JOHNS HOPKINS ALL CHILDREN'S HOSPITAL

Physical Child Abuse Clinical Pathway

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All Children's Hospital

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Johns Hopkins All Children's Hospital

Physical Child Abuse Clinical Pathway

Rationale

This clinical pathway was developed by a working group consisting of members from pediatric emergency medicine, child protection team and social work to standardize the management of children with possible physical child abuse or neglect. It addresses the following clinical scenarios:

1. Which injured children require a non-accidental trauma evaluation?
2. Which laboratory and imaging studies should one obtain when non-accidental trauma is suspected?
3. Which types of subspecialty care are needed for each patient?
4. When to report and the resources available at JHACH regarding non-accidental trauma patients.
5. Understand the various roles of individuals involved in non-accidental trauma patients, including the social worker (SW), the child protection investigator (CPI) and the child protection team (CPT).
6. Provide clear and precise treatment options and follow up needs for every patient who receives a clinical evaluation for non-accidental trauma.

Background

Child abuse and neglect can pose a risk to a child's health, ultimately impacting the child's development. Therefore, a thorough history (interviews with patient and/or family, how the injury occurred, etc.) and examination of the injured children is essential. This practice guideline will outline the essential elements of the evaluation for non-accidental trauma. Once the child has been stabilized and the identification of physical abuse through diagnostic methods has occurred then treatment, intervention, and protection should be provided to the patient.

Getting Started

"…Child abuse consultations are complex in that they are sensitive in nature while having both clinical and forensic/legal significance."

Council on Child Abuse and Neglect and
Section on Minority Health Equity and Inclusion
March 01, 2021

Many of those who work with children and families struggle with investigating and reporting concerns of child abuse. Long-term care providers often worry they will lose the family's trust and urgent/emergency providers deal with maintaining cooperation amongst the family members and care team during a stressful time. According to *CARES* (2008), child abuse is under-reported in the United States. Those of us at Johns Hopkins All Children's Hospital who work with such families understand these struggles. We encourage all providers to call the Transfer Center (727-767-7337) to discuss these concerns with any in-house social worker or emergency center specialist. We maintain the perspective that reporting a concern is always in the best interests of the child as it generates a multidisciplinary screening process. It brings resources to the family which in many cases, are all that are needed. It is not a medical provider's duty to decide who is guilty. Instead, it is our duty to advocate for those most vulnerable whenever possible.

On the next page, you will see a listing of circumstances in which medical providers should consider evaluating for child abuse and neglect. These are mostly high-risk circumstances. This is not an exhaustive list. If, when considering nonaccidental trauma, the provider feels that the family is reliable and an accidental etiology is an appropriate explanation, then no further investigation is necessary. This often occurs when evaluating a very worried parent who has dropped or fallen while holding an infant. Another example is a toddler, presenting straight from the park with a Toddler's fracture. Sometimes, consultation with social work may be necessary to evaluate for previous DCFS reports (patients with high use of emergency services, frequent visits with vague complaints or history of domestic violence in the home).

This pathway is intended as a guide for physicians, physician assistants, nurse practitioners and healthcare providers. It should be adapted to the care of specific patients based on the patient's individualized circumstances and the practitioner's professional judgment. Rationale for adapting the pathway should be documented in the medical record.

Medical Risk Assessment for Child Abuse and/or Neglect

Higher Risk Situations for Non-Accidental Trauma

"Red Flag" History of Present Injury

Inconsistent or changing history
Unwitnessed injury
Delay in seeking care
Prior ED visits with vague concerns
Domestic Violence in home
Premature infant (<37 weeks)
Low birth weight/IUGR
Chronic medical conditions
Injury not consistent with reported mechanism
Injury not compatible with developmental age
Previous DCF Involvement

"Red Flag" Radiographic Findings

High specificity
- Classic metaphyseal lesions
- Multiple posterior rib fractures
- Scapular fractures
- Sternal fractures
- Clavicular fractures
- Spinous process fractures

Moderate specificity
- Multiple fractures
- Fractures of differing ages
- Epiphyseal separations
- Vertebral body fractures
- Digital fractures
- Complex skull fractures

Any undiagnosed healing fractures
Any fracture in a non-ambulating infant
SDH and/or SAH in young children without reasonable history, particularly in the absence of skull fracture <1 year
Femur fracture in patients <15 months

