Required
DSS Authorization Form (#5143) attached? ☐ Yes ☐ No
SIS #:
Payment Source:
☐ CMEP ☐ Medicaid (#)
☐ Other

Child/Patient Name:
Date of Birth:
Date of Exam:

North Carolina Child Medical Evaluation Program (CMEP)
MEDICAL REPORT

Part A: Referral Information *(Note: **Pages 1-4** to be completed by DSS **prior to** CMEP evaluation)*

1. Referral Source(s)

DSS Involvement:
County:
Social Worker:
Address:

Phone Number:
Fax Number:

Law Enforcement Involvement
Agency:
Contact:
Address:

Phone Number:
Fax Number:

2. Child, Caregiver, and Household Member Information

Child (Patient)

Gender:
Race/Ethnicity
First Name:
Middle Name:
Last Name:
Date of Birth:
Age:
Address:

County of Residence:
Phone Number:
Alternate Number:

Mother

Relationship
Name:
Age:
Highest Level of Education:
Address:

County of Residence:
Phone Number:
Alternate Number:

Father

Relationship
Name:
Age:
Highest Level of Education:
Address:

County of Residence:
Phone Number:
Alternate Number:

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Child/Patient Name:
Date of Birth:
Date of Exam:

Other Adult Caregivers (if applicable)

Name:
Relationship to child:
Age:
Highest Level of Education:
Address:

County of residence:
Phone Number:
Alternate Number:

Other adult caregivers *(if applicable)*

Name:
Relationship to child:
Age:
Highest Level of Education:
Address:

County of residence:
Phone Number:
Alternate Number:

Household Composition:

Household #1

Name	Age	Relationship to Patient

Household #2 *(If applicable)*

Name	Age	Relationship to Patient

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Child/Patient Name:
Date of Birth:
Date of Exam:

3. Referral Concerns

This child has been referred for medical diagnosis and/or treatment related to the following concerns:
(Check all that apply)

Sexual Abuse/Assault/Victimization	☐ Yes	☐ No	☐ Unknown
Physical Abuse/Assault	☐ Yes	☐ No	☐ Unknown
Emotional Abuse	☐ Yes	☐ No	☐ Unknown
Neglect	☐ Yes	☐ No	☐ Unknown
Domestic Violence exposure	☐ Yes	☐ No	☐ Unknown
Dependency	☐ Yes	☐ No	☐ Unknown
Other concerns	☐ Yes	☐ No	☐ Unknown

*Brief description of each concern (Including disclosure details; type of abuse; frequency; last abusive encounter; neglect contributing to abuse)***:**

a. Has the child disclosed to a professional? ☐ Yes ☐ No ☐ Unknown/ NA

If yes, please describe:

b. Has the child disclosed to a *non*-professional? ☐ Yes ☐ No ☐ Unknown/ NA

If yes, please describe:

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Child/Patient Name:	
Date of Birth:	
Date of Exam:	

c. Perpetrator(s) name; relationship to child; and last known contact with child *(If known/applicable)***:**

d. Has there been a medical evaluation prior to this CMEP*? ☐ Yes ☐ No ☐ Unknown/ NA

If applicable Evaluation Date/Location: ______

Evaluator Name and Contact Information: ______

Sexual assault evidence collection kit obtained? ☐ Yes ☐ No ☐ Unknown/ NA

Summary of evaluation findings:

***DSS caseworker: Please provide a written copy of this evaluation at time of CMEP**

e. Has this child been referred for a CFE/formal interview? ☐ Yes ☐ No ☐ Unknown/ NA

f. Has this child/family had prior DSS/LE involvement? ☐ Yes ☐ No ☐ Unknown/ NA

If yes, please describe:

Child/Patient Name:	
Date of Birth:	
Date of Exam:	

Part B: Medical Team Interview of DSS/Law Enforcement

(Completed by medical team/examiner)

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Child/Patient Name:
Date of Birth:
Date of Exam:

Part C: Patient History *(Completed by the medical team/examiner)*

1. Medical History

Patient history provided by:

Primary care provider:

