

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						

Name

CHI

Date

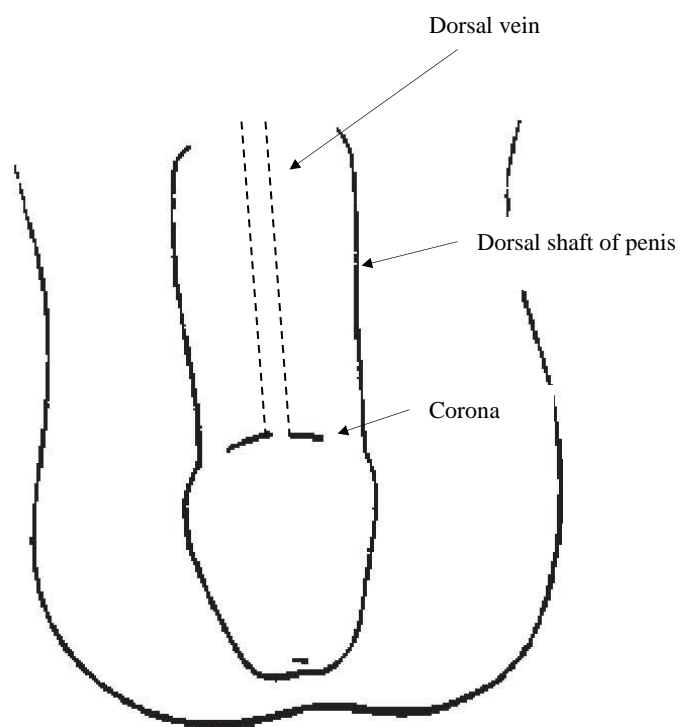
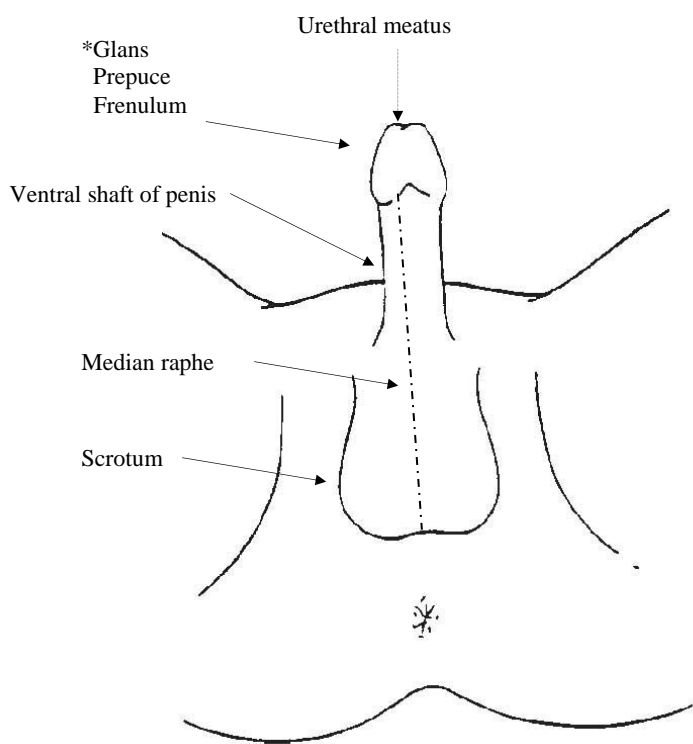


- Mons pubis
- Prepuce of clitoris
- Clitoris
- Frenulum of clitoris
- Orifice of urethra
- Labium majus (labia majora)
- Vestibule (area between labia minora)
- Labium minus (labia minora)
- Hymen (covering introitus of vagina)
- Fossa navicularis
- Posterior fourchette

17. 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			
Findings - genitalia	Normal	Non Specific	Abnormal
Describe abnormalities			

