Project Harmony

Child Advocacy Center

General template for our notes:

Clinic Visit

Patient ID #: ***
Date of Exam: ***
Date of Birth: ***
PCP: ***

HISTORY OF PRESENT ILLNESS:
*** is a *** y.o. male/female who ***

PAST MEDICAL HISTORY:

PAST SURGICAL HISTORY:

MEDICATIONS:

ALLERGIES:

IMMUNIZATIONS:

FAMILY HISTORY:

SOCIAL HISTORY:
***

DEVELOPMENTAL HISTORY:
Daycare: ***
School: ***
Grade: ***
Performance: ***
Special needs/delays/supports/concerns: ***

REVIEW OF SYSTEMS:
***

PHYSICAL EXAMINATION:

ASSESSMENT:
***

PLAN:
***

Project Harmony

Child Advocacy Center

HPI Template for sexual or physical abuse (edited as indicated):

*** is a *** y.o. male/female who presents to Project Harmony today for forensic interview and medical examination related to reported concern for sexual abuse. This case was referred by ****. *** with NE DHHS is also involved in this investigation. The NE DHS CAN report from *** states concern for ***

During the pre-interview the caregiver(s) were asked if child knew why they came to Project Harmony today and they stated ***.

Consent for medical treatment was given by *** prior to beginning of forensic interview. I introduced myself to child out in the waiting room and explained to them that they would be getting a checkup when they are done with their interview.

During the forensic interview today, child disclosed ***. This information was verbally reported to myself by ***, forensic interviewer. I did/did not watch the forensic interview today.

*** is examined in the clinic today without any caregivers present. I first met child in the ***. I introduce myself, explain my role, explain the medical exam and try to gather some history. ***

Project Harmony

Child Advocacy Center

Template used for HPI of sexual assault victim:

presents to Project Harmony today for forensic interview and medical examination related to reported concern for sexual abuse. This case was referred by ****. *** with NE DHHS is also involved in this investigation. The NE DHS CAN report from *** states concern for the following ***

During the forensic interview today, child ***

*** is examined in the clinic today without any caregivers present. I introduce myself, explain my role, explain the medical exam and try to gather some history. ***

Project Harmony

Child Advocacy Center

Template used for post assault hygiene questions:

Post-Assault Hygiene/Activity:
Urinated:
Defecated:
Genital or body wipes:
Vomited:
Oral rinse:
Bath/shower/wash:
Brushed teeth/floss:
Ate or drank:
Changed clothing:
Changed underwear/diaper:

Project Harmony

Child Advocacy Center

Template used for additional medical history for strangulation victims:

DETAILED MEDICAL HX R/T STRANGULATION
Situation in which strangulation occurred:
Method of strangulation:
Symptoms the child experienced during and after strangulation:
Current symptoms:
Time elapsed between strangulation episode and presentation to care:
Presence or absence of witnesses:
Presence of any medical conditions that might predispose child to petechiae:
Child's development level:

Project Harmony

Child Advocacy Center

Template used for obtaining additional social history:
Extracurriculars:
Household members:
ETOH self/household use:
Drugs self/household use:
Cigs self/household use:

DEVELOPMENTAL HISTORY:
School:
Grade:
Performance:
Concerns/IEP/Special needs:

MENSTRUAL HISTORY:
LMP:
Menarche:
Frequency:
Duration:
Pads/Tampons:
Concerns:

SEXUAL HISTORY:
History of consensual sexual activity:
Number of partners:
Gender of partners:
Type of sexual contact:
Contraception:
Past STI testing/results:
Past pregnancies or related concerns:
1. Has anyone ever asked you to have sex in exchange for something you wanted or needed (money, food, shelter, or other items)?
2. Has anyone ever asked you to have sex with another person?
3. Has anyone ever taken sexual pictures of you or posted such pictures on the Internet?

MENTAL HEALTH HISTORY:
Previous or existing diagnoses:
Therapy:
Self-harm/suicidal thoughts:
Supports:

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Child Advocacy Center

Template used for ROS:

A comprehensive 10 point review of systems was negative. Denies recent s/s illness. Good sleep. Good I/Os.

No ano-genital concerns reported.
No known hx of UTIs.
Some hx of constipation reported.

Project Harmony

Child Advocacy Center

Template used for post assault review of systems:

A comprehensive 10 point review of systems was negative. Denies recent s/s illness. Denies non-genital pain/bleeding. Good sleep. Good I/Os.

No ano-genital concerns reported; denies genital pain and/or bleeding
No known hx of UTIs.
Hx of constipation reported: ***

Project Harmony

Child Advocacy Center

Template used for ROS for strangulation victims:

A comprehensive 10 point review of systems was negative. Denies recent s/s illness. Good sleep. Good I/Os.
Denies any pain/bleeding before, during, or after event
Denies any pre-existing injuries or skin conditions
Denies difficulty swallowing or breathing
Denies voice changes, headache, dizziness, vomiting, fainting, or sore throat
Denies loss of consciousness or loss of memory

Project Harmony

Child Advocacy Center

Template used for post assault physical exam:

General appearance: normal, alert, cooperative. Adequate hygiene. Seems to have adequate speech/language skills for age.
Face: normal, without dysmorphic features
Head: Normocephalic and atraumatic
Eyes: Pupils: equal, reactive to light. Conjunctiva: normal, clear. Lids: normal. Irises: normal. EOMs: normal. Corneal light reflexes: congruent. Red reflexes intact bilat.
Ears: External canals are WNL, TMs clear with normal landmarks, Pinnae: normal, Hearing: Responds appropriately to conversation in normal tone
Nose: Normal external nose, mucus membranes and septum.
Throat: no erythema, no lesions, no exudate observed. Tonsils ***. No cervical lymphadenopathy noted.
Mouth: Mucousa: pink, moist, no lesions. Tongue: normal, Teeth: normal dentition and gums, no obvious caries noted.Palate: normal, Lips: normal
Neck: normal, supple, no masses, normal ROM
Chest: Normal contour, ***breast development
Respiratory: breathing nonlabored, clear to auscultation in all fields, no cough observed
Cardiovascular: regular heart rate and rhythm, equal pulses bilaterally, no extremity edema
Abdomen: Umbilicus normal. Symmetric with no masses palpable, no organomegaly, bowel sounds normoactive. Abdomen soft and non-tender.
Genitourinary: Cortexflo utilized. Tanner stage *** female who is examined the *** position. There is no abnormality of the mons. The labia majora appear normal. Labial separation is utilized. The labia minora and the posterior fourchette are intact and appear normal. The clitoris appears normal. Labial traction is utilized. The fossa navicularis is intact and appears normal. The urethral meatus is visible, appears normal, and is free of discharge. The hymen is annular; there is a smooth, continuous hymenal surface; there are no visible transections, lacerations, or contusions of the hymen. There are no lesions. There is no malodor. There is no vaginal discharge.
Anus: Normal appearing anal anatomy without tag, tear, fissure or contusion. Normal anal folds and rugae. There are no lesions. There is no anal discharge.

Skin/Hair/Nails: warm and dry; no rashes/lesions, pigment normal, hair and nails normal, turgor normal.
Extremities/Musculoskeletal: normal muscle tone, full ROM, normal gait
Neurologic: age appropriate behavior, interactive, grossly normal for age
Psychiatric: Oriented x 3, appropriate memory recollection, appropriate mood and affect for age.

Evidence collection kit completed (started at ***):
Foreign material sheet:
Outer clothing:
Underwear:
Oral swabs:
Additional evidence swabs:
Alternative light source swabs:
Fingernail swabs (left and right hand):
Mons Pubis swabs/combing:
External genitalia swabs:
Anal/Rectal swabs:
Patient's reference DNA swab:

Sexual assault kit number:
Evidence collection kit completed at *** and handed over to detective *** at ***.

*** present and assisting exam. Child tolerates the exam well and is in no distress.

Project Harmony

Child Advocacy Center

Template used for physical exam portion for strangulation victims:

General appearance: normal, alert, cooperative. Adequate hygiene. Seems to have adequate speech/language skills for age.
Face: normal, without dysmorphic features
Head: Normocephalic and atraumatic
Eyes: Pupils: equal, reactive to light. Conjunctiva: normal, clear. Sclera: normal, clear. Lids: normal, no petechiae. Irises: normal. EOMs: normal. Corneal light reflexes: congruent. Red reflexes intact bilat.
Ears: External canals are WNL, TMs clear with normal landmarks, Pinnae: normal, Hearing: Responds appropriately to conversation in normal tone
Nose: Normal external nose, mucus membranes and septum.
Throat: no erythema, no lesions, no exudate observed. Tonsils ***. No cervical lymphadenopathy noted.
Mouth: Mucousa: pink, moist, no lesions. Tongue: normal, no injury noted. Teeth: normal dentition and gums.Palate: normal, no petechiae or bruising. Lips: normal. Frenula tears: ***
Neck: normal, supple, no masses, normal ROM. Neck size: ***cm
Chest: Normal contour, ***breast development
Respiratory: breathing nonlabored, clear to auscultation in all fields. No distress, cough, stridor, difficulty speaking/swallowing, voice changes, and hemopysis observed.
Cardiovascular: regular heart rate and rhythm, equal pulses bilaterally, no extremity edema
Abdomen: Umbilicus normal. Symmetric with no masses palpable, no organomegaly, bowel sounds normoactive. Abdomen soft and non-tender.
Genitourinary: wnl external *** genitalia
Skin/Hair/Nails: warm and dry; no rashes/lesions, pigment normal, hair and nails normal, turgor normal. No petechiae, bruising, bites, redness, tenderness, or patterned marks noted