Immunizations up-to-date ☐ Yes ☐ No ☐ Unknown
Pregnancy/birth issues: ☐ Yes ☐ No ☐ Unknown
Chronic or active disease ☐ Yes ☐ No ☐ Unknown
Drug allergies/allergies ☐ Yes ☐ No ☐ Unknown
Hospitalizations ☐ Yes ☐ No ☐ Unknown
Surgeries ☐ Yes ☐ No ☐ Unknown
Trauma/Injury ☐ Yes ☐ No ☐ Unknown

Specify:

Medications ☐ Yes ☐ No ☐ Unknown ***Specify:***

Describe any significant medical history:

2. Genitourinary History

Genital pain/lesions/bleeding/discharge ☐ Yes ☐ No ☐ Unknown
Rectal pain/lesions/bleeding/discharge ☐ Yes ☐ No ☐ Unknown
Prior Urinary Tract Infection ☐ Yes ☐ No ☐ Unknown
Prior Sexually-Acquired Infection ☐ Yes ☐ No ☐ Unknown
Menarche ☐ Yes ☐ No Age: ______ LMP *(if applicable)*: ____________

Describe any significant genitourinary and/or reproductive health history:

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Child/Patient Name: ____
Date of Birth: ____
Date of Exam: ____

3. Developmental and/or Educational History

Developmental Concerns ☐ Yes ☐ No ☐ Unknown

Educational Concerns ☐ Yes ☐ No ☐ Unknown ☐ Not Applicable

School: ____ Grade Level: ____

Describe any significant developmental and/or educational history:

____

4. Family History

Significant Family History ☐ Yes ☐ No ☐ Unknown

Describe significant family history:

____

5. Psychosocial History

Prior DSS involvement ☐ Yes ☐ No ☐ Unknown
Domestic violence ☐ Yes ☐ No ☐ Unknown
Traumatic exposure/experience ☐ Yes ☐ No ☐ Unknown
Substance abuse ☐ Yes ☐ No ☐ Unknown
Alcohol abuse ☐ Yes ☐ No ☐ Unknown
Serious mental health problems ☐ Yes ☐ No ☐ Unknown
Criminal/gang involvement ☐ Yes ☐ No ☐ Unknown

Describe any significant psychosocial history:

____

Regular child care arrangement:

____

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Child/Patient Name:	
Date of Birth:	
Date of Exam:	

6. Behavioral and Mental Health History

Currently receiving mental health treatment? ☐ Yes ☐ No ☐ Unknown

If in treatment, please list name of provider and contact information:

Sleep disturbance	☐ Yes	☐ No	☐ Unknown
Eating disorder	☐ Yes	☐ No	☐ Unknown
Enuresis/encopresis	☐ Yes	☐ No	☐ Unknown
Self-injurious behavior	☐ Yes	☐ No	☐ Unknown
Hyperactivity/Impulsivity	☐ Yes	☐ No	☐ Unknown
Angry outbursts/violence	☐ Yes	☐ No	☐ Unknown
Sadness/depression	☐ Yes	☐ No	☐ Unknown
Suicidal ideation/attempts/plan	☐ Yes	☐ No	☐ Unknown
Excessive masturbation	☐ Yes	☐ No	☐ Unknown
Sexual acting-out	☐ Yes	☐ No	☐ Unknown

Adolescent Behavioral Supplement *(if applicable)*

Gang involvement	☐ Yes	☐ No	☐ Unknown
Delinquency	☐ Yes	☐ No	☐ Unknown
Alcohol use	☐ Yes	☐ No	☐ Unknown
Tobacco use	☐ Yes	☐ No	☐ Unknown
Substance use	☐ Yes	☐ No	☐ Unknown
Sexual activity	☐ Yes	☐ No	☐ Unknown
Pregnancy/pregnant partner	☐ Yes	☐ No	☐ Unknown

Describe above and/or any other significant mental health history and/or medically-concerning risk behaviors:

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Child/Patient Name:	
Date of Birth:	
Date of Exam:	

7. Review of Systems

Are there significant concerns? *(If so, please describe)*

System				System			
General	☐ Yes	☐ No	☐ Unknown	GI	☐ Yes	☐ No	☐ Unknown
Dental	☐ Yes	☐ No	☐ Unknown	Respiratory	☐ Yes	☐ No	☐ Unknown
Hearing	☐ Yes	☐ No	☐ Unknown	Musc/Skel	☐ Yes	☐ No	☐ Unknown
Vision	☐ Yes	☐ No	☐ Unknown	GU	☐ Yes	☐ No	☐ Unknown
ENT	☐ Yes	☐ No	☐ Unknown	Endo	☐ Yes	☐ No	☐ Unknown
Ophtho	☐ Yes	☐ No	☐ Unknown	Heme/Lymph	☐ Yes	☐ No	☐ Unknown
Skin	☐ Yes	☐ No	☐ Unknown	Neuro	☐ Yes	☐ No	☐ Unknown
CV	☐ Yes	☐ No	☐ Unknown	Psych	☐ Yes	☐ No	☐ Unknown

Please describe significant findings:

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Child/Patient Name:	
Date of Birth:	
Date of Exam:	

Part D: Medical Evaluation *(To be completed by medical team/examiner)*

1. <u>Caregiver HPI and Medical Interview</u> *(Child/patient should **not** be present during caregiver interview)*

Caregiver interviewed:

Describe caregiver's appropriateness and level of concerns about child safety:

Caregiver narrative (Key Points):

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Child/Patient Name:
Date of Birth:
Date of Exam:

2. <u>Child Medical Interview</u> *(Child/patient should be interviewed **alone** in most cases)*

Interpreter (if applicable) ☐ Yes ☐ No Name:

Communication skills age-appropriate ☐ Yes ☐ No ☐ Unknown/Unclear

Audio/video recording of interview ☐ Yes ☐ No ☐ N/A

Child interviewed alone ☐ Yes ☐ No ☐ N/A

If not, please describe reason:

CMEP Examiner: Please document key points: perpetrator(s); details of abuse/neglect; frequency of events; last abusive encounter/last contact with perpetrator; threats of harm; and neglect contributing to abuse. Whenever possible, specify question posed **and** child's responses in his/her "own words."

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Child/Patient Name:	
Date of Birth:	
Date of Exam:	

3. Physical Examination

Who was present during the physical examination?

General Appearance/Demeanor:

Vital Signs

Temperature:	
Heart Rate:	
Respiratory Rate:	
Blood Pressure:	

Growth Parameters (please include units)

Head Circumference:		(%-tile)
Weight:		(%-tile)
Height:		(%-tile)
Body Mass Index:		

Are there significant concerns upon general physical exam? *(Label significant findings on Page 13)*

Vision/Hearing	☐ Yes	☐ No	☐ Unknown/Not Assessed	
Skin	☐ Yes	☐ No	☐ Unknown/Not Assessed	
HEENT	☐ Yes	☐ No	☐ Unknown/Not Assessed	
Neck	☐ Yes	☐ No	☐ Unknown/Not Assessed	
Chest	☐ Yes	☐ No	☐ Unknown/Not Assessed	
Heart	☐ Yes	☐ No	☐ Unknown/Not Assessed	
Lungs	☐ Yes	☐ No	☐ Unknown/Not Assessed	
Abdomen	☐ Yes	☐ No	☐ Unknown/Not Assessed	
Back	☐ Yes	☐ No	☐ Unknown/Not Assessed	
Extremities	☐ Yes	☐ No	☐ Unknown/Not Assessed	
Lymph nodes	☐ Yes	☐ No	☐ Unknown/Not Assessed	
Neurological	☐ Yes	☐ No	☐ Unknown/Not Assessed	

Tanner/SMR Breast/Penis ____________ Pubic Hair ____________

Female Genital Examination *(With rare exception, a speculum should **not** be used during genital examination)*

Position	☐ Frog Leg	☐ Lithotomy	☐ Knee-chest
Technique	☐ Labial Separation	☐ Labial Traction	
Colposcopy/Photography	☐ Yes	☐ No	

