



PRIMARY CHILDREN'S MEDICAL CENTER
A Service of Intermountain Health Care



INDIAN HEALTH SERVICE CHILD ABUSE PROJECT

SITE VISIT EVALUATION FORM

Medical Provider: _____

Site/facility: _____

Address: _____

Phone: _____ E-mail: _____

Evaluator: _____ Date: _____

1. Location/atmosphere of exam facilities: _____

2. Policies and procedures:

___ Criteria for identification of victims

___ Education/experience requirements for those performing examinations

___ Intake procedures on how to obtain services

___ Forms to be a permanent part of the medical record

___ Detailed description of services provided

___ Scope of treatment available

___ Referral system to be utilized

___ How to obtain case consultation

___ How information will be documented and released (including data collection)

___ Quality improvement activities

___ Other: _____

Comments: _____

3. Patient records:

___ Location secure and confidential

___ Part/not a part of the regular chart

___ Documentation complete with drawings and signed consultation

Comments: _____

4. Interviews with:

___ Law Enforcement (local): _____

___ FBI: _____

___ Victim Advocate: _____

___ Social Services: _____

___ Nursing: _____

___ MDT: _____

___ Participant supervisor: _____

___ Other: _____

Comments: _____

5. Methodology used by medical provider to conduct exams: _____

6. Participation in Grand Rounds: _____

7. Evidence of serving as a resource for families/agencies/community: _____

8. Participant's perspective of project experience: _____

Other comments: _____

Evaluator comments: _____

Certificate of Excellence awarded: ___ Yes ___ No

CDR P. Jane Powers, Project Director

Date