Domestic Violence (DV) Screening/Documentation Form

Date__________________ Patient ID# ______________________

Patient Name__________________________________________

Provider Name_________________________________________

Patient Pregnant? □ Yes □ No

Examination Findings:____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
DV Screen
□ DV+ (Positive)
□ DV? (Suspected)

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?