SOUTH CAROLINA
DEPARTMENT OF SOCIAL SERVICES

SUSPECTED CHILD ABUSE AND NEGLECT REFERRAL
FOR
HEALTH PROFESSIONALS AND MEDICAL FACILITIES

CHILD'S NAME (FIRST, MIDDLE INITIAL, LAST)	SEX	RACE	DATE OF BIRTH	AGE

ADDRESS	TELEPHONE NUMBER	COUNTY OF RESIDENCE
	NAME OF HOSPITAL/MEDICAL FACILITY (IF APPLICABLE)	PATIENT'S RECORD NO. (IF APPLICABLE)

FAMILY INFORMATION

FATHER'S NAME (LAST, MIDDLE INITIAL, FIRST)	AGE	OCCUPATION
MOTHER'S NAME (LAST, MIDDLE INITIAL, FIRST)	AGE	OCCUPATION
GUARDIAN'S NAME (LAST, MIDDLE INITIAL, FIRST)	AGE	OCCUPATION

ADDRESS OF FAMILY IF DIFFERENT FROM CHILD'S ADDRESS	OTHER CHILDREN IN HOME

NAME AND ADDRESS OF INDIVIDUAL WHO BROUGHT CHILD IN	RELATIONSHIP TO CHILD	DOES FAMILY KNOW THIS REFERRAL IS BEING MADE? ☐ YES ☐ NO

REFERRAL INFORMATION

TYPE OF REFERRAL (GIVE DETAIL ON BACK OF FORM)

☐ PHYSICAL ABUSE ☐ SEXUAL ABUSE ☐ ABANDONED ☐ MENTAL INJURY ☐ CHILD NEGLECT

ACTION TAKEN BY HEALTH PROFESSIONAL

☐ CHILD SEEN IN EMERGENCY ROOM TREATED & RELEASED	FACILITY'S NAME	DATE
☐ CHILD SEEN BY PRIVATE PHYSICIAN	PHYSICIAN'S NAME	DATE
☐ CHILD SEEN BY CLINIC	CLINIC'S NAME	DATE
☐ CHILD HOSPITALIZED	HOSPITAL'S NAME	DATE
☐ CHILD REFERRED TO PHYSICIAN/CLINIC FOR FOLLOW-UP	PHYSICIAN/CLINIC'S NAME	DATE
☐ DSS CONTACTED BY TELEPHONE	NAME OF WORKER & AGENCY COUNTY DEPARTMENT	DATE
☐ FAMILY COURT/POLICE CONTACTED	NAME OF FAMILY COURT/POLICE	DATE

☐ X-RAYS TAKEN	DATE	☐ COLOR PHOTOGRAPHS TAKEN BY WHOM ____________	DATE

NAME OF PHYSICIAN OF RECORD (IF ANY)	PHYSICIAN'S ADDRESS

NAME & TITLE OF PERSON MAKING REFERRAL	SIGNATURE	DATE

FORM
DSS 3006
SEPT. 79

DESCRIPTION OF INCIDENT

1. MEDICAL STATEMENT REGARDING EXTENT AND NATURE OF INJURIES TO CHILD: ______

______

______

______

______

______

______

Diagnosis: ______

______

2. DESCRIPTION OF INCIDENT AS GIVEN BY CARETAKER (Time, Place, Who is alleged to have caused the injury). ______

______

______

______

______

______

Will there be continued involvement by your health professionals/clinic/hospital with this child? ☐ Yes ☐ No

3. PREVIOUS INCIDENTS INVOLVING THIS CHILD OR FAMILY (Include dates and type of incident). ______

______

______

______

______

______

Were these previous injuries referred to the Department of Social Services? ☐ Yes ☐ No

INSTRUCTIONS

THIS FORM IS TO BE USED TO TRANSMIT INFORMATION CONCERNING ALLEGEDLY ABUSED AND NEGLECTED CHILDREN TO THE DEPARTMENT OF SOCIAL SERVICES. IT SHOULD BE FORWARDED TO THE COUNTY DEPARTMENT OF SOCIAL SERVICES WHERE THE INVOLVED CHILD RESIDES. THIS FORM DOES NOT TAKE THE PLACE OF PROMPT VERBAL COMMUNICATION TO THE DEPARTMENT OF SOCIAL SERVICES THAT MAY BE NECESSARY TO PROTECT THE CHILD.

1. *Complete all parts of the form which are relevant to your professional area.*
2. *Forward the original to the appropriate County Department of Social Services.*
3. *Retain at least one copy for the patient record.*
4. *Follow—up information on cases can be provided on a case by case basis through the County Department of Social Services.*
5. *Pads of 50 forms each can be obtained by writing the S. C. State Department of Social Services, Attention: Supply, P. O. Box 1520, Columbia, S. C. 29202. Be sure to include:*
   - *(a) the number of pads needed.*
   - *(b) the form number (DSS Form 3006).*
   - *(c) the office or facility's street address.*

NOTE: Forms will be sent UPS.