**Child Medical Evaluation Referral and Report**

**CME Referral**

*Information provided by Child Protective Services (CPS) or Division of Child Development and Early Education (DCDEE)*

1. **Child welfare agency/DCDEE information**

|  |  |
| --- | --- |
| **County of Child Welfare Agency:** | Choose an item. |
| **CPS/DCDEE worker:** |  |
| **Phone number:** |  |
| **Email:** |  |
| **Fax:** |  |
| **Supervisor name/contact info:** |  |

1. **Child information**

**1. Basic information**

|  |  |
| --- | --- |
| **Name and age:** |  |
| **Date of Birth:**  |  |
| **Name of school/grade if applicable:**  |  |
| **Sex assigned at birth:** |  |
| **Gender identity:**  |  |
| **Current placement** | Choose an item. |
| **Name of primary caretaker and relationship:** |  |
| **Primary caretaker contact info:** |  |

**2. Household composition**

Primary

|  |  |  |
| --- | --- | --- |
| **Name** | **Age** | **Relationship to child** |
|  |  |  |

Secondary - *Complete if child is a member of a secondary household*

|  |  |  |
| --- | --- | --- |
| **Name** | **Age** | **Relationship to child** |
|  |  |  |

**C. Maltreatment concerns and history**

1. **This child has been referred for a CME due to concerns for (check all that apply)** *CPS/DCDEE should confirm that the CME provider can conduct the evaluation by accessing the* [*CMEP Provider Portal*](https://cmepweb.dhhs.nc.gov/Account/LogOn?ReturnUrl=%2F)*.*

|  |  |  |
| --- | --- | --- |
| **Sexual Abuse** [ ]  | **Neglect** [ ]  | **Emotional Abuse** [ ]  |
| **Physical Abuse** [ ]  | **Medical Child Abuse** [ ]  | **Medical Neglect** [ ]  |

1. **Did the child have prior medical care related to the concerns (including sexual assault medical forensic examination)? Yes** [ ]  **No** [ ]

|  |  |  |
| --- | --- | --- |
| **Date of care** Click or tap to enter a date. | **Facility** Click or tap here to enter text. | **Are the medical records included with referral\*?** **Yes** [ ]  **No** [ ]  |
| **Date of care** Click or tap to enter a date. | **Facility** Click or tap here to enter text. | **Are the medical records included with referral\*?** **Yes** [ ]  **No** [ ]  |
| **\* External medical records should be provided prior to CME to inform the medical evaluation**  |

1. **Current CPS/DCDEE Assessment concerns and findings***.*

|  |
| --- |
| Click or tap here to enter text. |

1. **Is there an alleged perpetrator? Yes** [ ]  **No, perpetrator is currently unknown** [ ]

**Alleged perpetrator(s) information**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Age** | **Relationship to child** | **Last date of contact with child** |
|  |  |  |  |

1. **Describe any prior involvement with child welfare or DCDEE**

|  |
| --- |
| Click or tap here to enter text. |

1. **Is law enforcement involved? Yes** [ ]  **No** [ ]

**Contact information**

|  |  |  |
| --- | --- | --- |
| **Assigned Investigator**  | **Agency**  | **Contact information:** |
|  |  |  |

**Summary of involvement**

|  |
| --- |
| Click or tap here to enter text. |

1. **Supplemental information –** *It is the responsibility of CPS/DCDEE to provide the medical team with the following information. Please* *indicate if it is included with the referral.*

|  |  |
| --- | --- |
| **Digital images**  | ***This may include photographs of injuries, alleged mechanisms of injury. Be sure images are appropriately labeled and dated.***  |[ ]
| **Timeline of maltreatment** | ***To include a history of supervision, preceding the alleged maltreatment and up to agency’s involvement***  |[ ]
| **External medical records** | ***Recent medical evaluations related to the concerns or documentation related to history of concerns. This includes all pediatric records of children < 3.***  |[ ]

