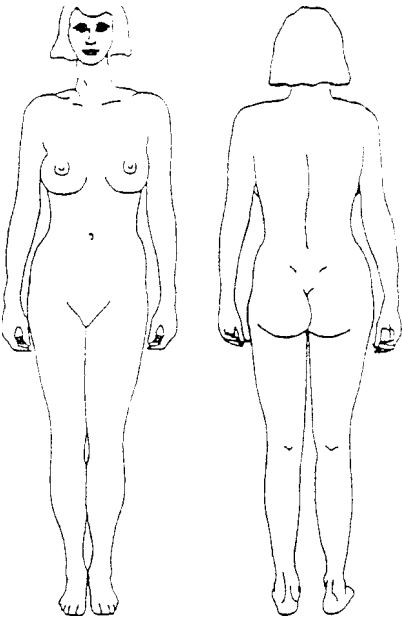


APPENDIX 3

DOMESTIC VIOLENCE SCREENING/DOCUMENTATION FORM FEMALE

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

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



ABUSE ASSESSMENT

- Have you ever been hit, slapped, kicked or physically hurt by anyone?
Who?
- Have you been physically hurt by someone in the past month?
- Have you ever been forced into unwanted sexual activities?
Who?
- Have you been forced into unwanted sexual activities in the last month?
Who?
- Are you afraid of anyone?
Who?
- Does anyone criticize you, make you feel bad about yourself, or try to control you?
Who?

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?

INTERVENTION

- 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*

Developed by the Family Violence Prevention Fund and Educational Programs Associates, Inc. Modified by the Ohio Domestic Violence Network.