Child Protection Paediatric CMA Examination Proforma

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

1. Child Details
Name of child
Date of birth / CHI number
Address
Age Gender Female ☐ Male ☐
School / Nursery attended
Ethnicity
Main Language

2. Examination details	
Date of examination	
Time of examination	
Day of week of examination	
Location of examination:	
Type of examination:	
CMA	

3. Doctor details
Paediatrician
Other doctors (if present)

4. Other agency details
Attending social worker

5. Family present
Parent(s)/Carer

6. Other relevant professionals
Care worker
Health visitor
GP
Others

7. 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	☐	☐	No clinical findings but other concerns that suggest abuse		☐
Emotional abuse	☐	☐	Not abuse		☐
Neglect	☐	☐			
Fabricated or induced illness	☐	☐			

8. Child on/ever been on Child Protection Register?	No☐ Yes ☐ Details:

Name : CHI: Date of Examination:

9. Consent to history, examination and report

Child's Name:..... DOB.....

Address:..... CHI No.....

Permission must be obtained from parent(s) or other(s) with responsibility for the child and from the child where appropriate.

I give permission for:

1.	Medical Examination	Yes	No	N/A
2.	Collection of specimens for laboratory tests	Yes	No	N/A
3.	Photography of Clinical Findings	Yes	No	N/A

Photographs will be stored securely as part of the clinical records. They may be used to support clinical evidence of injury and may need to be shared with other doctors involved in any court proceedings.

I give permission for photographs to be used to support clinical evidence in court proceeding.

Yes No N/A

Photographs can be used for Teaching and Training of other professionals working in Child Protection proceedings. Photographs used for this purpose are anonymised.

I give permission for anonymised photographs of my child to be used for Teaching and Training Yes No N/A

I understand that this medical examination and recorded clinical findings may be used for Peer Review with specialist doctors

I understand the information from the medical examination will be shared with: Social Services, Police, GP and Health Visitor/ School Nurse.

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.....

Name : CHI: Date of Examination:

10. Reason for referral

Briefing taken from

Names of persons present during briefing

History of events

Name : CHI: Date of Examination:

11. Detailed Medical History

Perinatal History

Birth Weight		Kg	Gestation	
Place of Birth			Delivery	
Pregnancy				
Neonatal Health			Feeding	

Immunisations (Get print out of recorded immunisations)

UK Routine childhood immunisation schedule from October 2017

Details: Cross out those not given.	Done	Date	
2 months	Diphtheria, tetanus, pertussis (whooping cough), polio, *Haemophilus influenzae* type b and Hepatitis B (DTaP/IPV/Hib/HepB)	☐	
	Pneumococcal (PCV)	☐	
	Rotavirus	☐	
	Meningococcal type B (MenB)	☐	
3 months	DTaP/IPV/Hib/HepB	☐	
	Rotavirus	☐	
4 months	DTaP/IPV/Hib/HepB	☐	
	Pneumococcal (PCV)	☐	
	Meningococcal type B (MenB)	☐	
12 -13 months	*Haemophilus influenzae* type b and meningococcal type C (Hib/MenC)	☐	
	Pneumococcal (PCV)	☐	
	Measles, mumps and rubella (MMR)	☐	
	Meningococcal type B (MenB)	☐	
2-11 yrs annually	Influenza (flu)	☐	
3 years 4 months or soon after	Diphtheria, tetanus, pertussis (whooping cough), and polio (DTaP/IPV or dTaP/IPV)	☐	
	Measles, mumps and rubella (MMR)	☐	
Girls age 11-13yrs	Human Papillomavirus (HPV)	☐	
Around 14 yrs	Tetanus, diphtheria and polio (Td/IPV)	☐	
	Meningococcal types ACWY (MenACWY)	☐	
Other	e.g. BCG / additional doses of Hep B	☐	

Medication

Allergies

Past History:
Includes review of Clinical Portal
(e.g. A&E Visits, hospital admissions)

Review of Primary Care information including HV growth measurements:

Review of Dental information:

Review of CAMHS information:

12. 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)	

Name : CHI: Date of Examination:

13. Developmental History / School Progress /

Under 5 years (Is the child meeting developmental mile stones?)

Gross Motor	normal ☐ delayed ☐	SOGS completed? Y ☐ N ☐ Date:	
Fine Motor	normal ☐ delayed ☐	Toilet training	
Speech and Language	normal ☐ delayed ☐	Details of any delay and specify any special needs	
Cognitive	normal ☐ delayed ☐		
All Ages			
Vision	Any concerns? Y ☐ N ☐	Wears glasses? Y ☐ N ☐	Date last test:
Hearing	Any concerns? Y ☐ N ☐	Wears hearing aid? Y ☐ N ☐	Date last test:

Nursery/School (How does the child/young person get on at school/nursery?)

