pennsylvania
DEPARTMENT OF HUMAN SERVICES
OFFICE OF CHILDREN, YOUTH AND FAMILIES

SAFE HAVEN REPORT
Relinquished Newborn Report Form
Hospital

PLEASE READ THE FOLLOWING INSTRUCTIONS BEFORE FILLING OUT THIS FORM

INSTRUCTIONS:

- The hospital is required to notify the local County Children and Youth Agency and the local municipal Police Department, or the Pennsylvania State Police when no municipal police jurisdiction exists, immediately by telephone when a newborn is received.
- It is recommended this report form be completed by the hospital staff member who has first contact with the newborn or per the hospital's Safe Haven policy or protocol.
- If you do not know or are unsure about an answer, write "unknown" in the space provided.
- Within 48 hours of taking protective custody of the newborn, one copy of the report form must be forwarded to:
  - The local County Children and Youth Agency (CYA) with custody;
  - The local municipal Police Department or the Pennsylvania State Police where no municipal police jurisdiction exists; and
  - The Pennsylvania Department Human Services, at RA-PWSafeHaven@pa.gov or to: Office of Children, Youth and Families, Attention: Safe Haven, P.O. Box 2675, Harrisburg, PA 17105-2675

Date newborn brought to hospital: Time of incident:	Name, address and phone number of hospital: County where hospital is located:

Name of newborn:	Name of Law Enforcement Agency and Police Officer, or emergency services provider (if newborn transported by EMS/Police Officer):
Sex of newborn:	
Race of newborn:	
Actual or estimated date of birth of newborn:	
Was the newborn a victim of abuse/neglect or any other crime?	
Name and relationship of person who brought the newborn to the hospital. If name and relationship are unknown please provide description of the individuals who brought the newborn to the hospital:	
Report made to county children and youth agency (date, time and person spoken to):	
Report to law enforcement officials (Name of law enforcement agency, date, time and person spoken to):	
Medical tests performed:	
Health concerns/problems:	
Name, title and direct phone number of hospital staff member who initially received the newborn:	
Name, title and direct phone number of hospital staff member completing this form (if different from above):	