Att 2.2.3b

LDSS-2221-A (Rev. 9/2002) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

REPORT OF SUSPECTED CHILD ABUSE OR MALTREATMENT

Report Date	Case ID	Call ID
Time AM/PM :	Local Case #	Local Dist/Agency

SUBJECTS OF REPORT

List all children in household, adults responsible and alleged subjects.

Line #	Last Name	First Name	Aliases	Sex (M, F, Unk)	Birthday or Age Mo/Day/ Yr	Ethnic Code	Relation Code	Role	Lang.
1.									
2.									
3.									
4.									
5.									
6.									
7.									

☐ MORE

List Addresses and Telephone Numbers (Using Line Numbers From Above)	(Area Code) Telephone No.

BASIS OF SUSPICIONS

Alleged suspicions of abuse or maltreatment. Give child(ren)'s line number(s). If all children, write "ALL".

____ DOA/Fatality	____ Child's Drug/Alcohol Use	____ Swelling/Dislocation/Sprains
____ Fractures	____ Poisoning/Noxious Substances	____ Educational Neglect
____ Internal Injuries (i.e. Subdural Hematoma)	____ Choking/Twisting/Shaking	____ Emotional Neglect
____ Lacerations/Bruises/Welts	____ Lack of Medical Care	____ Inadequate Food/ Clothing/Shelter
____ Burns/Scalding	____ Malnutrition/Failure to Thrive	____ Lack of Supervision
____ Excessive Corporal Punishment	____ Sexual Abuse	____ Abandonment
____ Inappropriate Isolation/Restraint(Institutional Abuse Only)	____ Inadequate Guardianship	____ Parent's Drug/Alcohol Misuse
____ Inappropriate Custodial Conduct(Institutional Abuse Only)	____ Other specify) ____	

State reasons for suspicion, including the nature and extent of each child's injuries, abuse or maltreatment, past and present, and any evidence or suspicions of "Parental" behavior contributing to the problem.

(If known, give time/date of alleged incident)
MO
DAY
YR

The Mandated Reporter Requests Finding of Investigation ☐ YES ☐ NO

CONFIDENTIAL SOURCE(S) OF REPORT *CONFIDENTIAL*

NAME	(Area Code) TELEPHONE	NAME	(Area Code) TELEPHONE
ADDRESS		ADDRESS	
AGENCY/INSTITUTION		AGENCY/INSTITUTION	

RELATIONSHIP (✓ = REPORTER, X = SOURCE)

___ Med. Exam/Coroner ___ Physician ___ Hosp. Staff ___ Law Enforcement ___ Neighbor ___ Relative ___ Instit. Staff
___ Social Services ___ Public Health ___ Mental Health ___ School Staff ___ Other Specify)

For Use By Physicians Only	Medical Diagnosis on Child	Signature of Physician who examined/treated child X	(Area Code) Telephone No.
	Hospitalization Required: ☐ None ☐ Under 1 week ☐ 1-2 weeks ☐ Over 2 weeks		

Actions Taken Or About To Be Taken
☐ Medical Exam ☐ X-Ray ☐ Removal/Keeping ☐ Not. Med Exam/Coroner
☐ Photographs ☐ Hospitalization ☐ Returning Home ☐ Notified DA

Signature of Person Making This Report	Title	Date Submitted Mo. Day Yr.