Extremities/Musculoskeletal: normal muscle tone, full ROM, normal gait
Neurologic: age appropriate behavior, interactive, grossly normal for age. No behavioral change, irritability, or lethargy noted.
Psychiatric: Oriented x 3, appropriate memory recollection, appropriate mood and affect for age.

ALS findings: ***

Photos taken include:
Full body
Close-up
Face
Head/Scalp
Neck
Chest
Mouth
Eyes
Demonstration of strangulation
Other injuries: ***

*** present and assisting exam. Child tolerates the exam well and is in no distress.

Project Harmony

Child Advocacy Center

Template used for obtaining physical exam portion of our infant exams:

General appearance: normal, spontaneous movement, no distress. Adequate hygiene.
Face: normal, without dysmorphic features
Head: Normocephalic and atraumatic, fontanelle soft and flat
Eyes: Pupils: equal, reactive to light. Conjunctiva: normal, clear. No discharge. Lids: normal without edema. Irises: Normal. Corneal light reflexes: congruent. Red reflexes intact bilat.
Ears: External canals are WNL, TMs clear with normal landmarks, Pinnae: Normal, Hearing: loud noise elicits startle reflex
Nose: Normal external nose, mucus membranes and septum. Nares patent bilaterally.
Throat: no erythema, no lesions, no exudate observed.
Mouth: Mucousa: pink, moist, no lesions. Tongue: normal, Teeth: *** dentition and gums, Palate: Normal, Lips: Normal
Neck: normal, turns easily side to side, some head control present
Chest: Normal contour, symmetric
Respiratory: breathing nonlabored, no intercostal retractions or use of accessory muscles, clear to auscultation in all fields, no cough observed
Cardiovascular: regular heart rate and rhythm without murmur
Abdomen: Umbilicus normal. Symmetric with no masses palpable, no organomegaly, bowel sounds normoactive. Abdomen soft and non-tender.
Genitourinary: Tanner stage *** female, normal external genitalia. Tanner stage *** male, circumcised with bilateral descended testes
Lymphatic: No lymphadenopathy appreciated
Skin/Hair/Nails: warm and dry; no rashes/lesions, pigment Normal without jaundice, hair and nails Normal, turgor normal; mongolian spots present to mid lower back; cradle cap on scalp; infant acne on face; milia on bilateral cheeks, chin, and nose
Extremities/Musculoskeletal: FROM of all joints, no hip click noted, equal and bilateral movement and tone, grasp reflex present, negative Barlow and Ortolani
Neurologic: age appropriate behavior, alert with cares, normal reflexes
***, RN, present and assisting exam. Child tolerates the exam well and is in no distress.

Project Harmony

Child Advocacy Center

Template used for obtaining physical exam portion of our foster care exams:

General appearance: normal, alert, cooperative, healthy, smiling. Adequate hygiene. Seems to have adequate speech and language skills for age.
Face: normal, without dysmorphic features
Head: Normocephalic and atraumatic
Eyes: Light Reflex: Normal, Pupils: equal, round, reactive to light, Sclera: normal, clear
Ears: TMs: external canals are WNL, TMs clear with normal landmarks and Pinnae: Normal
Nose: Normal external nose, mucus membranes and septum.
Throat: no erythema or exudates noted.
Mouth: Tongue: normal tongue and buccal mucosa, Teeth: normal dentition and gums, no obvious caries. Palate: Normal
Neck: normal, supple, no lymphadenopathy
Chest: Normal
Lungs: breathing nonlabored, no intercostal retractions or use of accessory muscles, clear to auscultation in all fields
Heart: regular rate and rhythm without murmur
Abdomen: soft, non-tender. Bowel sounds normal. No masses, no hepatosplenomegaly, no abdominal wall hernias
Back: symmetric, no curvature. ROM normal.
Genitalia: genitalia not examined
Skin/Hair/Nails: warm and dry; no rashes
Extremities/Musculoskeletal: normal muscle tone, no bowing present, full ROM, normal gait
Neurologic: age appropriate behavior, interactive and playful.
***, RN present and assisting with exam. Child tolerated exam well and was in no distress. Growth parameters noted and are appropriate for age

