REPORT OF ACTUAL OR SUSPECTED CHILD ABUSE OR NEGLECT

Michigan Department of Human Services

Was referral phoned to DHS?

☐ Yes ☐ No ▶ If yes, Log # _____ ▶ If no, contact the local DHS Office immediately

INSTRUCTIONS: REFERRING PERSON: Complete items 1-20. Send PART 1 to local County DHS where the child is found. Retain PART 2 for your records. See additional instructions on back.

1. Date

2. List of child(ren) suspected of being abused or neglected (list additional children on back of Part 1)

NAME	BIRTH DATE	SOCIAL SECURITY #	SEX	RACE
3. Mother's name				
4. Father's name				

5. Child(ren)'s address (No. & Street)	6. City	7. County	8. Phone No.

9. Name of alleged perpetrator of abuse or neglect	10. Relationship to child(ren)
11. Person(s) the child(ren) living with when abuse/neglect occurred	12. Address, City & Zip Code where abuse/neglect occurred

13. Describe injury or conditions and reason for suspicion of abuse or neglect (Attach additional sheets if necessary)

_____

_____

14. Source of Referral (Check appropriate box)

☐ PHYSICIAN
☐ MEDICAL EXAMINER (Coroner)
☐ DENTIST/DENTAL HYGIENIST
☐ NURSE
☐ EMERGENCY MEDICAL SERVICES PERSONNEL
☐ FAMILY INDEPENDENCE MANAGER
☐ SOCIAL WORK SPECIALIST MANAGER
☐ AUDIOLOGIST
☐ *SOCIAL WORKER
☐ SCHOOL ADMINISTRATOR
☐ SCHOOL COUNSELOR
☐ HOSPITAL
☐ FAMILY INDEPENDENCE SPECIALIST
☐ WELFARE SERVICES SPECIALIST
☐ PSYCHOLOGIST
☐ PROFESSIONAL COUNSELOR
☐ TEACHER
☐ LAW ENFORCEMENT OFFICER
☐ CHILD CARE PROVIDER
☐ CLERGY
☐ MARRIAGE/FAMILY THERAPIST
☐ DHS FACILITY
☐ DCH FACILITY
☐ ELIGIBILITY SPECIALIST
☐ SOCIAL WORK SPECIALIST
☐ SOCIAL SERVICES SPECIALIST
☐ Other (Specify below)

15. Referring person's name	16. Name of referring organization (school, hospital, etc.)			
17. Address (No. & Street)	18. City	19. State	20. Zip Code	21. Phone No.

TO BE COMPLETED BY MEDICAL PERSONNEL WHEN PHYSICAL EXAMINATION HAS BEEN DONE

22. Summary report and conclusions of physical examination (Attach Medical Documentation)

_____

_____

23. Laboratory report	24. X-Ray
25. Other (specify)	26. History or physical signs of previous abuse/neglect ☐ YES ☐ NO

27. Prior hospitalization or medical examination for this child

DATES	PLACES

28. Physician's Signature	29. Date	30. Hospital (if applicable)

Department of Human Services (DHS) will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.

AUTHORITY: P.A. 238 of 1975.
COMPLETION: Mandatory.
PENALTY: None.

*INCLUDES CERTIFIED SOCIAL WORKER, SOCIAL WORKER, SOCIAL WORK TECHNICIAN (Act No. 352, P.A. of 1972, as amended)

INSTRUCTIONS

GENERAL INFORMATION:
This form is to be completed as the written follow-up to the oral report required in the above Sec. 3. (1) Act. No 238, P.A. of 1975, as amended and mailed to the local county Department of Human Services. Indicate if this report was phoned into DHS as a report of suspected CA/N? If so, indicate the Log # (if known). Referring person is to fill out as completely as possible items 1-21. Only medical personnel may complete items 22-30.

1. Date - Enter the date the form is being completed.

2. List child(ren) suspected of being abused or neglected - Enter available information for the child(ren) believed to be abused or neglected. Indicate if child has a disability that may need accommodation.

3. Mother's name - Enter mother's name (or mother substitute) and other available information. Indicate if mother has a disability that may need accommodation.

4. Father's name - Enter father's name (or father substitute) and other available information. Indicate if father has a disability that may need accommodation.

5. Child(ren's) address - Enter the address of the child(ren).

6. City - Self explanatory

7. County - Self explanatory

8. Phone - Enter phone number of the household where child(ren) resides.

9. Name of alleged perpetrator of abuse or neglect – Indicate person(s) suspected or presumed to be responsible for the alleged abuse or neglect.

10. Relationship to child(ren) - Indicate the relationship to the child(ren) of the alleged perpetrator of neglect or abuses, i.e. parent, grandparent, babysitter.

11. Person(s) child(ren) living with when abuse/neglect occurred - Enter name(s). Indicate if individuals have a disability that may need accommodation.

12. Address where abuse / neglect occurred - Self explanatory.

13. Describe injury or conditions and reason of suspicion of abuse or neglect - Indicate the basis for making a report and the information available about the abuse or neglect.

14. Source of referral - Check appropriate box noting professional group or appropriate category
Note: If abuse or neglect is suspected in a hospital, check hospital.

DHS Facility - Refers to any group home, shelter home, halfway house or institution operated by the Department of Human Services.

DCH Facility - Refers to any institution or facility operated by the Department of Community Health.

15. Referring person's name - Enter your name if you are referring or reporting this matter.

16. Name of referring organization - Enter the name of the agency or organization, if appropriate.

17. Address - Self explanatory

18. City - Self explanatory

19. State - Self explanatory

20. Zip Code – Self explanatory

21. Phone Number - Self explanatory