**CME Report**

 ***Completed by the CME provider and medical team during the medical evaluation***

**A. Interviews** *Conducted by the medical team at the time of medical evaluation.*

1. **Interview with CPS/DCDEE and updates from initial referral**

|  |  |  |
| --- | --- | --- |
| **Date of interview** | **Name** | **Method** |
| Click or tap to enter a date. | Click or tap here to enter text. | **Phone** [ ]  **In person** [ ]  |
| **Name of interviewer(s):**  | Click or tap here to enter text. |

|  |
| --- |
| Click or tap here to enter text. |

1. **Law enforcement interview** *If conducted during the CPS/DCDEE interview, identify source of specific information*

|  |  |  |
| --- | --- | --- |
| **Date of interview** | **Name** | **Method** |
| Click or tap to enter a date. | Click or tap here to enter text. | **Phone** [ ]  **In person** [ ]  |
| **Name of interviewer(s):**  | Click or tap here to enter text. |
| **Has LE interviewed the child? Yes** [ ]  **No** [ ]  |

|  |
| --- |
| Click or tap here to enter text. |

1. **Caregiver interview** *Children over 3 years should not be present during interview. Should address caretaker’s concerns for maltreatment and well-being. The CME provider should document the caretaker’s HPI.*

|  |  |  |
| --- | --- | --- |
| **Date of interview** | **Name** | **Method** |
| Click or tap to enter a date. | Click or tap here to enter text. | **Phone** [ ]  **In person** [ ]  |
| **Name of interviewer(s):**  | Click or tap here to enter text. |

|  |
| --- |
| Click or tap here to enter text. |

|  |  |  |
| --- | --- | --- |
| **Date of interview** | **Name** | **Method** |
| Click or tap to enter a date. | Click or tap here to enter text. | **Phone** [ ]  **In person** [ ]  |
| **Name of interviewer(s):**  | Click or tap here to enter text. |

|  |
| --- |
| Click or tap here to enter text. |

1. **Child interview**

|  |  |
| --- | --- |
| **Name of interviewer**  | Click or tap here to enter text. |
| **Interpreter used? Yes** [ ]  **No** [ ]  | **Name of interpreter**  | Click or tap here to enter text. |
| **Was the interview recorded? Yes** [ ]  **No** [ ]  | **Was child interviewed alone?** **Yes** [ ]  **No** [ ]  **If no, explain why:** Click or tap here to enter text. |
| **Does child have age-appropriate language abilities?**  | **Yes** [ ]  **No** [ ]  **Unable to assess** [ ]  |

|  |
| --- |
| Click or tap here to enter text.Additional history provided by child to CME provider (if applicable):Click or tap here to enter text. |

1. **Review of supplemental information**
2. **Medical record review** *Indicate medical records reviewed and provide a brief summary. Table for more extensive record review available in Appendix.*

|  |
| --- |
| Click or tap here to enter text. |

1. **Consultations** *Document information obtained from subspecialists or other treating providers*

|  |  |  |
| --- | --- | --- |
| **Date**  | **Medical provider** | **Notes** |
|  |  |  |
|  |  |  |
|  |  |  |

1. **Photographic images reviewed**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Provided by** | Click or tap here to enter text. | **Taken by** | Click or tap here to enter text. | **Date** | Click or tap to enter a date. |
| **Description:** |
| **Provided by** | Click or tap here to enter text. | **Taken by** | Click or tap here to enter text. | **Date** | Click or tap to enter a date. |
| **Description:** Click or tap here to enter text. |

1. **Child’s medical history**
2. **Well Child/General Pediatric history**

|  |  |
| --- | --- |
| **History obtained/provided by:** | Click or tap here to enter text. |
| **Primary care provider:**  | Click or tap here to enter text. |
| **Immunizations up-to-date** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  | **Pregnancy/birth issues** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Chronic/active disease** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  | **Allergies** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Hospitalizations** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  | **Surgeries** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Trauma/injury** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |  |
| **Specify:**  Click or tap here to enter text. |

1. **Medications**

|  |  |
| --- | --- |
| **History obtained/provided by:** | Click or tap here to enter text. |
| **Name of medication**  | **Dosage** | **Purpose** | **Prescribing clinician**  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

1. **Genitourinary history**

**Standard screening tool used:** Yes [ ]  No [ ]

|  |
| --- |
| **History obtained/provided by:** Click or tap here to enter text. |
| **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** |  |
| **Describe any significant genitourinary and/or reproductive health history:** Click or tap here to enter text. |

