**“Red Flag” History of Present Injury**
- No history or inconsistent hx
- Changing history
- Unwitnessed injury
- Delay in seeking care
- Prior ED visit
- Domestic Violence in home
- Prior ED visit
- Delay in seeking care
- Unwitnessed injury
- Changing history
- No history or inconsistent hx

**“Red Flag” Physical Exam Findings Infant**
- Torn frenulum
- FTW (weight, length, head circumference)
- Large heads in infants (consider measuring of OFC in children < 1 yr)
- Any bruise in any non-ambulating child - “If you don’t cruise you don’t bruise”
- Any bruise in a non-exploratory location (especially the TEN region-Torso (area covered by a standard girl’s bathing suit), Ears and Neck) < 4 yrs old (TEN-4)
- Bruises, marks, or scars in patterns that suggest hitting with an object

**“Red Flag” Radiographic Findings**
- Metaphyseal fractures (corner)
- Rib fractures (especially posterior) in infants
- Any fracture in a non-ambulating infant
- An undiagnosed healing fracture
- SDH and/or SAH on neuro-imaging in young children, particularly in the absence of skull fracture < 1 year

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**Recommended evaluation in cases of suspected physical abuse**

Note: If patient presents at any MHS Hospital other than Mary Bridge Children’s Hospital, with “Red Flag” findings, please call the MBCH Emergency Department at (253) 403-1418 to arrange transfer for complete NAT workup.

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**Laboratory**
- CBC & platelets; PT/PTT/INR (if concern of low/falling Hgb, repeat in am with retic)
- CMP
- Lipase
- Urinalysis – Dip, send for microscopic

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**Radiology**
- Skeletal survey for < 2 years old (with 2 week follow up)
  - In ED if needed for disposition; or
  - Within 24 hours of admission
- Head CT (non-contrast with 3D reconstruction) if
  - < 6 months of age and other findings of abuse
  - Bruising to face or head injuries AND < 12 months of age
  - Neurologic symptoms < 12 months of age (including soft symptoms such as vomiting, fussiness)
- Abdominal CT if
  - Sx of abdominal trauma
  - ALT or AST if twice normal

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**Consults**
- Crisis Intervention Social Work
- Call CAID if diagnosis of abuse or likely abuse at:
  - 403-1478, Monday-Friday 8 am to 5 pm; if after hours, leave a message and call will be returned when they return
  - 403-1418, MB ED, after hours and weekends (they can reach the CAID Medical Director if necessary)
- Report to Child Protective Services if:
  - Injuries are severe and above diagnosis is clear cut and/or
  - There are other young children in the same home
- Pediatric General Surgery for trauma evaluation
- If Head CT abnormal and abuse is being considered, call
  - Neurosurgery
  - Ophthalmology for retinal exam*
  - Neuropsychology
  - Child Advocacy
- *An Ophthalmology consult for a dilated eye exam is not necessary as part of the evaluation for physical abuse

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**Disposition**
- **if any suspicion of NAT has been raised during the ED encounter, a face-to-face care team “huddle” must take place prior to ED discharge.** All members involved in the patient’s care should participate including (at a minimum) the ED physician, ED RN and Social Worker.
- **For suspected abusive head trauma NAT cases that require admission as clinically indicated with either intracranial abnormality identified on head CT or suspected seizures from abusive head trauma:**
  - Medical/Surgical trauma service admission with 24 hour neuro checks for further child abuse work up
  - Consider PICU admission for:
    - Any child with intracranial injury/bleed or skull fracture(s) identified on head CT
    - Any child with normal head CT/no seizures but GCS < 15
  - For suspected NAT cases not involving head trauma, admission to Medical/Surgical or PICU after injuries are reviewed by ED MD and Pediatric General Surgeon as medically indicated.
  - Prior to hospital discharge: care team “huddle” including all members involved in the patient’s care. Phone communication between may be utilized as necessary.
  - Outpatient CAID follow-up as needed.

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**Communication**
- Inform parents if a CPS Referral has been filed and/or if Child Advocacy is consulted.
- Be direct and objective. Inform parents inflicted trauma is part of diagnostic consideration.
- Keep the focus on the child. Avoid appearing judgmental. Assure parents of thoroughness of evaluation.
- If you are unable to have this conversation with the parents, ask SWS or a senior colleague to do so.