

SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICES		SUSPECTED CHILD ABUSE AND NEGLECT REFERRAL FOR HEALTH PROFESSIONALS AND MEDICAL FACILITIES			
CHILD'S NAME (FIRST, MIDDLE INITIAL, LAST)		SEX	RACE	DATE OF BIRTH	AGE
ADDRESS		TELEPHONE NUMBER		COUNTY OF RESIDENCE	
		NAME OF HOSPITAL/MEDICAL FACILITY (IF APPLICABLE)		PATIENT'S RECORD NO. (IF APPLICABLE)	
FAMILY INFORMATION					
FATHER'S NAME (LAST, MIDDLE INITIAL, FIRST)		AGE	OCCUPATION		
MOTHER'S NAME (LAST, MIDDLE INITIAL, FIRST)		AGE	OCCUPATION		
GUARDIAN'S NAME (LAST, MIDDLE INITIAL, FIRST)		AGE	OCCUPATION		
ADDRESS OF FAMILY IF DIFFERENT FROM CHILD'S ADDRESS				OTHER CHILDREN IN HOME	
NAME AND ADDRESS OF INDIVIDUAL WHO BROUGHT CHILD IN		RELATIONSHIP TO CHILD	DOES FAMILY KNOW THIS REFERRAL IS BEING MADE? <input type="checkbox"/> YES <input type="checkbox"/> NO		
REFERRAL INFORMATION					
TYPE OF REFERRAL (GIVE DETAIL ON BACK OF FORM)					
<input type="checkbox"/> PHYSICAL ABUSE <input type="checkbox"/> SEXUAL ABUSE <input type="checkbox"/> ABANDONED <input type="checkbox"/> MENTAL INJURY <input type="checkbox"/> CHILD NEGLECT					
ACTION TAKEN BY HEALTH PROFESSIONAL					
<input type="checkbox"/> CHILD SEEN IN EMERGENCY ROOM TREATED & RELEASED	FACILITY'S NAME			DATE	
<input type="checkbox"/> CHILD SEEN BY PRIVATE PHYSICIAN	PHYSICIAN'S NAME			DATE	
<input type="checkbox"/> CHILD SEEN BY CLINIC	CLINIC'S NAME			DATE	
<input type="checkbox"/> CHILD HOSPITALIZED	HOSPITAL'S NAME			DATE	
<input type="checkbox"/> CHILD REFERRED TO PHYSICIAN/CLINIC FOR FOLLOW-UP	PHYSICIAN/CLINIC'S NAME			DATE	
<input type="checkbox"/> DSS CONTACTED BY TELEPHONE	NAME OF WORKER & AGENCY COUNTY DEPARTMENT			DATE	
<input type="checkbox"/> FAMILY COURT/POLICE CONTACTED	NAME OF FAMILY COURT/POLICE			DATE	
<input type="checkbox"/> X-RAYS TAKEN	DATE	<input type="checkbox"/> COLOR PHOTOGRAPHS TAKEN		DATE	
		BY WHOM _____			
NAME OF PHYSICIAN OF RECORD (IF ANY)			PHYSICIAN'S ADDRESS		
NAME & TITLE OF PERSON MAKING REFERRAL		SIGNATURE		DATE	

DESCRIPTION OF INCIDENT

1. MEDICAL STATEMENT REGARDING EXTENT AND NATURE OF INJURIES TO CHILD: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Diagnosis: \_\_\_\_\_  
\_\_\_\_\_

2. DESCRIPTION OF INCIDENT AS GIVEN BY CARETAKER (Time, Place, Who is alleged to have caused the injury). \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Will there be continued involvement by your health professionals/clinic/hospital with this child?  Yes  No

3. PREVIOUS INCIDENTS INVOLVING THIS CHILD OR FAMILY (Include dates and type of incident). \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Were these previous injuries referred to the Department of Social Services?  Yes  No

INSTRUCTIONS

THIS FORM IS TO BE USED TO TRANSMIT INFORMATION CONCERNING ALLEGEDLY ABUSED AND NEGLECTED CHILDREN TO THE DEPARTMENT OF SOCIAL SERVICES. IT SHOULD BE FORWARDED TO THE COUNTY DEPARTMENT OF SOCIAL SERVICES WHERE THE INVOLVED CHILD RESIDES. THIS FORM DOES NOT TAKE THE PLACE OF PROMPT VERBAL COMMUNICATION TO THE DEPARTMENT OF SOCIAL SERVICES THAT MAY BE NECESSARY TO PROTECT THE CHILD.

- 1. Complete all parts of the form which are relevant to your professional area.
- 2. Forward the original to the appropriate County Department of Social Services.
- 3. Retain at least one copy for the patient record.
- 4. Follow-up information on cases can be provided on a case by case basis through the County Department of Social Services.
- 5. Pads of 50 forms each can be obtained by writing the S. C. State Department of Social Services, Attention: Supply, P. O. Box 1520, Columbia, S. C. 29202. Be sure to include:

- (a) the number of pads needed.
- (b) the form number (DSS Form 3006).
- (c) the office or facility's street address.

NOTE: Forms will be sent UPS.