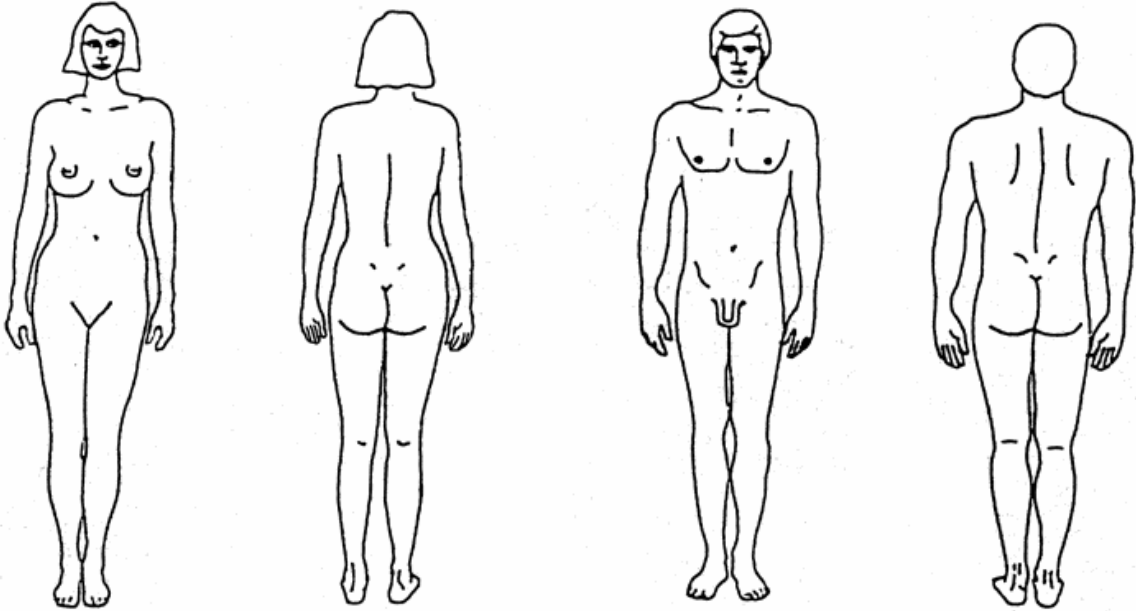


DOMESTIC VIOLENCE SCREENING/DOCUMENTATION FORM

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

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 photograph and consent form

Intimate Partner Violence: A Major Public Health Concern