1. **Developmental and/or educational history**

**Standard screening tool used:** Yes [ ]  No [ ]

|  |
| --- |
| **History obtained/provided by:** Click or tap here to enter text. |
| **Developmental concerns** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Educational concerns** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Describe any significant developmental and/or educational history:** Click or tap here to enter text. |

1. **Behavioral and mental health history**

**Standard screening tool used:** Yes [ ]  No [ ]

|  |
| --- |
| **History obtained/provided by:** Click or tap here to enter text. |
| **Currently receiving mental health treatment?**  | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Reason for mental health services:**  | Click or tap here to enter text. |
| **Clinician and/or practice** | Click or tap here to enter text. |
| **Sleep disturbance** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Poor concentration** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Anxiety** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Hypervigilance/exaggerated startle** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Re-experiencing/nightmares/flashbacks** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Avoidance/withdrawal** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Eating disorder** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Enuresis/encopresis** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Self-injurious behavior** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Hyperactivity/impulsivity** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Anger outbursts/irritability** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Depressed mood** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Suicidal behavior** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Sexualized behavior problems** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
|  |
| **Describe significant behavioral/mental health history:** Click or tap here to enter text. |

**Adolescent behavioral supplement** *Child should provide history separate from caretaker, if applicable*

**Standard screening tool used:** Yes [ ]  No [ ]

|  |
| --- |
| **History obtained/provided by:** Click or tap here to enter text. |
| **Describe any significant behavioral history:** Click or tap here to enter text. |

1. **Family medical history** *Document the health history of parents’ and immediate family*

|  |  |
| --- | --- |
| **History obtained/provided by:** | Click or tap here to enter text. |
| **Significant family history** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Describe significant family history:** Click or tap here to enter text. |

1. **Psychosocial history**

**Standard screening tool used:** Yes [ ]  No [ ]

|  |
| --- |
| **History obtained/provided by:** Click or tap here to enter text. |
| **Prior CPS involvement** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Prior LE/criminal history** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Domestic violence** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Trauma exposure** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Substance misuse/disorder** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Mental health concerns/diagnosis:**  | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Describe any significant psychosocial history:** Click or tap here to enter text. |

1. **Review of systems**

**Are there any significant concerns?**

|  |  |
| --- | --- |
| **History obtained/provided by:** | Click or tap here to enter text. |
| **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** [ ]  |
| **Visions** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  | **GU** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **ENT** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  | **Endo**  | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Ophthalmology**  | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  | **Heme/Lymph** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Skin** | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  | **Neuro**  | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **CV**  | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  | **Psych**  | **Yes** [ ]  **No** [ ]  **Unknown** [ ]  |
| **Describe significant findings:** Click or tap here to enter text. |

1. **Medical evaluation**
2. **Physical examination**

|  |  |
| --- | --- |
| **Who was present during the physical examination?** | Click or tap here to enter text. |
| **Patient demeanor during physical examination** | Click or tap here to enter text. |

1. **Vitals and growth parameters**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Temperature** |  | **Head circumference** |  | % |
| **Heart Rate** |  | **Weight**  |  | % |
| **Respiratory Rate** |  | **Height**  |  | % |
| **Blood Pressure**  |  | **BMI** |  | % |

1. **General examination** *Label findings on diagram in Appendix*

|  |  |
| --- | --- |
|  | **Notes** |
| **Vision/Hearing** | **Yes** [ ]  **No** [ ]  **Not Assessed** [ ]  | Click or tap here to enter text. |
| **Skin** | **Yes** [ ]  **No** [ ]  **Not Assessed** [ ]  | Click or tap here to enter text. |
| **HEENT** | **Yes** [ ]  **No** [ ]  **Not Assessed** [ ]  | Click or tap here to enter text. |
| **Neck** | **Yes** [ ]  **No** [ ]  **Not Assessed** [ ]  | Click or tap here to enter text. |
| **Chest** | **Yes** [ ]  **No** [ ]  **Not Assessed** [ ]  | Click or tap here to enter text. |
| **Heart** | **Yes** [ ]  **No** [ ]  **Not Assessed** [ ]  | Click or tap here to enter text. |
| **Lungs** | **Yes** [ ]  **No** [ ]  **Not Assessed** [ ]  | Click or tap here to enter text. |
| **Abdomen** | **Yes** [ ]  **No** [ ]  **Not Assessed** [ ]  | Click or tap here to enter text. |
| **Back** | **Yes** [ ]  **No** [ ]  **Not Assessed** [ ]  | Click or tap here to enter text. |
| **Extremities** | **Yes** [ ]  **No** [ ]  **Not Assessed** [ ]  | Click or tap here to enter text. |
| **Lymph nodes** | **Yes** [ ]  **No** [ ]  **Not Assessed** [ ]  | Click or tap here to enter text. |
| **Neurological**  | **Yes** [ ]  **No** [ ]  **Not Assessed** [ ]  | Click or tap here to enter text. |