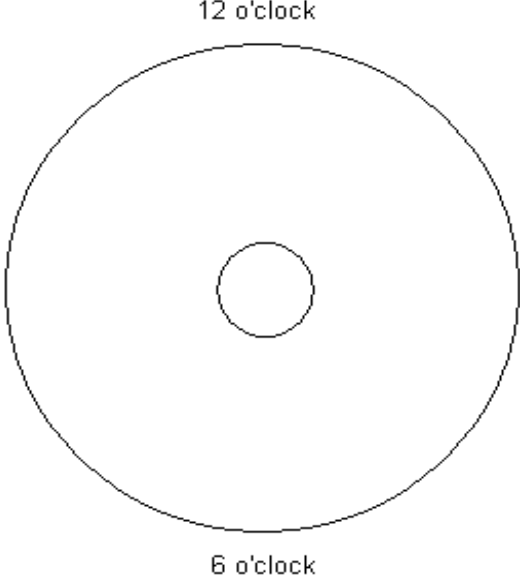


* Glans – the conic expansion that forms the head of the penis
 Prepuce - the free fold of skin that covers, more or less completely, the glans penis in the uncircumcised male.
 Frenulum – small fold of skin that attaches the prepuce to the ventral surface of the penis

18. 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			

Name

CHI

Date

19. Investigations

	Investigation	Date Requested	Result or Why not done				
Eyes	Retinal examination						
Radiology	CT Head						
	MRI Brain and spine						
	Skeletal survey						
	Follow up skeletal survey views						
	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	Anal	Urine	Oral	Date	Result
Universal							
Gonococcal PCR							
Chlamydia PCR							
Trichomonas							
HSV and syphilis PCR							
Photography	Taken by:				Sites:		

19. Investigations - continued

Forensic sample	ID Number; Wet/dry	Time
Skin swab ¹ ; Site:		
Vulva swab		
Low vagina swab		
High vagina swab		
Endocervical swab		
Speculum swab		
'Blind' swab		
Additional samples ²		
Early Evidence ³		
Toxicology: Urine	N/A	
Toxicology: Blood	N/A	
Toxicology: Hair		
Photographs locus:	N/A	

1. Skin swab of body fluids such as semen or blood, over scratch, bite mark, 'lovebite', hands, inner thighs, breasts, buttocks (not an exhaustive list)
2. Additional samples – mouth swab, mouth rinse, fingernail swabs or clippings
3. Urine, Tissue paper, sanitary wear for perpetrator DNA

20. Conclusions / Advice given to Police / Social Services

Remember to complete section 3 - categorise type(s) of abuse after assessment for data collection

✓ 21. Safety Planning

Where is the child/young person to go after leaving?

What concerns do you have about safety?

Details:

Details of any safety plan discussion:

✓ 22. Action Plan

Referrals	Details	
Referral to GP	Required <input type="checkbox"/>	Arranged <input type="checkbox"/>
Referral to general paediatrician	Required <input type="checkbox"/>	Arranged <input type="checkbox"/>
Referral to specialist	Required <input type="checkbox"/>	Arranged <input type="checkbox"/>
Referral to ophthalmologist	Required <input type="checkbox"/>	Arranged <input type="checkbox"/>
Medication		
Medication given	YES <input type="checkbox"/>	NO <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"/>
Reports		
Initial Report to SW/Police/GP <input type="checkbox"/>	Soul and Conscience report to be provided within 4 weeks <input type="checkbox"/>	

Name

CHI

Date

✓ 22. Action Plan – continued

For CSA Cases

Emergency contraception Required Arranged Method given:

STI screening referral Required Arranged

Is the child/YP considered to be at risk of Hep B? : Yes No

If **yes** has treatment been offered?: Yes Declined

If within 48hrs has child/YP been commenced on prophylaxis?: Yes No

Is the child/YP considered to be at risk of HIV? : Yes No

If **yes** has treatment been offered?: Yes Declined

If within 72 hours has the child/YP been commenced on prophylaxis ? : Yes No

Referral to CAMHS Required Arranged

Referral to other support service: Required Arranged

Define service referral made too:

If No please give reason: i.e. services not available Details:

Post sexual assault leaflet given YES NO

Advice given to patient &/carer YES NO

Name / Title of examining doctor(s) **Signature of examining doctor(s)**

Date / time completed:
