SUSPICIOUS INJURY REPORT

STATE OF CALIFORNIA
California Office of Emergency Services

Cal OES 2-920

Confidential Document

Penal Code Section 11160 requires that if any health practitioner, within their scope of their employment, provides medical services for a wound or physical injury inflicted as a result of assaultive or abusive conduct, or by means of a firearm, shall make a telephone report immediately or as soon as possible. They shall also prepare and submit a written report within 2 working days of receiving the information to a local law enforcement agency. This is the official form (Cal OES 2-920) for submitting the written report.

This form is used by law enforcement only and is confidential in accordance with Section 11163.2 of the Penal Code. In no case shall the person identified as a suspect be allowed access to the injured person's whereabouts.

Part A: PATIENT WITH SUSPICIOUS INJURY

1. Name of Patient (Last, First, Middle)	2. Birth Date	3. Gender ☐ M ☐ F	4. SAFE Telephone Number ( )

5. Patient Address (Number and Street / Apt – **No P.O. Box**) City State Zip

6. Patient Speaks English ☐ Yes ☐ No If No, identify language spoken:_____	7. Date and Time of Injury Date: Time: ☐ am ☐ pm ☐ unknown

8. Location / Address Where Injury Occurred, if Available. Check here if unknown: ☐

9. Patient description of the incident. Include any identifying information about the person the patient alleges caused the injury and the names of any persons who may know about the incident. ☐ Additional Pages Attached

10.Name of Suspect, if Identified by the Patient	11. Relationship to Patient. ☐ No Relationship

12. Suspicious Injury Description. Include a brief description of physical findings, lab tests completed or pending, and other pertinent information. ☐ Additional Pages

Part B: REQUIRED – AGENCIES RECEIVING PHONE AND WRITTEN REPORTS

13. Law Enforcement Agency Notified By Phone (Mandated by PC 11160)	14. Date and Time Reported Date: Time: am pm

15. Name of Person Receiving Phone Report (First and Last)	16. Title	17. Phone Number ( )

18. Law Enforcement Agency Receiving Written Report (Mandated by PC 11160)	19. Agency Incident Number

Part C: PERSON FILING REPORT

20. Name of Health Practitioner (First and Last)	Title	Telephone

21. Employer's Name	Phone Number

22. Employer's Address (Number and Street) City State Zip

23. HEALTH PRACTITIONER'S SIGNATURE:	26. Date Signed:

San Francisco Supplement to Health Practitioner Suspicious Injury Report

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Provider Instructions

1. If the patient wishes to meet with law enforcement immediately or the provider assesses that the patient has near lethal circumstances and/ or a life threatening injury, call 911 or 415-553-8090.
2. For patients who do not wish to meet with law enforcement immediately or at all, and do not have near lethal circumstances and/or life threatening injury, call 415-553-9220 and speak with the Special Victims Unit representative, or follow instructions on the voicemail after hours.
3. Transmit Cal OES 2-920 and this form via fax to 415-734-3086 or via e-mail to sfpd.svumedrec@sfgov.org or via mail to San Francisco Police Department Special Victims Unit, 850 Bryant St., Room 500, San Francisco, CA 94103.

OES Form 2-920 is mandated to fulfill a health practitioner's reporting requirement under Penal Code Section 11160 et seq., whether or not the patient wishes to make a police report at the time of the initial examination. In San Francisco, we are requesting that providers complete this optional form in addition to OES Form 2-920 to improve patient care and ensure proper patient-centered follow-up

Please Note: A patient is not required to provide any information that they feel puts them at further risk.

Patient Information

Name:

Safe way(s) for police/advocate to contact the patient without the abuser/perpetrator knowing (complete all that apply):

Email:

Phone:

Alternate Contact (Friend/Family) Name and Phone:

Reason for report (check all that apply):

[ ] Firearm [ ] Assaultive or abusive conduct

a. Does the patient desire immediate contact with law enforcement (which may result in arrest of the perpetrator)?

[ ] Yes [ ] No

b. Does the patient believe police involvement would increase the risk for patient?

[ ] Yes [ ] No

c. Did you inform the patient that police may still contact them for further information?

[ ] Yes [ ] No

d. Would the patient like a follow-up call from a confidential domestic violence advocate based at the Police Department?

[ ] Yes [ ] No

e. Did you inform the patient that a confidential domestic violence advocate will attempt to contact them even if they answered "no" to question "d" above?

[ ] Yes [ ] No

Are there any special needs (i.e. disabilities) or other things that the patient wants the police or domestic violence advocate to be aware of:

_____

_____

*This form is not a substitute for complete documentation in the patient's medical record. **Never** attach a patient's medical record to this form. Consult your institution's Privacy Officer if you are unsure about whether to include certain information in the mandatory report.*

Date and Time Form Sent: _____

Last revised 5/30/2017