1. **Anogenital Examination**

|  |  |  |  |
| --- | --- | --- | --- |
| **Tanner/SMR:**  | Choose an item. | **Breast/Chest** | Choose an item. |
| **Pubic Hair**  | Choose an item. |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Position**  | **N/A** [ ]  | **Frog leg** [ ]  | **Lithotomy** [ ]  | **Knee-chest** [ ]  | **Lateral Decubitus** [ ]  |
| **Technique**  | **N/A** [ ]  | **Labial separation** [ ]  | **Labial** **traction** [ ]  | **Q-tip** [ ]  | **Saline** [ ]  | **Anal exam** [ ]  |
| **Colposcopy/****Photographs**  | **Yes** [ ]  | **No** [ ]  |
| **Device used** | Click or tap here to enter text. |

**Significant Findings** *Label findings on diagram in Appendix*

|  |  |
| --- | --- |
|  | **Description of findings** |
| **Labia majora/minora** | **N/A** [ ]  | **Yes** [ ]  **No** [ ]  **Not Assessed** [ ]  | Click or tap here to enter text. |
| **Clitoris/Urethra** | **N/A** [ ]  | **Yes** [ ]  **No** [ ]  **Not Assessed** [ ]  | Click or tap here to enter text. |
| **Hymen**  | **N/A** [ ]  | **Yes** [ ]  **No** [ ]  **Not Assessed** [ ]  | Click or tap here to enter text. |
| **Peri-hymenal tissue** | **N/A** [ ]  | **Yes** [ ]  **No** [ ]  **Not Assessed** [ ]  | Click or tap here to enter text. |
| **Posterior fourchette** | **N/A** [ ]  | **Yes** [ ]  **No** [ ]  **Not Assessed** [ ]  | Click or tap here to enter text. |
| **Vagina/Cervix**  | **N/A** [ ]  | **Yes** [ ]  **No** [ ]  **Not Assessed** [ ]  | Click or tap here to enter text. |
| **Penis**  | **N/A** [ ]  | **Yes** [ ]  **No** [ ]  **Not Assessed** [ ]  | Click or tap here to enter text. |
| **Testes/Scrotum** | **N/A** [ ]  | **Yes** [ ]  **No** [ ]  **Not Assessed** [ ]  | Click or tap here to enter text. |
| **Anus/Perineum**  | **N/A** [ ]  | **Yes** [ ]  **No** [ ]  **Not Assessed** [ ]  | Click or tap here to enter text. |

