Domestic Violence (DV) Screening/Documentation Form

Date_____ **Patient ID#** _____
Patient Name _____
Provider Name _____
Patient Pregnant? □ **Yes** □ **No**

DV Screen
☐ DV+ (Positive)
☐ DV? (Suspected)

Examination Findings:
_____
_____
_____
_____
_____
_____

Assess Patient Safety
□ yes □ no Is abuser here now?
□ yes □ no Is patient afraid of 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 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
□ 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?