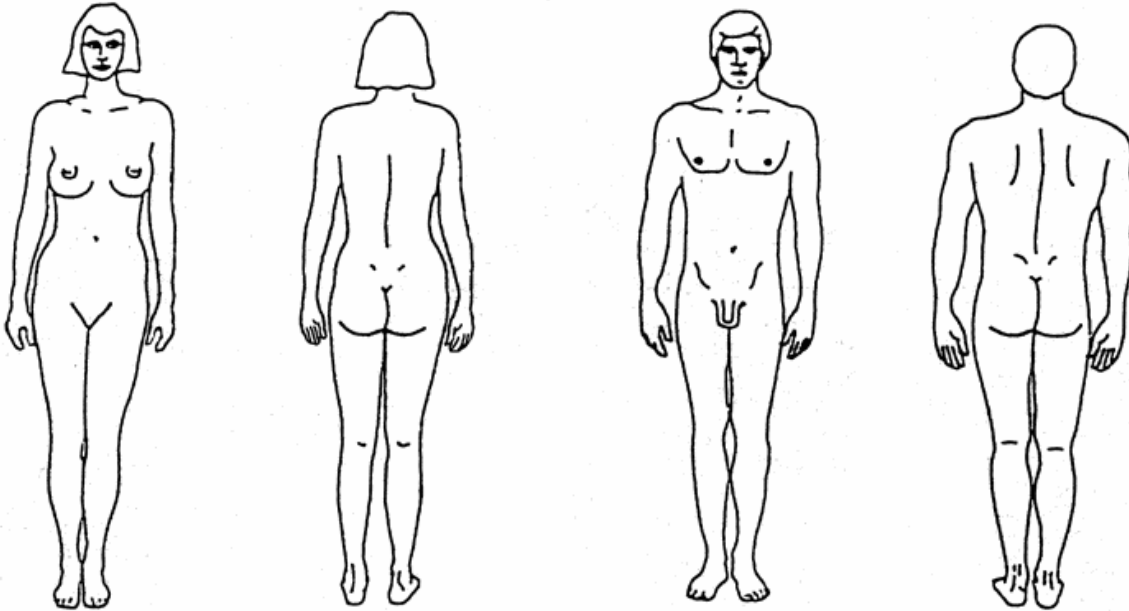


**Appendix C**

**DOMESTIC VIOLENCE SCREENING/DOCUMENTATION FORM**

<p><b>DV Screen</b>  <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?