1. **Laboratory/Radiological Studies** *Only document final results*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Study** | **Date ordered**  | **Type** | **Site**  | **Results** |
|[ ]  **Trichomonas**  | Click or tap to enter a date. | **Urine** [ ]  |  | Click or tap here to enter text. |
|  |  |  | **Culture** [ ]  | Choose an item. |  |
|  |  |  | **Wet mount** [ ]  |  |  |
|  |  |  | **PCR/NAAT**[ ]  | Choose an item. |  |
|[ ]  **Neisseria gonorrhea**  | Click or tap to enter a date. | **PCR/NAAT** [ ]  | Choose an item. | Click or tap here to enter text. |
|  |  |  | **Culture** [ ]  | Choose an item. |  |
|[ ]  **Chlamydia trachomatis** | Click or tap to enter a date. | **Urine** [ ]  |  | Click or tap here to enter text. |
|  |  |  | **PCR/NAAT** [ ]  | Choose an item. |  |
|  |  |  | **Culture** [ ]  | Choose an item. |  |
|[ ]  **Other viral/bacteria studies**Click or tap here to enter text. | Click or tap to enter a date. | **Antibody** [ ]  |  | Click or tap here to enter text. |
|  |  |  | **PCR/NAAT** [ ]  | Choose an item. |  |
|  |  |  | **Culture** [ ]  | Choose an item. |  |
|[ ]  **RPR**  | Click or tap to enter a date. |  |  | Click or tap here to enter text. |
|[ ]  **HIV** | Click or tap to enter a date. |  |  | Click or tap here to enter text. |
|[ ]  **Urine/serum pregnancy test** | Click or tap to enter a date. |  |  | Click or tap here to enter text. |
|[ ]  **UA/urine culture** | Click or tap to enter a date. |  |  | Click or tap here to enter text. |
|[ ]  **CBC** | Click or tap to enter a date. |  |  | Click or tap here to enter text. |
|[ ]  **PT/PTT/vWF**  | Click or tap to enter a date. |  |  | Click or tap here to enter text. |
|[ ]  **Skeletal survey** | Click or tap to enter a date. |  |  | Click or tap here to enter text. |
|[ ]  **Repeat skeletal survey** | Click or tap to enter a date. |  |  | Click or tap here to enter text. |
|[ ]  **MRI/CT** | Click or tap to enter a date. |  |  | Click or tap here to enter text. |
|[ ]  **Other (specify)** Click or tap here to enter text. | Click or tap to enter a date. |  |  | Click or tap here to enter text. |

1. **Child Medical Evaluation Summary**
2. **Overall medical summary**

|  |
| --- |
| Click or tap here to enter text. |

1. **Maltreatment summary** *Check N/A if not assessed during this evaluation.*

|  |  |
| --- | --- |
| **Physical abuse findings**  | **N/A** [ ]  |
| Click or tap here to enter text. |
| **Sexual abuse findings**  | **N/A** [ ]  |
| Click or tap here to enter text. |
| **Neglect findings**  | **N/A** [ ]  |
| Click or tap here to enter text. |
| **Medical child abuse findings**  | **N/A** [ ]  |
| Click or tap here to enter text. |
| **Emotional abuse findings** | **N/A** [ ]  |
| Click or tap here to enter text. |

1. **Impact of harm and risk of future harm**

|  |  |
| --- | --- |
| **Impact of maltreatment to the child**  | **N/A** [ ]  |
| Click or tap here to enter text. |
| **Psychosocial risk factors which increase the future risk of harm** | **N/A** [ ]  |
| Click or tap here to enter text. |
| **Medical characteristics that are associated with an increased risk of harm** | **N/A** [ ]  |
| Click or tap here to enter text. |

1. **Recommendations**

|  |  |
| --- | --- |
| **Medical – what are the specific needs of this child to ensure their well-being?**  | **N/A** [ ]  |
| Click or tap here to enter text. |
| **Development/Mental health – note who is referring or how to refer** | **N/A** [ ]  |
| Click or tap here to enter text. |
| **Safety – are there additional safety recommendations not identified above (i.e. public health messaging)?**  | **N/A** [ ]  |
| Click or tap here to enter text. |

1. **Contact Information: Examining Clinician**

|  |  |
| --- | --- |
| **Signature** |  |
| **Name and Title** | Click or tap here to enter text. |
| **Practice Name** | Click or tap here to enter text. |
| **Address** | Click or tap here to enter text. |
|  |  |
| **Phone** | Click or tap here to enter text. |
| **Fax** | Click or tap here to enter text. |

**Appendix**

1. **Review of supplemental information**

**1. Medical record review**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date**  | **Location & Visit Type** | **Reason for Contact** | **Reported Signs or Symptoms by Caregiver** | **Objective Observation by Medical Provider**  | **Conclusions/****Diagnosis** | **Treatment/****Intervention** | **Comments** |
|   |  |  |  |  |  |  |  |

1. **Medical evaluation**
2. **Physical Examination**
3. **General examination**



1. **Anogenital Examination**



This illustration is from Berkoff, M. C. et al. “Has this prepubertal girl been sexually abused?” JAMA 300 23 (2008): 2779-92.



The illustration is fromthe California Office of Emergency Services (2001), reprinted with permission

**Addendum**

|  |
| --- |
| Click or tap here to enter text. |