

EVALUATION OF MEDICAL NEGLECT OF A CHILD

Child's Name:	Date of Referral:
Child's date of birth:	Date of Report:
Child's age:	SCR:
Parent's Name:	DCFS Contact: Name: Telephone: Fax:
Caretaker's Name:	
Caretaker's Relationship to the Child:	
	Supervisor: Name: Telephone:

Dear Medical Provider:

The Department of Children and Family Services ("DCFS") is authorized by the Abused and Neglected Child Reporting Act ("ANCRA"), 325 ILCS 5/1 *et seq.*, to investigate reports alleging child abuse or neglect. DCFS is investigating a report alleging Medical Neglect of the above named child pursuant to ANCRA and Part 300 titled Reports of Child Abuse and Neglect, 89 Ill. Adm. Code 300.

[Appendix B](#) in Part 300 requires that

[i]t must be verified that the child has/had an untreated health problem, or that a prescribed treatment plan was not implemented. The verification must come from a physician, registered nurse, dentist, or by a direct admission from the alleged perpetrator. It must further be verified by a physician, registered nurse or dentist that the problem or condition, if untreated, could result in serious or long-term harm to the child. 89 Ill. Adm. Code 300. Appendix B (emphasis added).

To assist DCFS in the investigative process, please respond to the following questionnaire by _____

DCFS is committed to "protect the health, safety, and best interests of the child in all situations in which the child is vulnerable to child abuse or neglect, offer protective services in order to prevent any further harm to the child and to other children in the same environment or family, stabilize the home environment, and preserve family life whenever possible." 325 ILCS 5/2.

Sincerely,

Investigation Specialist

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1. What is your relationship to the child named above:

- ☐ Primary care provider
- ☐ Medical subspecialist
- ☐ Physical/occupational/developmental specialist
- ☐ Other _____

2. How long have you provided care for this child? _____

3. Does the child have additional medical providers, subspecialty providers, therapists, etc.? If yes, please list:

Name	Specialty	Hospital System Affiliation	Phone, Fax, Address, Email

4. List medications and treatments prescribed to the child, dosage, frequency and the medical condition for which they are prescribed. Example: Flovent inhaler two puffs twice a day every day for asthma.

5. Does the child have chronic medical condition(s)? If yes, please list the conditions. Example: Asthma

6. Is this a medically complex child? ☐ NO ☐ YES If yes, please explain.

7. In your opinion, has the child been medically neglected? ☐ NO ☐ YES If yes, please provide the reasons for your opinion by marking all that apply.

- ☐ Missed medical appointments/failure to follow up for medical care:
- Purpose of missed medical appointments:
 - Number of missed medical appointments:
- ☐ Failure to provide medication or medical treatments
- ☐ Failure to seek care for acute illness or worsening of a medical condition
- ☐ Other_____

8. What are the consequences of the alleged medical neglect?

- ☐ Worsening of medical condition
- ☐ Preventable ER or hospitalization
- ☐ Poor outcome due to delay in seeking medical care
- ☐ At risk for serious outcome. Explain:_____
- ☐ Other_____

9. Please explain how you identified that the child may be experiencing medical neglect:

10. Did the caregiver provide a reason why medical care was not provided? If yes, please explain.

11. Summarize the child's current medical condition and recommended medical care at this point.

12. Who should DCFS contact for further information regarding this child's medical condition and treatment?

13. Please indicate if you have concerns about any of the following:

- ☐ Physical Abuse
- ☐ Sexual Abuse
- ☐ Neglect (including Nutritional Neglect)
- ☐ Domestic Violence
- ☐ Substance Abuse
- ☐ Mental Health

Physician's Signature

Date

Physician's Name (Printed)

Telephone

Fax

Street Address, City, State, Zip Code