Significant Findings *(Document: Lesions, discharge, bleeding, ecchymosis, erythema, etc.)*

Labia majora/minora	☐ Yes	☐ No	☐ Unknown/Not Assessed	
Clitoris/Urethra	☐ Yes	☐ No	☐ Unknown/Not Assessed	
Peri-hymenal tissue	☐ Yes	☐ No	☐ Unknown/Not Assessed	
Posterior fourchette	☐ Yes	☐ No	☐ Unknown/Not Assessed	
Vagina/Cervix	☐ Yes	☐ No	☐ Unknown/Not Assessed	
Hymen	☐ Yes	☐ No	☐ Unknown/Not Assessed	

Description (Configuration; estrogenized; notches; transections; etc):

Other:

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Child/Patient Name:	
Date of Birth:	
Date of Exam:	

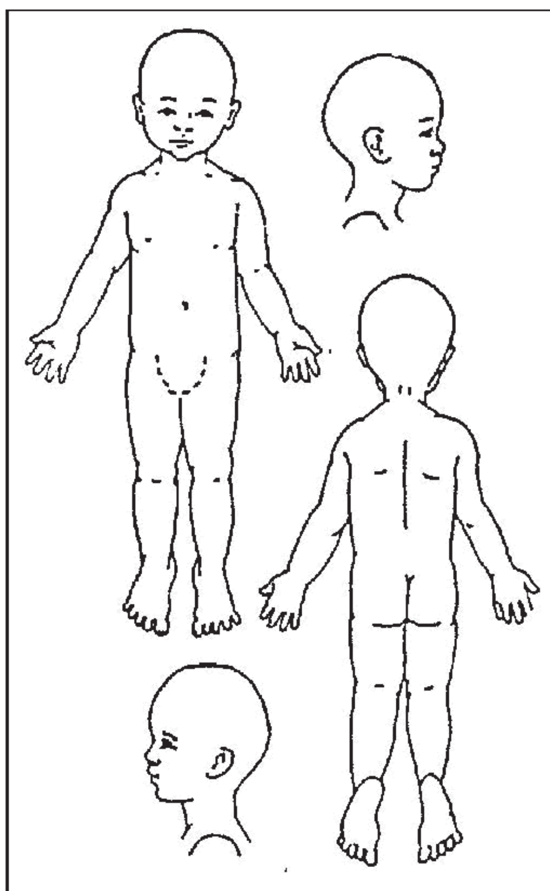
Male Genital Examination

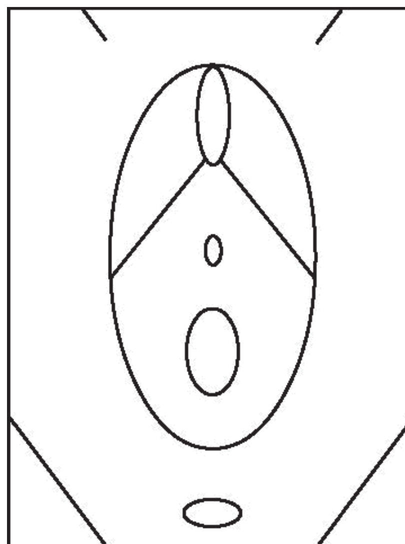
Photography ☐ Yes ☐ No

Significant findings ☐ Yes ☐ No

Anus and Perineum, eg. bruising, warts, fissures (Describe significant findings):

4. Diagrams





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Child/Patient Name:	
Date of Birth:	
Date of Exam:	

5. Laboratory/Radiological Studies and Results

Study	Results
☐ Wet Mount Preparation	
☐ GC Culture (specify sites)	
☐ Chlamydia Culture (specify sites)	
☐ Other viral/bacteria culture (specify)	
☐ RPR (Use CDC guidelines)	
☐ HIV (use CDC guidelines)	
☐ Urine/serum pregnancy test	
☐ UA/Urine culture	
☐ PCR/NAAT	
☐ CBC	
☐ PT/PTT/Bleeding time	
☐ Skeletal Survey	
☐ MRI/CT	
☐ Other (specify)	

