HEAD INJURY SECONDARY TO SUSPECTED CHILD MALTREATMENT (ABUSE OR NEGLECT) (HI)

CANADIAN PAEDIATRIC SURVEILLANCE PROGRAM

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REPORTING INFORMATION
(To be completed by the CPSP Senior Coordinator)

Report number:	
Month of reporting:	
Province:	
Today's date:	

Please complete the following sections for the case identified above.

Strict confidentiality of information will be assured.

CASE DEFINITION FOR CHILD INJURY SECONDARY TO SUSPECTED CHILD MALTREATMENT (ABUSE OR NEGLECT) (HI)

All new cases of a child up to 14 years of age inclusively, who has any mechanism of head or brain injury consistent with abuse/neglect* (e.g., shaking, impact, suffocation) and that has been reported to provincial/territorial child welfare agencies. Report regardless of whether or not you reported the case yourself to the agency.

Inclusion criteria

- Objective diagnostic evidence of head or brain injury. These may include radiologic, ophthalmologic or forensic findings, such as skull fracture, cerebral contusion, subdural or epidural or subarachnoid haemorrhage, cerebral oedema, retinal haemorrhages.

OR

- Clinical evidence of a significant head or brain injury (e.g., severe head soft tissue injury, depressed level of consciousness, seizures, focal neurological findings).

* See definition of "neglect" in protocol.

SECTION 1 – DEMOGRAPHIC INFORMATION

1.1 Date of birth: ____ /_____ /_______ (DD MM YYYY)   1.2 Sex: Male ___ Female ___

1.3 Province/Territory of residence: ____________________

1.4 Total number of children in household (including patient): _______

Specify number per age group: <1 year ___ 1-4 years ___ 5-9 years ___ 10-14 years ___ >14 years ___

SECTION 2 – CHILD MALTREATMENT

2.1 First presented to: Family physician ___ Paediatrician ___ ER ___ Other ___

2.2 Date of initial presentation of injury: ____ /_____ /_______ (DD MM YYYY)

2.3 Initial presentation (please check all that apply): Irritability ___ Lethargy ___ Vomiting ___
Respiratory difficulty ___ Apnea ___ Seizure ___ Soft tissue injury ___ Decreased consciousness ___
Other (specify) ____

2.4 Date of current presentation: ____ /_____ /_______ (DD MM YYYY)

SECTION 2 – CHILD MALTREATMENT (con'td)

2.5 Current presentation (please check all that apply): Irritability ___ Lethargy ___ Vomiting ___
Respiratory difficulty ___ Apnea ___ Seizure ___ Soft tissue injury ___ Decreased consciousness ___
Other (specify) ______________________________

2.6 Admitted to hospital: Yes ___ No ___ Unknown ___
If yes: Date of admission to hospital: ____ /_____ /_______ (DD MM YYYY)
Date of discharge from hospital: ____ /_____ /_______ (DD MM YYYY)

2.7 Admitted to ICU: Yes ___ No ___ Unknown ___ If yes: Length of ICU stay (days) ______

2.8 Hospital child protection team involved: Yes ___ No ___ Unknown ___

2.9 Police involved: Yes ___ No ___ Unknown ___

2.10 Previously investigated by child welfare: Yes ___ No ___ Unknown ___

2.11 Injury event (examples are: slip/trip • fall on same level • fall from furniture • fall >3 feet • fall downstairs • collided with object • struck by object • struck/pushed by person • shaken by person • no report of trauma given)
Description of injury (attach non-nominal relevant information if available):

____
____
____
____
____
____
____

2.12 Informant(s): mother ___ father ___ babysitter ___ other(s) (please specify): ______________

2.13 Estimated date of injury: ____ /_____ /_______ (DD MM YYYY)

2.14 Past medical history (check all that apply):

___ Prematurity (<36 weeks)
___ Developmental delay
___ Premorbid condition (specify)
____
___ Previous maltreatment
___ Excessive crying
___ Colic
___ Feeding difficulty
___ Apnea
___ Other (specify)
____

2.15 Clinical findings (check all that apply):

___ Subdural haematoma
___ Subarachnoid haematoma
___ Epidural haematoma
___ Cerebral oedema
___ Brain infarct/cerebral contusion
___ Seizures
___ Focal neurological findings
___ Retinal haemorrhage
___ Skull fracture(s)
___ Cervical spine injury
___ Rib fracture(s)
___ Long bone fracture(s)
___ Other fracture(s)
___ Burns/scalds
___ Abdominal injury (specify)
____
___ Bruising
___ Abrasions
___ Glasgow Coma Scale
___/___ (worst recorded)
___ Other (specify)
____

SECTION 2 – CHILD MALTREATMENT (con'td)

2.16 Investigations done (check all that apply):

___ CT of head
___ MRI of head
___ Skull X-ray
___ Skeletal survey (e.g., X-ray)
___ Bone scan
___ Ophthalmology exam
___ Abdominal imaging
___ Coagulation screening
___ Metabolic bone workup
___ Other (specify) ______________________________

2.17 Type of suspected abuse/neglect: Shaken baby syndrome ___ Other physical abuse ___ Neglect ___

2.18 Medical status at time of discharge (if available):

Normal ___ Neurological sequelae (specify mild, moderate or severe) _________________ Dead ___

2.19 Social status at time of discharge: Foster care ___ In care of family ___ Other (specify) ____________________

SECTION 3 – PERPETRATOR INFORMATION
Suspected ___ Confirmed ___ Unknown ___

3.1 Age (years): _____
3.2 Sex: Male ___ Female ___
3.3 Relationship to patient: ____________________
3.4 Marital status: ____________________________
3.5 Highest educational level: __________________
3.6 Employment status: ________________________
3.7 History of risk factors (check all that apply)

__ Alcohol abuse
__ Drug abuse
__ Mental health issues
__ Physical health issues
__ Criminal activity
__ Few social supports
__ Domestic violence
__ Other

3.8 Lives with child: Yes ___ No ___

SECTION 4 – PRIMARY CAREGIVER INFORMATION
Complete if different from perpetrator

4.1 Age (years): _____
4.2 Sex: Male ___ Female ___
4.3 Relationship to patient: ____________________
4.4 Marital status: ____________________________
4.5 Highest educational level: __________________
4.6 Employment status: ________________________
4.7 History of risk factors (check all that apply)

__ Alcohol abuse
__ Drug abuse
__ Mental health issues
__ Physical health issues
__ Criminal activity
__ Few social supports
__ Domestic violence
__ Other

4.8 Lives with child: Yes ___ No ___

SECTION 5 – REPORTING PHYSICIAN

First name_________________________ Surname____

Address____

City___________________________________ Province_________________________ Postal code______________

Telephone number____________________________________ Fax number_______________________________

E-mail____ Date completed___________________________

Thank you for completing this form.

Please keep a record of this report in your CPSP binder. If you require more information or clarification, please call Sue Bennett at (613) 737-7600, ext. 3626.

(HI 2005-03)