

Child Name:	
Date of Birth:	
Age:	Click or tap here to enter text.
Date of CME:	

## Child Medical Evaluation Referral and Report

### CME Referral

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

#### A. Child welfare agency/DCDEE information

<b>County of Child Welfare Agency:</b>	Choose an item.
<b>CPS/DCDEE worker:</b>	
<b>Phone number:</b>	
<b>Email:</b>	
<b>Fax:</b>	
<b>Supervisor name/contact info:</b>	

#### B. Child information

##### 1. Basic information

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

##### 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

Child Name:	
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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](#).

Sexual Abuse <input type="checkbox"/>	Neglect <input type="checkbox"/>	Emotional Abuse <input type="checkbox"/>
Physical Abuse <input type="checkbox"/>	Medical Child Abuse <input type="checkbox"/>	

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

Date of care	Facility	Are the medical records included with referral*? Yes <input type="checkbox"/> No <input type="checkbox"/>
Date of care	Facility	Are the medical records included with referral*? Yes <input type="checkbox"/> No <input type="checkbox"/>
* External medical records should be provided prior to CME to inform the medical evaluation		

3. Current CPS/DCDEE Assessment concerns and findings.

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4. 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

5. Describe any prior involvement with child welfare or DCDEE

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6. Is law enforcement involved? Yes  No

Contact information

Assigned Investigator	Agency	Contact information:

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**Summary of involvement**

**7. 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.*

<b>Digital images</b>	<b><i>This may include photographs of injuries, alleged mechanisms of injury. Be sure images are appropriately labeled and dated.</i></b>	<input type="checkbox"/>
<b>Timeline of maltreatment</b>	<b><i>To include a history of supervision, preceding the alleged maltreatment and up to agency's involvement</i></b>	<input type="checkbox"/>
<b>External medical records</b>	<b><i>Recent medical evaluations related to the concerns or documentation related to history of concerns. This includes all pediatric records of children &lt; 3.</i></b>	<input type="checkbox"/>