CANTS 65-A
Revised 10/2010

State of Illinois
Department of Children and Family Services

Referral Form for Medical Evaluation of a Physical Injury to a Child

Child's Name:	Date of Referral:
Case #:	Parent's Name:
Caretaker's Name:	Caretaker's Relationship:
DCFS Contact:	Telephone:
	Fax:
Supervisor:	Telephone:

Dear Medical Provider:

As part of a pending investigation of child abuse or neglect conducted in pursuant to the Department of Children and Family Services Act [20 ILCS 505/1 *et seq*.] and the Abused and Neglected Child Reporting Act [325 ILCS 5/1 *et seq.*], the parents of the above child have been directed to bring the child for evaluation and treatment. The following injury or injuries and concerns have been noted:

_____

_____

_____

In addition to the injury or injuries the following concerns have been noted:

☐ Domestic Violence ☐ Substance Abuse ☐ Mental Illness

The parent/caretaker provided the following explanation or explanations of the injury or injuries.

_____

_____

_____

_____

Please complete the sections on the reverse side of this form, and contact me at the above telephone number to discuss the results of your examination relevant to the factors checked, or any other information you have found. In addition, please contact me if I can provide any additional information to you that would be helpful to you in your examination or determination.

Please respond by _____

Sincerely,

_____
Investigation Specialist

Over

I. Explanation of the injury or injuries provided by the parent/caretaker:

_____

_____

_____

_____

_____

II. Please note if any of the following risk factors are present:

☐ Injury in non-cruising infant ☐ Unexplained injury

☐ Changing explanation of injury ☐ Un-witnessed injury

☐ Explanation may be inconsistent with the injury

☐ Explanation may be inconsistent with the child's abilities

☐ Other information seems to contradict explanation for the injury:

_____

_____

_____

☐ Delay in seeking treatment ☐ Injury shaped like an object, hand or pattern

☐ Various stages of healing of injuries ☐ Multiple injuries

☐ Bruises on non-prominent areas ☐ Prior injuries

☐ Missed medical appointments/missed follow-up treatment

☐ Other:

_____

_____

_____

III. Additional injuries or concerns:

_____

_____

_____

_____

Physician's Signature Date

_____

Physician's Name (Printed) Telephone Fax

_____

Street Address, City, State, Zip Code