Victorian Forensic Paediatric Medical Service (VFPMS)
Medical Report Template

Letterhead

Contact numbers – phone / fax / email

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

Date (report dictated and 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

Acknowledgement of Code of Conduct

Reason for Medical Assessment

Site and time of assessment(s)

Consent

Observers

Sources of information

Presenting complaint

Past Medical History

Psychosocial information (including genogram and family medical history)

Examination findings

Forensic Specimen Collection

Medical Investigations and interpretation

Medical Management

Information sharing

Limitations to opinion

OPINION

Recommendations

Signature

+/- Jurat

INSTRUCTIONS

INFORMATION TO PROVIDE USING VFPMS REPORT TEMPLATE

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Code for report (for your records eg include Dr's and typist initials)

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Report prepared for
Title, Name
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RE Name: full name and also-known-as names.
(also provide variations in spelling, if any)
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
(approximately ½ page maximum)

Reason for Medical Assessment
Who requested the medical evaluation, and why (1-2 sentences)

Acknowledgement of Code of Conduct

In Victoria include as follows (note, modify "he" to "she" if you are female)

> **EXPERT WITNESS CODE OF CONDUCT**
> This report has been prepared in accordance with the **Practice Direction for Expert Evidence in Criminal Trials** as approved by the judges of the Supreme Court and of the County Court of Victoria. The author acknowledges that he has read this code and agrees to be bound by it.

The author declares that, at the time of preparation of this report, he has made all the inquiries and considered all the issues which the author believes are desirable and appropriate, and that no matters of significance which the author regards as relevant have, to the knowledge of the author, been withheld.

The opinion expressed is based on the sources of information listed in this report. Should, however, additional information become available that might have a bearing on the author's conclusions, the author retains the right to modify the opinion expressed.

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

Who provided consent and for what procedures?
Time, date, manner, use of what consent forms (eg VFPMS mature minor consent form)
Details of how consent was obtained and by whom
Note if consent was given to obtain information from other professionals

Observers

Who, for what part of assessment / examination?
Document when and how assistance was provided

Sources of information

Full details of all people who provided information, (face-to-face conversations, telephone conversations, email and letters, diary entries, drawings, images captured on mobile phones etc)
Reports – medical and others
Medical files and hospital records
Investigations and reports/correspondence/opinions obtained from other professionals

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 person)
Who did what to whom?
Where?
When?
What symptoms occurred at what time(s)?
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)
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

Psychosocial information (including genogram and family medical history)

Genogram and family history – medical and psychosocial information
Medical
- Family history of medical conditions
- Ask specific questions in relation to trauma if subject has physical injury

Psychosocial
- History of subject's transitions between care-givers – when, why?
- Subject's prior involvement with Child Protection (chronology of past reports, investigations and outcomes)
- Full details of current Children's Court orders and expiry dates

Specific questions related to alleged assault

Since alleged assault has patient (as appropriate to nature of alleged assault)

- Voided?
- Defecated?
- Eaten?
- Drunk?
- Changed clothing?
- Changed sanitary products?
- Showered or bathed?
- Had sexual intercourse? (and had sexual intercourse in preceding week)

(if so, what?, when? any additional symptoms?)

Note specific questions about symptoms and signs should be asked in relation to possible

- significant blood loss (including loss into tissues and extravascular spaces)
- head injury
- strangulation
- drug and alcohol use
- suspected ingestion of foreign substance

Examination findings

Appearance and demeanour, cooperation, affect, clarity of speech, movements
Odour, state of clothing, cleanliness
Orientation and mentation (mini mental state exam if required), memory
Quality of interpersonal interactions and engagement, eye contact
Measure height, weight and head circumference, plot on growth charts, record percentiles
Describe clothing, jewellery
Record general exam findings – systems and ear, nose, throat, mouth
thoroughly examine 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? Who took them?
Special photographic techniques?
If possible include information about where the images are located.

Specimen Collection for Forensic analysis

Use proforma to document the full list of all specimens

- Drop sheet
- Debris
- Clothing (one item per bag)
- Wet and dry swabs and slides (one site on body per envelope)
- Swabs and slides
- Swabs alone
- Buccal swab for victim DNA (outside of FMEK)
- 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 (rarely collected these days)
Swabs in special medium (chlamydia, gonococcus)
Full blood examination

Clotting studies (provide information about exact what tests were ordered)
Other blood tests (list)
Radiology (list)

Medical Management
Treatment
Prescriptions and medications prescribed and/or dispensed
- Morning after pill / Post coital contraception
- Antibiotics as prophylaxis for sexually transmissible infection

Specialist referral (who, where? what opinion and treatment is sought?)
Planned review and medical follow up – document your case management plan

Information sharing
Information provided to investigators (Who? When? What?)
Information provided to subject's healthcare provider(s)
Information provided to subject and care-givers

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)

Jurat with witness details (for court report)
I hereby acknowledge that this statement is true and correct and I make it in the belief that a person making a false statement in the circumstances is liable to the penalties of perjury.

Signature
Typed name and title
Contact details of author
Date signed

Witnessed by (name) at (place) on (date and time) + stamp