"Red Flag" Physical Exam Findings

Torn frenulum
FTT (weight, length, head circumference)
Large heads in fussy infants (consider head circumference in children < 1 yr)
Any bruise in any non-ambulating child- "if you don't cruise you don't bruise"
Any bruise in a non-exploratory location. *Think*: TEN-FACES, especially in a < 4 yr
__T__orso (area covered by a standard girl's bathing suit), __E__ars, __N__eck, __F__renulum, __A__ngle of jaw, __C__heek, __E__yelid, __S__ubconjunctiva,
Bruises, marks, or scars in patterns that suggest hitting with an object, hand or fist
Multiple injuries to multiple organ systems or multiple parts of body
Patterned or circumferential burns
Adult bite marks (inter-canine distance >3cm, arch width >4cm)

Special Considerations for Non-Accidental Trauma Patients:

Do siblings require evaluation?
- Discuss with Social Work and CPT
- Plan with Emergency Center Charge Nurse/Attending (#727-767-7280).

If NAT is of concern for an admitted patient, consult Trauma Team as soon as possible.
If NAT is of concern for a patient who presents for outpatient services not already referred to JHACH by CPT (OCC, Radiology, Phlebotomy, Audiology) call Social Work (#727-767-4147) & make arrangements for Emergency Center evaluation (#727-767-7280).
If patient from EC or direct admit to PICU, must be admitted to either the Trauma or Neurosurgery Service for at least 24 hours.
Prior to discharge from inpatient or EC, the care team should discuss follow up appointments with social work for patient safety. Use attached appointment sheet as needed (Addendum #1).

If there are special circumstances, JHACH Transfer Center is available 24/7 to connect you with an EC social worker or child protection specialist at 727-767-7337.

How to Make a Report to the Florida Department of Children and Families Child Abuse Hotline

Per JHACH Clinical Policy - Handling of Child and Adult Victims of Alleged or Suspected Abuse, Neglect, or Abandonment (Policy # CLNPOL030).

1. If patient is receiving services at Main Hospital, OCC Clinics and Tampa Clinic, and there is concern for suspected child abuse and/or neglect, JHACH Social Work should be consulted to conduct assessment and determine need to file DCF report.
2. If JHACH staff member witnesses in-person child abuse, while patient is at JHACH, that staff member is required to make a DCF report and contact law enforcement. All staff members are mandated reporters.
3. If patient is receiving services at any other JHACH location and there is concern for suspected child abuse and/or neglect, where JHACH Social Work is not present, then staff should contact JHACH Social Work Department (#727-767-4147) to receive guidance on making a DCF report, if necessary.
4. If patient is initially receiving care and services at any facility other than a JHACH affiliate and there is concern of child abuse or neglect, the healthcare team should contact FL DCF Child Abuse Hotline directly.

When making a DCF report to the FL DCF Child Abuse Hotline (1-800-962-2873) the Hotline counselor will ask for the following information:

- Patient name
- Demographic information
- D.O.B./SSN
- Address
- Current location
- Parent/guardian information
- Reason of concern for suspected child abuse and/or neglect.

Clinical Evaluation for Suspected Physical Child Abuse, By Injury Type

Presentation	Labs	Radiology	Consults
Suspected Abusive Head Trauma (AHT) / Shaken Baby Syndrome	Standard Labs[1] Urine Drug Screen • If negative, *consider* ordering Toxicology Profile if altered mental status is present at any time and normal CT/MRI results	Skeletal Survey if child <2 years of age[2], *Consider* for 24-36 months Brain CT, Trauma, w/o contrast Brain MRI w/o contrast[3] if abnormal findings on CT (unless reasonably explained by history) or altered mental status without medical explanation. Include NAT concern in order *Comments* section.	Trauma Neurosurgery, *as needed* Ophthalmology for all skull fracture/head injuries in patients <12 months[5] Social Work[7]
Suspected Abusive Fracture	Standard labs[1] Phosphate Calcium Magnesium Alk Phos PTH Vitamin D 25-OH	Skeletal Survey if child <2 years of age[2], *Consider* for 24-36 months Brain CT, Trauma if: • Age < 12 months • Facial bruising • Altered mental status	Trauma Orthopedics Social Work[7]
Suspected Abusive Bruising	Standard labs[1] Von Willebrand diagnostic evaluation • vWF Antigen & Activity (ristocetin co-factor) Factor VIII level Factor IX level Platelet function assay Factor XIII *Troponin*, if bruising on chest wall	Skeletal Survey if child <2 years of age[2], *Consider* for 24-36 months *Consider* Brain CT, Trauma if: • Age < 12 months • Facial bruising • Altered mental status	Social Work[7] *Consider* Hematology Consult

