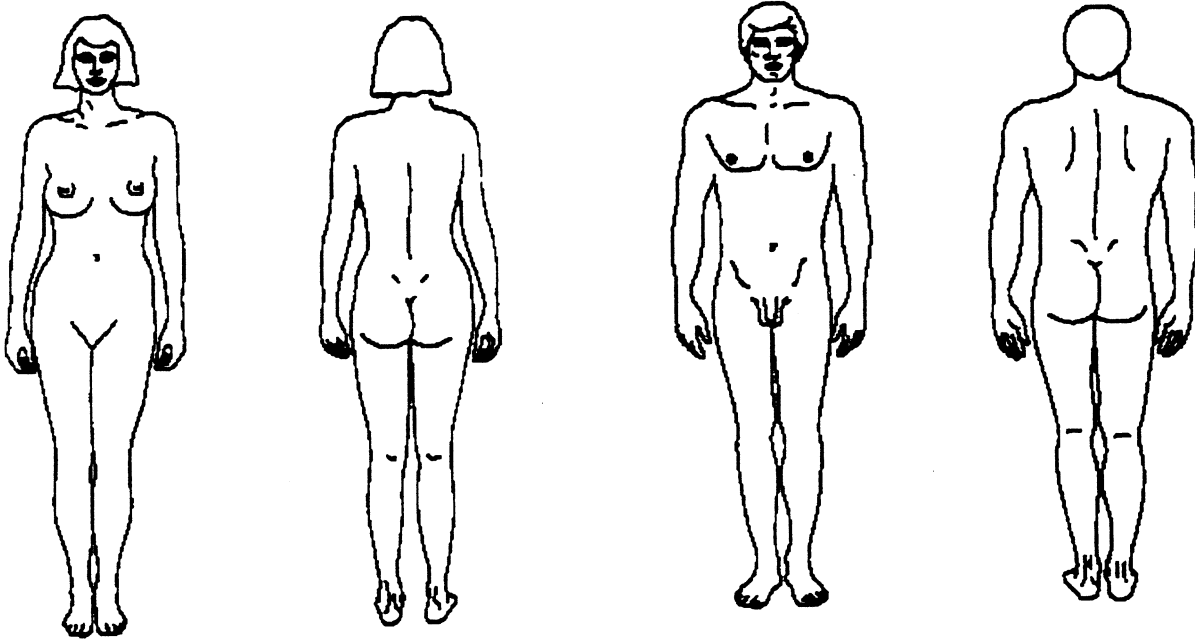


DOMESTIC VIOLENCE SCREENING/DOCUMENTATION FORM

DV Screen <input type="checkbox"/> DV+ (Positive) <input type="checkbox"/> DV? (Suspected)
--

Date _____ Patient ID# _____
 Patient Name _____
 Provider Name _____
 Patient Pregnant? Yes No



ASSESS PATIENT SAFETY

- Yes No Is abuser here now?
 Yes No Is patient afraid of their partner?
 Yes No Is patient afraid to go home?
 Yes No Has physical violence increased in severity?
 Yes No Has partner physically abused children?
 Yes No Have children witnessed violence in the home?
 Yes No Threats of homicide?
 By whom: _____
 Yes No Threats of suicide?
 By whom: _____
 Yes No Is there a gun in the home?
 Yes No Alcohol or substance abuse?
 Yes No Was safety plan discussed?

REFERRALS

- Hotline number given
 Legal referral made
 Shelter number given
 In-house referral made
 Describe: _____
 Other referral made
 Describe: _____

REPORTING

- Law enforcement report made
 Child Protective Services report made
 Adult Protective Services report made

PHOTOGRAPHS

- Yes No Consent to be photographed?
 Yes No Photographs taken?

Attach photographs and consent form