



**Townsville  
Division of  
General  
Practice**

**REPORT OF A REASONABLE SUSPICION OF CHILD ABUSE AND NEGLECT**

**1. DETAILS OF CHILD SUBJECT TO REPORT**

Family name: ..... Given names: .....

Aliases (if know) ..... Sex:  M  F

Address of usual residence .....

Date of Birth: ..... Telephone no: ..... Gestation (if unborn) ..... / 40 wks

Temporary address (if applicable) .....

Indigenous Status:  Aboriginal  Torres Strait Islander  Ethnicity .....

Does the child speak English?  Yes  No

If no, specify the child's preferred language: ..... Is an interpreter required?  Yes  No

Does the child have a disability?  No  Yes If yes, please specify.....

**Parent's details**

Name: ..... Name: .....

Address of usual residence: ..... Address of usual residence: .....

Telephone no: ..... Telephone no: .....

State the child's primary care giver (name and relationship): .....

Are there any relevant orders in place (eg. Child Protection, Domestic Violence)  Yes  No  Unknown

If yes, please specify.....

**2. DETAILS OF CARERS, SIBLINGS, OTHERS LIVING AT THE CHILD'S USUAL RESIDENCE (if known)**

Name (including aliases)	Date of birth / Age	Relationship to child

**3. ABUSE TYPE BEING REPORTED (more than one may be ticked)**

Suspected:  Physical abuse  Emotional abuse  Sexual abuse  Neglect

At risk of:  Physical abuse  Emotional abuse  Sexual abuse  Neglect



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**4. DETAIL OF REPORT (if further space is required please attached additional pages)**

*Provide as much detail as possible about your reasonable suspicion of child abuse and neglect. Include any previous suspicions, concerns or reports. Also include details of any other agencies involved with this family.*

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Has the parent / carer / child been advised of the report to the Department of Child Safety?  
 Yes  No  Unknown If yes, has a referral to a support agency been given to the parent / carer / child (eg. Mental Health Service):  Yes  No Please specify the support agency: .....

**5. DETAILS OF PERSON ALLEGEDLY RESPONSIBLE FOR HARM OR RISK OF HARM TO CHILD (if known)**

Name (including aliases): .....	
Address of usual residence: .....	Age / Date of birth: .....
.....	Telephone no: .....
.....	Relationship to child: .....

**6. DETAILS OF CONTACT WITH THE DEPARTMENT OF CHILD SAFETY**

Name of authorised DChS officer: .....  
DChS Service Centre: .....  
Date reported: ..... Time reported: ..... Fax No: .....

**7. DETAILS OF STAFF MEMBER MAKING REPORT**

Reporting officer's name: .....  
Reporting officer's position: .....  
Clinical / Professional stream:  
Nursing Allied health (specify): .....  
Medical Health worker Other (specify): .....  
Signature of reporting officer: ..... Telephone no: ..... Date: .....

Send to: Northern Zone - Department of Child Safety  
Telephone: (07) 4799 7943  
Facsimile: (07) 4721 1936