Presentation	Labs	Radiology	Consults
Suspected Abusive Abdominal Trauma	Standard labs[1] *Consider* trending AST/ALT and lipase if patient is suspected to have severe injury without laboratory evidence, or delay to care *Consider* troponin if bruising on chest wall	Abdominal/pelvic CT with IV contrast: • AST/ALT >80 • UA >20 RBCs • significant abdominal injury/bruising • comatose patient • suspected delay of care[6] Brain CT, Trauma < 2 yrs • age <1 year • comatose patient • suspected delay of care[6] Skeletal Survey if child <2 years of age[2], *Consider* for 24-36 months	Trauma, if labs/CT positive or patient presents in unstable condition Social Work[7]
Suspected Abusive Burns	Standard labs[1]	Skeletal Survey if child <2 years of age[2], *Consider* for 24-36 months	Social Work[7] *Consider transfer to Burn Center per Trauma Burn CPG*
Unexplained fussiness or altered mental status in child (+- transient) <12 months	*Consider* Standard Labs[1] UDS *if altered or breastfeeding*	*Consider* skeletal survey[2] *Consider* Brain CT, Trauma < 2 yrs	Also consider: • hair tourniquet • corneal abrasion • starvation/FTT • abnormal head circumference

Clinical Evaluation for Suspected Physical Child Abuse, By Age

Age	Labs	Radiology	Consults/Other
0-12 months	Standard Labs[1] See injury-type table, as needed *Consider* UDS for altered mental status (AMS), breastfeeding infants; if UDS is negative, consider Toxicology profile if imaging and other labs normal	Skeletal Survey Brain CT, Trauma < 2 yrs. Abdominal/pelvis CT with IV contrast if: • Signs of abdominal trauma • AST/ALT/Lipase >80 • Positive FAST • UA >20 RBCs ○ Get delayed CT images Brain MRI w/o contrast[3] for clinically stable patients with suspected abusive head trauma. Include NAT concern in order "Comments." MRI is an adjunct and should not be used in place of CT scan. Should be used to confirm and further delineate findings on CT, as well as reveal suspected diffuse axonal injury, ligamentous injury of the neck and brain edema.	Social Work[7] Trauma Ophthalmology, *as indicated* Neurosurgery, *as indicated*
12-24 months	Standard Labs[1] See injury type table, as needed *Consider* UDS for altered mental status, breastfeeding infants; if UDS is negative, consider Toxicology profile		
24-36 months	Standard Labs[1] See injury type table, as needed *Consider* UDS for altered mental status, breastfeeding infants; if UDS is negative, consider Toxicology profile	*Consider* Skeletal Survey Brain CT, Trauma/3D > 2 yrs. if: • Altered mental status present Abdominal/pelvis CT with IV contrast if: • Signs of abdominal trauma • AST/ALT/Lipase >80 • Positive FAST • UA > 20 RBCs (get delayed CT images) Brain MRI w/o contrast[3] for clinically stable patients with suspected abusive head trauma. Include NAT concern in order "Comments." MRI is an adjunct and should not be used in place of CT scan. Should be used to confirm and further delineate findings on CT, as well as reveal suspected diffuse axonal injury, ligamentous injury of the neck and brain edema.	Social Work [7] Trauma, *if admitted or clinically indicated* Neurosurgery, *as indicated*
36+ months	Standard Labs[1] See injury type table, as needed	Focused imaging based on H&P and evaluation	Social Work[7] Trauma, *as indicated* Neurosurgery, *as indicated*

Clinical Evaluation Footnotes

1. **Standard Labs:** CBC, CMP, lipase, UA (bagged specimen), Coagulation studies (PT/PTT/INR) (Recommendation: strong; Evidence: moderate). Screening Labs that warrant abdominal/pelvis CT with contrast: AST/ALT > 80, Lipase > 80, UA blood > 20. If UA positive for blood but negative for RBCs, order myoglobin.
2. **Skeletal Survey:** All radiographs should be in accordance with the collaborative practice parameter issued by the *American College of Radiology and the Society for Pediatric Radiology and American Academy of Pediatrics*. This study is recommended for all children up to age 24 months and considered in children ages 36 months and older if they have communication impairment or other developmental delays (Recommendation: strong; Evidence: moderate). A **repeat skeletal survey** is indicated in 2 weeks when abuse is suspected on clinical grounds and/or initial findings are abnormal or equivocal. *Radiological examination may be ordered without consent of a child's parent or legal guardian if there is reasonable cause to suspect that an injury was the result of child abuse.*
3. **Brain Imaging:** If abusive head injury is suspected, order Brain CT without contrast for Trauma, which will give 3D reconstructive views (Recommendation: strong; Evidence: strong). This has high specificity and sensitivity for intracranial hemorrhage and can also easily demonstrate cranial and facial fractures. If there are any abnormalities on CT scan, plans for a FULL Brain MRI w/o contrast (**not** a Fast MRI.) should be arranged once clinically stabilized. MRI is the best imaging modality to identify and diagnose diffuse axonal injury and brain edema. Therefore, if CT is normal but there is altered mental status can cannot be attributed to another medical cause, an MRI should be ordered urgently (Recommendation: strong; Evidence: moderate). Please include concerns for NAT under "Comments" Section of such orders.
4. **Admission:** If admitted, must be admitted to a surgical service (i.e., trauma, neurosurgery, orthopedics)
5. **Ophthalmology Exam**: Recommended by the *American Academy of Pediatrics* for any patient < 12 months of age with concerns for abusive head trauma or as per CPT. However, consultation can be delayed until discussion with Child Protection Specialist for patients between ages 12-36 months at the physician's discretion. Should not be used to screen for abusive head injury.
6. **Abusive abdominal trauma:** Evidence of trauma with delay in care (liver function tests may have decreased to normal levels). AST/ALT/Lipase levels >80 and/or UA > 20 RBC's warrant abdominal/pelvic CT with IV contrast to evaluate for injury (Recommendation: strong; Evidence: moderate). If there is concern for renal injury, additional delayed abdominal CT images should be obtained.
7. **Child Protection Team** can be consulted for any questions for any patient in JHACH at any time. This service, however, may differ from the team required to continue work up as an inpatient, since this is determined by the county from which the abuse occurred in. Please discuss any concerns with the Social Worker. **If any JHACH staff person is concerned for suspected child abuse and/or neglect of a patient**, staff should consult Social Work. The Social Work team will **assist** with reporting, coordinating care, and appropriate documentation.

Non-Accidental Trauma Definitions and Evaluation Process

1. Definition of Child Abuse and/or Neglect
   The harm or threatened harm to the child's physical or mental health or welfare by acts or omissions of a parent, adult household member, or any adult responsible for the child's welfare.

2. Definition of Stakeholders
   A. **JHACH Social Worker** - Works as liaison between medical team, patient, family, DCF, CPT, and law enforcement.
   B. **Department of Children and Families (DCF) Florida Abuse Hotline -** Determines whether a report meets criteria to be accepted or not. If report is accepted, then the following stakeholders may have a role in the investigation.
   C. **Child Protection Investigator (CPI) -** A member of the Child Protection Division in the County in which the abuse and/or neglect occurred. The CPI investigates the allegations of child abuse and/or neglect. The CPI collaborates with the designated law enforcement agency when necessary.
   D. **Law Enforcement** – A city or county law enforcement officer will present if the allegations of abuse and/or neglect warrant a criminal investigation.
   E. **Child Protection Team (CPT)** - Group of multidisciplinary providers trained specifically in providing medical examinations, assessments, and family evaluations to assist law enforcement in the investigation and prosecution of child abuse. CPT may present to JHACH for the aforementioned services or schedule a follow up appointment at their local office.

3. Non-Accidental Trauma Evaluation Process at JHACH
   If risk factors for suspected child abuse and/or neglect are present, a Social Work consult will be initiated. The following steps will occur:
   A. JHACH Social Worker will complete an assessment of the patient and family and collaborate with the medical team regarding medical findings concerning for non-accidental trauma.
   B. If there is suspected child abuse or neglect, JHACH Social worker will make a report to the Department of Children and Families Florida Abuse Hotline where a hotline counselor will determine whether the case meets statutory criteria for DCF investigation.
   C. If the report is accepted, the case is referred to the Child Protection Division and the case is assigned to a Child Protection Investigator (CPI) in the County that the abuse and/or neglect occurred. If the abuse and/or neglect occurred outside of Pinellas County and the child is here at JHACH the primary county may request that a Pinellas County CPI do a courtesy face-to-face visit with patient and family.
   D. JHACH Social Worker will facilitate communication between JHACH medical team and all stakeholders regarding the investigation and disposition. JHACH SW documents whether a CPI must provide clearance prior to patient's discharge. An FYI flag will be placed in patient chart with updated information.
   E. When a patient is medically cleared in the EC and there is CPI involvement, JHACH social worker will attempt to contact CPI and determine response time of CPI. JHACH care team and JHACH social work can discuss if patient can have follow up investigation at home.
   F. If CPI presents to JHACH for investigation, CPI will identify the appropriate individual for the patient to be discharged.

G. If patient is admitted to the hospital for further evaluation and care, it must be to a surgical service.
H. Most cases of suspected child abuse or neglect that are being investigated by Pinellas County CPI will automatically generate a Child Protection Team referral by assigned CPI. However, referral should be confirmed with the JHACH Social Work team. If referral is needed, it will be placed by primary surgical service.
I. JHACH Social Worker will communicate necessary updates regarding the patient and the investigation. The CPI communicates directly with the family regarding case updates. Law enforcement may be involved, if the allegations of abuse and/or neglect warrant a criminal investigation and they may present to JHACH at any time.
J. JHACH Social Worker will provide necessary information regarding patient visitation, custody, and with whom medical information may be discussed. An FYI flag will be placed in patient chart with updated information.
K. If patient is not evaluated within 24 hours of arrival to the hospital by the CPT, please call the CPT and discuss patient evaluation and management with team to ensure they are aware of patient. Please place consultation order in EPIC if indicated.

For any process concerns, please discuss with JHACH Social Worker and/or reference the JHACH Clinical Policies and Practice Guidelines Handling of Child and Adult Victims of alleged or Suspected Abuse, Neglect, or Abandonment (Policy # CLNPOL03).

Disposition

Disposition Scenarios

1. Patient is screened and found to have no evidence of injury or concern for suspected child abuse and/or neglect and can be discharged home.
2. Patient is screened and found to have evidence of injury or concern for suspected child abuse and/or neglect and is medically cleared for discharge. JHACH Social Work will obtain clearance for discharge from assigned CPI, when able. Patient requires close follow-up from outpatient services (i.e., appointment with CPT, repeat skeletal survey in 2 weeks, close orthopedic follow-up, complicated psychosocial circumstances). Disposition will be determined by CPI.
3. Patient has injuries that are concerning for suspected child abuse and/or neglect and is admitted to the hospital.

Inpatient Checklist

Medical

1. Admission: Trauma patients must be admitted to a surgical service. Patients with multisystem trauma or incomplete workup for non-accidental trauma must be admitted to the General Surgery service. Patients will remain on a surgical service until acute trauma issues are addressed, typically a minimum of 24 hours.
2. Laboratory studies:
    1. Have all the necessary laboratory studies been ordered?
    2. Have all abnormal values been addressed?
    3. Were any additional studies required by the CPT?
3. Radiology Studies:
    1. Have all necessary radiology studies been ordered?
    2. Have all injuries been addressed?
    3. Do they require follow up?
4. Consultations: Discuss with CPT for specific ongoing needs.
    1. Neurosurgery
    2. Ophthalmology
    3. Orthopedics
5. Be sure to review all histories and physical exams in notes for accuracy.

Social

1. Identify JHACH Social Worker who will be following patient.
2. Communicate any new medical findings to the assigned JHACH Social Worker, so that this information can be provided to the appropriate stakeholders in the investigation.
3. JHACH Social Worker will communicate necessary updates in regard to the patient and the investigation. Law enforcement may be involved, if the allegations of abuse and/or neglect warrant a criminal investigation and they may present to JHACH at any time.
4. JHACH Social Worker will provide necessary information regarding patient visitation, custody, and with whom medical information may be discussed.
5. JHACH Social Worker will place an FYI Flag in EPIC to provide basic information and inform care team of DCF involvement.

Discharge

1. At the time of Discharge, follow up appointments will be listed on the After Visit Summary.
2. JHACH SW will provide a copy of the After Visit Summary to CPI or DCF case manager, upon request.

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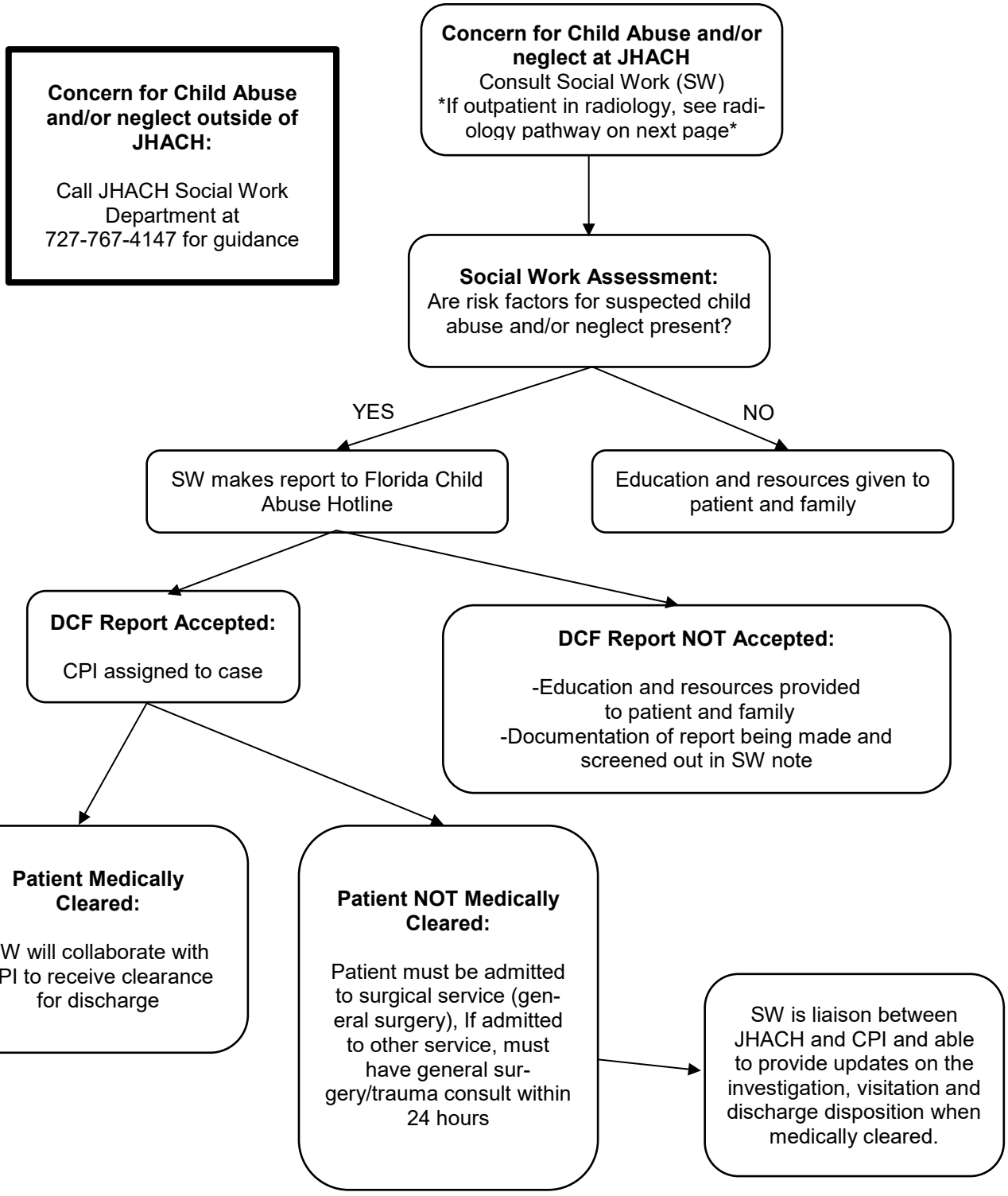
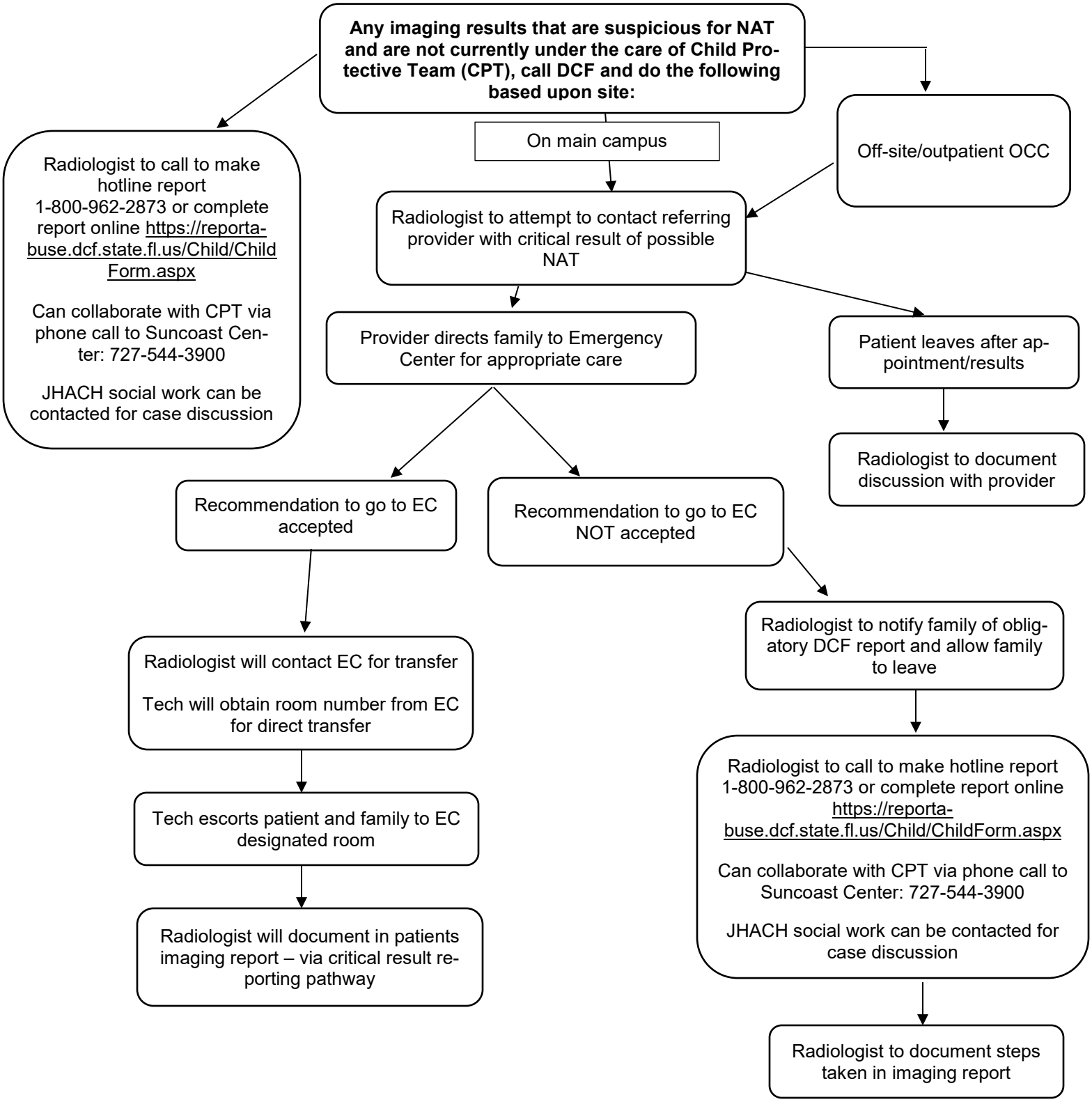
Suspected Child Abuse/Neglect Pathway