Any concerns with behaviour?	Y ☐ N ☐	Details
Able to concentrate at school?	Y ☐ N ☐	Details
Any speech and language input?	Y ☐ N ☐	Details
Need for learning support?	Y ☐ N ☐	Details
Is there a coordinated support plan?	Y ☐ N ☐	Details

14. Relationships and Emotional Well-being

Relationships to others Good ☐ Concerns ☐	Details
Temperament of child/YP as viewed by adults	Contented ☐ Affectionate ☐ Happy ☐ Aggressive ☐ Withdrawn ☐ Other ☐ Details:
Mood as described by child/young person (as appropriate for age)	N/A ☐ Happy ☐ Angry ☐ Sad ☐ Worried ☐ Tearful ☐ Other ☐ Details:
Concerns regarding emotional well-being? (Ask about self-harm, suicidal thoughts age appropriately)	Y ☐ N ☐ Details
Has the child /young person anyone to confide in, any adults they can trust?	Y ☐ N ☐ Details

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

Family Tree:

16. Social History

Consider: Parental Health including Drug use / Alcohol use / Domestic violence/ Mental Health issues / Learning difficulty or disability / ADHD/ASD
Past and Current SW involvement
Information on Child Protection involvement

Name : CHI: Date of Examination:

17. General examination

Name(s) of persons present

Weight		Height		Head circumference	
kgs	centile	cm	centile	cm	centile

Concerns regarding growth?	Y ☐ N ☐ Details
General appearance (hygiene)	
Skin condition	
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	Body charts attached? Yes ☐ No ☐
Scalp/hair	Y ☐ N ☐	Y ☐ N ☐	
Face	Y ☐ N ☐	Y ☐ N ☐	
Inside mouth/palate	Y ☐ N ☐	Y ☐ N ☐	
Teeth	Y ☐ N ☐	Y ☐ N ☐	
Neck	Y ☐ N ☐	Y ☐ N ☐	
Back	Y ☐ N ☐	Y ☐ N ☐	
Genitalia/Buttocks	Y ☐ N ☐	Y ☐ N ☐	
Arms R	Y ☐ N ☐	Y ☐ N ☐	
L	Y ☐ N ☐	Y ☐ N ☐	
Hands/wrists R	Y ☐ N ☐	Y ☐ N ☐	
L	Y ☐ N ☐	Y ☐ N ☐	
Fingers/nails R note if cut/broken/false	Y ☐ N ☐	Y ☐ N ☐	
L	Y ☐ N ☐	Y ☐ N ☐	
Front of chest	Y ☐ N ☐	Y ☐ N ☐	
Breasts (Tanner stage)	Y ☐ N ☐	Y ☐ N ☐	
Abdomen	Y ☐ N ☐	Y ☐ N ☐	
Legs R	Y ☐ N ☐	Y ☐ N ☐	
L	Y ☐ N ☐	Y ☐ N ☐	

Name : CHI: Date of Examination:

Feet/ankles/soles **R** **L**	Y ☐ N ☐ Y ☐ N ☐	Y ☐ N ☐ Y ☐ N ☐	

Name : CHI: Date of Examination:

18. Investigations

Investigation	Date Requested	Result

19. Summary of evidence

(Factors influencing how the child/young person grows and develops – include protective factors and factors of resilience, adversity, vulnerability)

Remember to complete section 7 - categorise type(s) of abuse after assessment for data collection

20. Action Plan and advice to family

Referrals		Details
Referral to GP	YES ☐ NO ☐	
Referral to general paediatrician	YES ☐ NO ☐	
Referral to paediatric specialist	YES ☐ NO ☐	
Referral to audiology	YES ☐ NO ☐	
Referral to orthoptics	YES ☐ NO ☐	
Referral to dentist	YES ☐ NO ☐	
Referral to CAMHS	YES ☐ NO ☐	
Referral to other support service	YES ☐ NO ☐	
Advice given to patient &/carer	YES ☐ NO ☐	

Name : CHI: Date of Examination:

21. Health Action Plan

Date	Identified Health Issue	Action required

22. Multi-agency actions

Phone call/report to SW/Police/Update IRD/GP		☐	
Other Actions			
Admit to hospital	☐	Consider CPO / CAO	☐
Case Conference requested	☐	Other	☐

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

Date / time completed: