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| **ADT Safe Infant Assessment** |

**Case Number: Case Name:**

 **Assessment Number:**

**Section 1: Assessment Summary**

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| Name: Role:  Refused to be interviewed Unable to be interviewed   |

**Summary of current allegations/Type of maltreatment alleged:**

**Section 2: Safe Infant**

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|  **(INTAKE) Case: (Case Name) Individual:**  |

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| **Safe Infant (check all that apply)** |  |
| **Birth related data**Premature BirthDifficult/problematic deliveryProblems with pregnancyPre-natal careNo pre-natal careMother was physically abused during pregnancyNo information | **Infant was left at:** Police StationFire departmentHospitalEMSStaffed place of worship  |
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| Date Infant was left: |  |
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| **Mother’s Information (check all that apply)****Parent’s Medical**DiabetesAllergiesAsthmaSeizuresCancerHeart diseaseHigh blood pressureMental illnessSexually transmitted diseaseOtherNo information available | **Did the parent do one of the following before or during the pregnancy?** SmokeUse alcoholUse drugs or medicationNo information available  |

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| **Father’s Information (check all that apply)****Parent’s Medical**DiabetesAllergiesAsthmaSeizuresCancerHeart diseaseHigh blood pressureMental illnessSexually transmitted diseaseOtherNo information available | **Did the parent do one of the following before or during the pregnancy?** SmokeUse alcoholUse drugs or medicationNo information available  |

**Notes**

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**Section 3: Child/Youth Assessment (Complete for each child)**

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| **Intake ID: Case: (Case Name) Individual:**  |

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| **Interview**  |
| **Interview** Refused to be interviewedUnable to be interviewed | **Native American**οNo οUnknown οYesοDeclined to disclose  |

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| **Child Physical/Mental Health** (check all that apply)  |
| **Risk Factors** Hearing or vision impaired History of seizuresMedical diagnosis requiring life sustaining measureMedical diagnosis requiring ongoing careMedical issues (asthma, broken arm, severe allergy)Mental health diagnosis ongoing medicationsPhysical disabilityRequires psychotropic meds to function No Risk Factors | **Protective Factors**No physical/mental health issuesReceived care for identified mental health issuesReceives care for identified medical issuesUp to date on immunizations |

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| **Describe child and any factors that need further explanation:** |

**Section 4: Chronology Information**

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| **Investigative Related Data**Report received:Assigned by Supervisor:Inv Worker Received Report: First Attempt to Make Contact:First Face to Face Contact Made with Victim:First FSOS Consultation:  | *mm/dd/yyyy**mm/dd/yyyy**mm/dd/yyyy**mm/dd/yyyy**mm/dd/yyyy**mm/dd/yyyy* |

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| **Roles of Individuals****Interviewed**Alleged PerpetratorAlleged VictimAttorneyClergyCustodial ParentDay Care ProviderEmployerEMS/Fire DepartmentFormer Spouse | Family FriendFamily Support/KamesForensic ConsultationHousehold Member-RelatedHousehold Member Non-RelatedLandlordLaw EnforcementMedical Provider | Mental Health ProviderNeighborNon-Custodial ParentParamour/PartnerRelativeSchool PersonnelNo collateral contactSpouse |
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| **Evidence Collected**Child Care Provider recordsCourt recordsLaw Enforcement recordsDrug Screen | Medical recordsMental Health recordsOther CPS agency records | PhotographsSchool recordsSubstance abuse assessment |

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| **Investigation narrative:** |

**Section 5: Assessment Results**

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| **Outcome** | **Plan** |
| οClose Referral | Prevention Plan |
| οIn home ongoing caseοOut of home ongoing case | Aftercare Plan |

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| **Assessment Conclusion** |