Project Harmony

Child Advocacy Center

Template used for GU Male Exam portion:

Genitourinary: Cortexflo utilized. Tanner stage *** circumcised male who was examined in the *** position. Testes are descended bilaterally and palpable in the scrotum. No testicular masses appreciated. No evidence of injury noted upon the glans, penile shaft, or scrotum. No lesions. No discharge.
Anus: Normal appearing anal anatomy without tag, tear, fissure, or contusion. Normal anal rugae. No anal lesions or anal discharge. Some stool debris

Project Harmony

Child Advocacy Center

Template used for notifying social worker at primary care office that child entered foster care:

This child has been placed into Foster Care, and will be needing a followup appointment in the next 30 days with their PCP. Other concerns noted from their initial foster care exam include: ***
Please contact the DHHS Worker for consents.
NE DHHS worker = *** (name/phone)
PromiseShip Worker = *** (name/phone)
Foster Caregiver = (name/phone)

Project Harmony

Child Advocacy Center

Template used for assessment/plan of strangulation victims:

ASSESSMENT:

1. Child disclosed physical abuse, which included strangulation. Injuries are consistent with child's disclosure. Had the strangulation incident persisted, or lasted for longer duration, *** could have suffered serious health consequences, even including death. A history of abuse/neglect places child at significant risk of long-term mental health and physical health complications.

PLAN:

1. CPS and LE staff notified of exam results
2. Photos taken in the clinic
3. Initiate therapy with a trauma-informed provider, as directed by advocacy staff
4. Routine home cares and contact Project Harmony with any questions or concerns.
5. Discharge instruction paperwork reviewed and given to caregiver. Follow up appointment suggested with PCP in 1-2 weeks

60 minutes time spent face-to-face, >50% of time spent on counseling / care coordination.

Project Harmony

Child Advocacy Center

Template used for assessment/plan of foster care exams:

ASSESSMENT:
1. Suspected Child Neglect. A history of neglect places child at significant risk of long-term mental health and physical health complications.
2. Foster care status
3. Tooth decay/Dental caries
4. Impaired vision
5. BMI = *** % for age

PLAN:
1. Finger stick for Hemoglobin completed in clinic today, results =
2. Vision screen completed in clinic today, results =
3. Increase physical activity, eliminate all sugary beverages (juice, soda etc.), offer well-balanced diet with ample veggies and lean protein sources, limit foods/snacks high in calories/carbs, restrict milk to 1-2 glasses per day, encourage water

RECOMMENDATIONS/REFERRALS:
1. See PCP in apx. 30 days for comprehensive exam to reestablish care.***Referral made to Foster Care Clinic at Children's Hospital, follow up with PCP as directed by them.
2. PCP to update immunizations if needed.
3. If placement is stable, referral to Children's HEROES weight-management clinic can be considered
4. Evaluation by Early Development Network recommended for ***
5. Therapy with a trauma-informed provider is indicated and should be reinitiated in a timely manner
6. Pediatric eye exam needed every 12 months
7. Pediatric dental exam needed now and then every 6 months; most first exams done between the ages of 1-3 years old

60 minutes time spent face-to-face, >50% of time spent on counseling / care coordination.

Project Harmony

Child Advocacy Center

Template used for assessment and plan of sexual assault victim:

1. *** who disclosed being a victim of sexual abuse. A history of sexual abuse places this child at significant risk for long-term mental health and physical health complications.
2. Normal ano-genital examination. A normal ano-genital examination neither confirms nor excludes the possibility of sexual abuse.

PLAN:

1. Education and reassurance provided to child and caregiver. CPS and LE staff notified of exam results.
2. Initiate therapy with a trauma-informed provider trained in sexual abuse, as directed by advocacy staff
3. Routine home cares and contact Project Harmony with any questions or concerns.

60 minutes time spent face-to-face, >50% of time spent on counseling / care coordination.

Project Harmony

11949 Q St. Omaha, NE 68137
402-595-1326

Thank you for taking care of: _____
Date of Birth: _____

Medicaid #: _____

Primary Care Provider (PCP): _____
Address: _____
Phone #: _____

CHILD'S KNOWN MEDICAL HISTORY/MEDICATIONS:

Special Instructions:
All children entering Foster Care need to have timely physical, dental, and eye exams. Additionally, children entering foster care are often in need of therapy and/or an early development assessment.

- ☐ Child did have an exam at Project Harmony. Follow-up with PCP within the next month to determine if child has immunization, wellness, or other health care needs.
- ☐ Child did NOT have an exam at Project Harmony. Please call Project Harmony at (402) 595-1326, on the next business day, to schedule a medical foster care exam with a provider at Project Harmony.
- ☐ Child did NOT have an exam at Project Harmony. Please call the child's PCP to schedule a medical foster care exam.

Please contact Project Harmony or child's assigned case worker with any questions. Referrals for eye, dental, primary care, therapy, and/or developmental evaluation can be provided.

Project Harmony
Child Advocacy Center

HEALTH HISTORY

Full Name	Preferred Name	Birthdate	Today's Date

Personal Medical History

- ☐ Allergies
- ☐ Anemia
- ☐ Asthma
- ☐ Behavioral, emotional, psychiatric problems (ADD/ADHD, depression)
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chest Pain
- ☐ Chronic Cough
- ☐ Chronic Diarrhea
- ☐ Constipation
- ☐ Cystic Fibrosis
- ☐ Diabetes
- ☐ Dizziness/fainting
- ☐ Eating Disorder
- ☐ Eczema/other skin problems
- ☐ Frequent exposure to tobacco smoke
- ☐ Frequent headaches
- ☐ Frequent infections (MRSA, TB, etc.)
- ☐ Frequent stomachaches
- ☐ GERD
- ☐ Heart murmur
- ☐ Heart palpitations (irregular heart beat)
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Incontinence
- ☐ Joint/muscle/bone problems
- ☐ Kidney/bladder problems
- ☐ Liver problems
- ☐ Menstrual problems
- ☐ Past abuse or neglect
- ☐ Phlebitis (blood clots)
- ☐ Pneumonia
- ☐ Rash/hives
- ☐ Seizures/convulsions
- ☐ Sexually transmitted infections
- ☐ Sickle cell disease/trait
- ☐ Sleep problems
- ☐ Thyroid Disease
- ☐ Other: _____
- ☐ Other: _____

Current Medications

Drug Allergies

Environmental Allergies

Hospitalizations and Major Surgeries

Reason	Year/Age	Reason	Year/Age

Family History

	Father	Mother	Siblings	Other	Describe		Father	Mother	Siblings	Other	Describe
Congenital Heart Disease	☐	☐	☐	☐		Mental Illness	☐	☐	☐	☐	
High Blood Pressure	☐	☐	☐	☐		Kidney Disease	☐	☐	☐	☐	
High Cholesterol	☐	☐	☐	☐		Bleeding Disorder	☐	☐	☐	☐	
Alcohol Abuse	☐	☐	☐	☐		Substance Abuse	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐		Other	☐	☐	☐	☐	
Asthma	☐	☐	☐	☐		Other	☐	☐	☐	☐	
Stroke	☐	☐	☐	☐		Other	☐	☐	☐	☐	

Please List Year of Last

Dentist Exam:	Eye Exam:	Well-child check:

Current

Daycare:	School:

Household Members (Name/Age)

PCP: _____ Up to date on immunizations? (Circle) Yes / No

Any Concerns/Other Information

Project Harmony

Child Advocacy Center

Template used when we completed STI testing (edited as indicated per case):

1. Serum was collected for HIV, syphilis, and hep B evaluation; results are pending at time of discharge. Repeat testing may be considered at standard intervals (syphilis can be repeated at 4–6 weeks and 3 months; HIV testing can be repeated at 6 weeks and at 3 and 6 months s/p sexual contact; if hep B immunity is adequate and antigen is negative, no further hep B testing needed)
2. Urine HCG screen today: NEGATIVE
3. Urine was collected for gonorrhea/chlamydia testing via NAAT; results are pending at time of discharge.
4. Vaginal swab was collected for gonorrhea/chlamydia testing via NAAT; results are pending at time of discharge.
5. Vaginal swab collected for BV/trich/yeast testing; results are pending at time of discharge
6. Throat swab was collected for gonorrhea/chlamydia testing via NAAT; results are pending at time of discharge.
7. Anal swab was collected for gonorrhea/chlamydia testing via NAAT; results are pending at time of discharge.