Pathway for Suspicion of Non-Accidental Trauma (NAT) in Outpatient Radiology



Patient Status

- Observation status: The patient should be placed under Observation status if expected length of stay is less than 24 hours, or no formal CPI involvement.
- Inpatient status: The patient should be placed under Inpatient status for length of stays expected to be greater than 24 hours, including objective evidence of injury, and formal CPI/SW involvement.

Documentation/Coding

- Document the acuity, character, laterality and location of all injuries (i.e., acute, non-displaced right parietal skull fracture)
- Document any co-morbidities or circumstances that necessitate hospital admission (i.e., frequent neuro checks, IV pain medication, surgical intervention, etc.)
- Code suspected or confirmed abuse, consider ICD-10 Codes:
    - ❖ Child neglect or abandonment, confirmed, initial encounter T74.02XA
    - ❖ Child neglect or abandonment, suspected, initial encounter T76.02XA
    - ❖ Child physical abuse, confirmed, initial encounter T74.12XA
    - ❖ Child physical abuse, suspected, initial encounter T76.12XA

Outcomes

1. For NAT admission from the JHACH age <12 months, percent that have a complete lab evaluation (CBC, CMP, amylase, lipase, UA)
2. For NAT admission from the JHACH age <12 months, percent that have complete imaging evaluation (head CT, skeletal survey)
3. For NAT admission from the JHACH age <12 months, percent that have a trauma consult within 24 hours of admission
4. For NAT admission from the JHACH age <12 months, percent that are admitted to surgical service
5. For NAT admission from the JHACH age 12-24 months, percent that have a complete lab evaluation (CBC, CMP, amylase, lipase, UA)
6. For NAT admission from the JHACH age 12-24 months, percent that have complete imaging evaluation (skeletal survey)

Order Set

Order set currently in EPIC: Peds ED Non-Accidental Trauma - JHH-BMC-ACH.

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Physical Child Abuse Clinical Practice Guideline

Johns Hopkins All Children's Hospital

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Disclaimer

Clinical Pathways are intended to assist physicians, physician assistants, nurse practitioners and other health care providers in clinical decision-making by describing a range of generally acceptable approaches for the diagnosis, management, or prevention of specific diseases or conditions. The ultimate judgment regarding care of a particular patient must be made by the physician in light of the individual circumstances presented by the patient.