Part E: Additional Information/photographs

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Child/Patient Name:	
Date of Birth:	
Date of Exam:	

Part F: Impressions and Recommendations *(Completed by medical team/examiner)*

1. General Impressions

Briefly describe any general medical, mental health, developmental, or psychosocial concerns:

2. Impressions Related to Maltreatment, Assault and/or Risk

a. Based upon the information available at the time of this evaluation, we have the following concerns:

Sexual Abuse/Assault	☐ Yes	☐ No	☐ Unknown/Not Assessed
Including:			
Digital/hand contact	☐ Yes	☐ No	☐ Unknown/Not Assessed
Oral contact	☐ Yes	☐ No	☐ Unknown/Not Assessed
Penile/genital contact	☐ Yes	☐ No	☐ Unknown/Not Assessed
Use of force/threats	☐ Yes	☐ No	☐ Unknown/Not Assessed
Pornography exposure/particip.	☐ Yes	☐ No	☐ Unknown/Not Assessed
Sexual exploitation/prostitution	☐ Yes	☐ No	☐ Unknown/Not Assessed
Enticement	☐ Yes	☐ No	☐ Unknown/Not Assessed
Physical Abuse/Assault	☐ Yes	☐ No	☐ Unknown/Not Assessed
Emotional Abuse	☐ Yes	☐ No	☐ Unknown/Not Assessed
Neglect	☐ Yes	☐ No	☐ Unknown/Not Assessed
Domestic Violence Exposure	☐ Yes	☐ No	☐ Unknown/Not Assessed
Dependency	☐ Yes	☐ No	☐ Unknown/Not Assessed
Significant Psychosocial Risk	☐ Yes	☐ No	☐ Unknown/Not Assessed

Other Concerns

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Child/Patient Name:	
Date of Birth:	
Date of Exam:	

b. Based upon the information available at the time of this evaluation, the following preliminary and/or final diagnosis(s) have been made with regard to child abuse; neglect; dependency and/or significant risk exposure:

CMEP Examiners: Please comment on each type of type of suspected abuse/neglect/risk with particular reference to: Current/past disclosure; supportive physical/forensic findings; corroborative information; likelihood of abuse/neglect; and your level of concern regarding this child's safety and well-being.*

***Note:** An unremarkable examination does NOT preclude the possibility of physical, sexual, or psychological maltreatment. Specifically, an unremarkable genital and/or anal examination does <u>not</u> exclude the possibility of sexual abuse, assault, or victimization.*

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Child/Patient Name:	
Date of Birth:	
Date of Exam:	

3. Recommendations *(CMEP Examiners: Please provide specific recommendations on lines provided)*

☐ Yes	STD/HIV testing/treatment	*(Especially if there has been body fluid contact)*
☐ Yes	Medical/follow-up	*(Including pregnancy prophylaxis, STD prophylaxis, etc)*
☐ Yes	"Second opinion" physical exam	
☐ Yes	Further interview and/or CFE	
☐ Yes	Routine/well-child medical care	
☐ Yes	Routine reproductive healthcare	
☐ Yes	Mental health follow-up	
☐ Yes	Developmental evaluation	
☐ Yes	Educational evaluation/testing	
☐ Yes	Continued DSS/LE investigation	
☐ Yes	Safety recommendations	
☐ Yes	Sibling evaluation *(Specify)*	
☐ Yes	Offender evaluation	
☐ Yes	Domestic violence evaluation	
☐ Yes	Substance abuse evaluation (child)	
☐ Yes	Substance abuse evaluation (caregiver)	

4. Contact Information: Examining Clinician

Signature (*Do not type*)	
Name and Title (Please print or type)	
Practice Name	
Address	
Phone: incl. area code	
Fax: incl. area code	

CMEP Examiner: Please retain all original evaluation materials.

Please send a copy of this report to the referring DSS office; send a copy to the CMEP office within 60 days of the date of service.

NC Child Medical Evaluation Program

CB #3415

Chapel Hill, NC

27514-9864

phone: 919-843-9365 fax: 919-843-9368

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Child/Patient Name:	
Date of Birth:	
Date of Exam:	

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