

Victorian Forensic Paediatric Medical Service (VFPMS) Medical Reports

Letterhead

Contact numbers – phone / fax / email

Code for report (includes Dr's and typist initials)

Date (report typed)

Report prepared for

Title, Name

Organisation

Address

RE Name: full name and also-known-as names.
 Date of birth
 Hospital unit record number

Author of report

Reason for Medical Assessment

Site and time of assessment(s)

Consent

Observers

Sources of information

Presenting complaint

Past Medical History

Examination

Forensic Specimen Collection

Medical Investigations

Medical Management

Information sharing

Limitations to opinion

OPINION

Recommendations

Signature

Victorian Forensic Paediatric Medical Service (VFPMS)
Medical Reports

INFORMATION ABOUT FORMAT OF VFPMS REPORTS

Letterhead

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Title, Name

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Address

RE Name: full name and also-known-as names.
Date of birth
Hospital unit record number

Personal details of doctor (author of report)

Full name

Qualifications and medical registration (where registered – not the registration number)

Work address

Position title

Employment history as it relates to this case.

Experience relevant to this case

Reason for Medical Assessment

Who requested the medical evaluation, and why (1-2 sentences)

Site and time (record information for each event)

Location where service provided

time and date called out

time and date assessment commenced

time and date assessment concluded

Consent

Time, date, manner, use of forms

Details of nature of consent

Observers

Who, for what part of assessment / examination?

Document when and how assistance was provided

Sources of information

Victorian Forensic Paediatric Medical Service (VFPMS)

Medical Reports

Full details of all people who provided information, (conversations, telephone conversations, email and letters)
Reports – medical and other
Medical files and hospital records
Investigations and reports

Presenting complaint

Identity of who requested service, time and date, manner of enquiry (who, when, how and why?)

History of complaint and involvement of person requesting the medical assessment (chronological order, dot points may be used)

History of complaint from the person being assessed

From whom (may be more than one person, separate section for each)

Who did what to whom?

Where?

When?

What symptoms occurred at time?

What symptoms developed between time of alleged assault and now?

Current symptoms – physical and mental health

Past Medical History

Birth and neonatal history

Illness and injury

Operations

Development (cognitive and emotional) including milestones

Behaviour (including problems with attachment)

Genogram and relevant family history – medical and psychosocial

 Include history of transitions between care-givers – when, why?

 Include prior involvement with Child Protection

 Include details of current Children's Court orders

Puberty and menstrual history

Medication (including contraception and immunization)

Allergies

For adolescents use HEADSS structure to enquire about psychosocial factors, alcohol and drug use, sexuality and other factors relevant in this age group

Specific questions related to alleged assault

Since alleged assault has patient (if so, what?, when? any additional symptoms?)

Voided?

Defecated?

Eaten?

Drunk?

Changed clothing?

Changed sanitary products?

Showered or bathed?

Had sexual intercourse?

Victorian Forensic Paediatric Medical Service (VFPMS)

Medical Reports

Examination findings

Appearance and demeanour, cooperation, affect
Orientation and mentation (mini mental state exam if required)
Quality of interpersonal interactions and engagement
Measure height, weight and head circumference,
plot on growth charts and document percentiles
clothing, jewellery
general exam findings – systems and ear, nose, throat, mouth
thorough examination of skin
CNS
Development
Behaviour

Examination of injuries

Note lighting and magnification
Use of any equipment (magnifying lights, torch, colposcope)
Fully describe individual injuries / pattern of injury
Use Body diagrams
Number injuries and use a format that makes identification / reference easy

Photodocumentation

Video or DVD colposcopic recording
(Note that our MOU with the OPP means that we MUST indicate in each report when a video or DVD colposcopic recording has been made)
Photographs – where? when? what region of patient's body?
Special photographic techniques?
If possible include with report or note where they may be located.

Specimen Collection for Forensic analysis

Use proforma to document the full list of all specimens

- Drop sheet
- Debris
- Clothing
- Wet and dry swabs and slides
- Swabs and slides
- Swabs alone
- Buccal swab for victim DNA
- Other (nail scrapings, hair etc)

Chain of evidence

Specimens were given to..... at (location).....
At ...date and time

Investigations

Serology (Hep B, Hep C, HIV, VDRL)
Swabs in culture medium for microscopy culture and sensitivities
Swabs in viral culture medium
Swabs in special medium (chlamydia, gonococcus)

Victorian Forensic Paediatric Medical Service (VFPMS)

Medical Reports

Full blood examination
Clotting studies
Other blood tests (list)
Radiology (list)

Medical Management

Treatment
Prescriptions and medications dispensed
 Morning after pill
 Antibiotics as prophylaxis for sexually transmitted infections
Specialist referral (who, where? what opinion and treatment is sought?)
Planned review and medical follow up

Information sharing

Information provided to investigators (Who? When? What?)
Information provided to health provider
Information provided to patient

Limitations to opinion

List any omissions or limiting factors

OPINION

This is the most important part of the report and must be very carefully worded!

Comment in terms of likelihood

Recommendations

(This is also REALLY important and must be carefully considered)
For improved safety and well being of this child
For improved safety and well being of siblings
Intervention from Child Protection
Intervention from Vic Police
Intervention from health services
Intervention from community based agencies
Parenting assessments, psychological evaluation of parent(s)
Services/ for parents / carers
Other (including psychological interventions / counselling)

Signature

Typed name and title

Contact details of author

Date signed

Jurat with witness details (for court report)