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ADDENDUM#1 **Adapted from CLNPOL030*

Risk Assessment for Possible Child Abuse and/or Neglect

	Consult Social Work **Risk assessment will be completed by Social Work to determine if Hotline report should be made**	**Consult Social Work** **Risk assessment will be completed by Social Work to determine if Hotline report should be made**	**Consult Social Work at the discretion of the physician.**
Skull Fractures	* Complex fractures with inconsistent history * Depressed skull fractures with inconsistent history * Multiple fractures or fractures which cross suture lines *Skull fracture with intracranial hemorrhage and inconsistent history—	* Linear fractures in children under 15 months with inconsistent history * Linear fractures associated with other injuries, at the discretion of the physician	* Linear fractures * Fractures with a verifiable mechanism
Upper Extremities	* Scapula fractures * Humerus fractures, child < 15 months * "Corner" or "bucket handle" fractures	* Spiral fractures of humerus, > 15 months * Humerus, radius and ulna fractures associated with other injuries * Radius/ulna fractures < 15 months * Metacarpal/phalangeal fractures, < 15 months without external evidence of trauma	Other upper extremity fractures (e.g. older children)
Ribs & Spine	* Lateral and posterior rib fractures <age 5 * Sternum fractures * Vertebral fractures	* Clavicle fracture in infant >1 month & <15 months * Clavicle fracture, medial 1/3 * Pelvis fracture if history is uncertain	Other fractures of the trunk
Lower Extremity	* Femur fractures < 15 months * "Corner" and/or "bucket handle" fractures	* Metatarsal fractures <4 years old * Femur fractures >15 months and <= 4 years, no witness other than caretaker * Tibia/fibula fractures in non-ambulatory infants * Fractures associated with other injuries	Other lower extremity fractures
Bruises	* All bruises with a handprint or fist pattern * All bruises which suggest an object; whip, belt, stick, buckle, cord, etc.	* Bruises in non-ambulatory infants * Bruises that involve soft areas instead of the usual bony prominences * Bruises with linear and/or petechial components	Other bruises that raise concern (e.g. large, multiple, etc.)
Burns	* Pattern burns (except palm burns from stove top burner) e.g. grid, flame * Pattern burns from iron or curling iron of the dorsum of hand, back, or buttocks * Circumferential burns of hand or feet: stocking/glove patterns	* Burns possibly caused by a cigarette * Hot liquid burns > 3 cm diameter. (Accidental scald burns usually have a V shape as the liquid cools and flows with gravity.) * Burns with poor or no history, or involving neglect * Other, non-glancing iron or curling iron burns * Bilateral burns e.g. both hands, both feet	Other burns that raise concern (e.g. large, multiple. etc.)
Other	* Parafalcine subdural hematomas * Blunt abdominal and/or chest trauma (except as above) without verifiable cause * Adult bite marks (inter-canine distance >3 cm or arch width >4 cm) * Catastrophic injury with history of routine fall * Delay in seeking care for a serious injury * Anything suggesting abusive head trauma (unexplained altered state of consciousness, intracranial hemorrhage, retinal hemorrhage)	* Apparent life-threatening injury in which the history is not clear or social factors seem to be present * Hair loss/baldness related to trauma * Fictitious illness suspected * History changes in the course of the work-up * Caretakers appear incompetent or under the influence of substances * Failure to thrive (primarily non-organic) * Repeat injuries or repeat ingestions * Injury is attributed to another child, related or non-related (Other than common minor household injuries)	At the discretion of the physician

ADDENDUM #2 Appointment Follow Up Worksheet, use as needed.

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Patient Follow-Up Recommendations for Child Protective Investigators

Discharge Date:

Patient's Name: DOB:

Child Protective Investigator: Phone: Fax:
JHACH Social Worker: Phone: Fax:

Follow-up appointments:

☐ Primary physician:	Date:	Time:	Location:
☐ Radiology:	Date:	Time:	Location:
☐ Lab/bloodwork:	Date:	Time:	Location:
☐ Neurosurgery:	Date:	Time:	Location:
☐ Ophthalmology:	Date:	Time:	Location:
☐ Trauma surgery:	Date:	Time:	Location:
☐ Orthopedic surgery:	Date:	Time:	Location:
☐ Plastic surgery:	Date:	Time:	Location:
☐ Child Protection Team (CPT):	Date:	Time:	Location:

Completed by: Date:
Title: Department: