Drug Endangered Children Protocol Feedback Form: Health Care Provider

DO NOT include any personally identifying information on this feedback form. Your feedback will help us improve the protocol and process. Thank you.

Date protocol was initiated: ______________________________
County where protocol was initiated: _______________________

Age and gender of child(ren) involved:
________________________________________

1. To what degree was the protocol helpful to you in dealing with the child(ren)?
   Very Helpful 1……….2……….3………. 4……….5 Not Helpful At All
   Comments:

2. Did you receive information about the child(ren)’s exposure at the scene?
   Yes ___ No ___ If yes, how helpful did you find it?
   Very Helpful 1……….2……….3……….4……….5 Not Helpful At All
   Comments:

3. Did you receive information about the child(ren)’s health history?
   Yes ___ No ___ If yes, how helpful did you find it?
   Very Helpful 1……….2……….3……….4……….5 Not Helpful At All
   Comments:

4. Did you review the information on the reverse side of the Medical Assessment Form?
   Yes ___ No ___ If yes, how helpful did you find it?
   Very Helpful 1……….2……….3……….4……….5 Not Helpful At All
   Comments:

5. How many of the children you examined showed signs of the following?
   Physical abuse _____, Sexual abuse _____, Neglect _____, Developmental Delay ______,
   Behavior and/or mental health problems _____. Effects of chemical exposure ______

(Over)
6. How can this protocol be improved?

Name: ______________________ Role: ________________
Date: ______________________

Please return to: ______________________________________