Kansas
Department for Children and Families

# CARE Provider Evaluation Referral

Click here to open email to: mailto:SafeCareKS@cmh.edu Once email opens, attach saved form

**The Integrated Referral and Intake System (IRIS) is not being utilized for one or more of the following reasons:**
☐Parent and/or caregiver does not consent to usage of the IRIS Referral System
☐Concerted efforts to obtain consent from parents/caregivers have been unsuccessful
☐Report is a conflict of interest and needs to be confidential

| Assigned Date: | Date of Referral: | FACTS Event Number: |
|---|---|---|

**CASE DATA**

| CHILD'S NAME | DATE OF BIRTH | AGE | GENDER | Injury/Reported Injury ☐ |
|---|---|---|---|---|
| CHILD'S NAME | DATE OF BIRTH | AGE | GENDER | Injury/Reported Injury ☐ |
| CHILD'S NAME | DATE OF BIRTH | AGE | GENDER | Injury/Reported Injury ☐ |

**ALLEGED PERPETRATOR(S)** ☐ **UNKNOWN**

| NAME | RELATIONSHIP |
|---|---|
| NAME | RELATIONSHIP |

| PPS SPECIALIST NAME | PHONE NUMBER | COUNTY |
|---|---|---|
| PPS SPECIALIST'S EMAIL ADDRESS | | PPS SUPERVISOR'S EMAIL |

**ALLEGATIONS: CATEGORY OF ABUSE/NEGLECT** (Check all that apply)

☐ PHYSICAL ABUSE ☐ PHYSICAL NEGLECT ☐ OTHER

**REPORTED CONCERN**

**ADDITIONAL INFORMATION OBTAINED FROM CONTACTS**

**MEDICAL INFORMATION**

Has the child received medical attention for these allegations? ☐ YES ☐ NO ☐ UNKNOWN

If yes, treating physician's information:
Name: Hospital:

Does the child have an injury or did the report indicate the child had an injury? ☐ YES ☐ NO ☐ UNKNOWN

Do you have any medical records for this incident yet? ☐ YES (Attach to referral) ☐ NO

Do you have any pictures for this incident? ☐ YES (Attach to referral) ☐ NO

Explain/describe any injuries or suspicion of injury, **including** location and any possible mechanism of injury. If there are no concerns of injury, are there any other medical concerns related to the allegation? Are there statements from a witness or from someone who has additional information?

Kansas
Department for Children and Families

# CARE Provider Evaluation Referral

Click here to open email to: mailto:SafeCareKS@cmh.edu Once email opens, attach saved form

| |
|---|
| |
| **RECOMMENDATIONS FOR FOLLOW UP MEDICAL EVALUATION (TO BE COMPLETED BY PHYSICIAN) more than one recommendation may be made in situations where more than one child was referred. Please review recommendations for each child below.** |
| ☐ no medical/forensic evaluation required based on information provided for child . |
| ☐ medical exam by general practitioner needed for child . |
| ☐ medical examination by a CARE provider needed for child . |
| ☐ medical examination by a board-certified child abuse pediatrician needed for child . |
| ☐ case review by a CARE provider needed for child . |
| Further recommendations for medical treatment: |

| SIGNATURE OF PHYSICIAN | DATE |
|---|---|
| | |