

COMMUNITY PUBLIC HEALTH SERVICES
DOMESTIC VIOLENCE PROTOCOL

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COMMUNITY PUBLIC HEALTH SERVICES
DOMESTIC VIOLENCE PROTOCOL

Definition

Domestic violence is a pattern of coercive behaviors that involves physical abuse or the threat of physical abuse. It also may include repeated psychological abuse, sexual assault, progressive social isolation, deprivation, intimidation, or economic coercion. Domestic violence is perpetrated by adults or adolescents against their intimate partners in current or former dating, married or cohabiting relationships of heterosexuals, gay men and boys, lesbians, bisexuals and transgendered people.

The US Dept of Justice estimates that 95% of reported assaults on spouses or ex-spouses are committed by men and boys against women and girls. (Douglas, 1991) There are no prevalence figures for domestic violence in gay and lesbian relationships but experts indicate that domestic violence is a significant problem in same sex relationship as well.

This protocol does not address other forms of family violence such as child abuse or abuse of elders by their caretakers which are serious problems and need attention.

Purpose

The purpose of this protocol is to set a standard to improve both the quality of the care given by individual health care providers and the overall CPHS response to domestic violence. This protocol outlines the elements of an effective response.

Guiding Principles

1. Treat patients with dignity, understanding, respect, and compassion.
2. Treat patients of different ages, cultures, and sexual orientation with sensitivity, while remembering that violence is unacceptable in any relationship.
3. Recognize that the process of leaving a violent relationship is often a long and gradual one.
4. Attempt to engage patients in long-term continuity care within the health care system, in order to support patients through the process of attaining greater safety and control.
5. Respect the integrity and authority of patients' life choices.
6. Discuss confidentiality issues with all patients.

Policy

This protocol applies to all staff, students, and volunteers working within Community Public Health Services. The roles and responsibilities of staff in each clinical site should be outlined in Appendix A.

Process

This protocol will be reviewed at a minimum of every 18 months by a CPHS employee/team trained in domestic violence and by the medical director of Community Public Health Services. Staff training will be included as part of the review process.

Training

To respond effectively and appropriately to domestic violence, providers and all other staff in the health care setting should receive orientation to the current protocol and regularly updated training in domestic violence.

Supplies

- 1. DOMESTIC VIOLENCE PACKET: Blue Folders kept in agreed upon location in each clinic. Contents of folder will be restocked by medical records department.

List locations: _____

- 2. CAMERA & FILM: Locked in _____.

- 3. DOMESTIC VIOLENCE RESOURCE MANUALS: Educational Materials and protocol in _____.

I. SCREENING

Standards:

- * In all primary care clinics, family planning clinics, prenatal clinics, mental health clinics, social work intakes, PHN intakes:

Screen all women and adolescent girls. Also, screen men and boys presenting with symptoms or signs of domestic violence (see Appendix B).

- * In pediatric clinics:

Screen mother or other female legal guardian when it is possible to remove children and others from the room to speak with mother/female guardian privately. Screen male parent/guardian when he shows symptoms or signs of domestic violence. Again, screening should be done without child in the room.

- * In drop-in or urgent care clinics:

Screen women, adolescents, and men and boys who present with symptoms or signs of domestic violence (see Appendix B).

- * In dental clinics:

Screen all patients with signs of facial, dental, or other trauma.

Procedures:

- A. Screen for domestic violence in a safe environment.
 - Use your own words in a non-threatening, non-judgmental manner.
 - Ask the patient about domestic violence in a private place.
 - Separate any accompanying person or child from the patient while screening for domestic violence.
 - If it is not possible to screen for domestic violence safely do not screen patient. Arrange for return visit.
- B. Use questions that are direct, specific, and easy to understand (see Appendix C).
 - "Has your partner ever physically hurt or threatened you?"
 - If the patient has a physical injury: "Many people come in with injuries like yours and often they are from someone hurting them. Is this what happened to you?"
- C. When unable to converse fluently in the patient's primary language:
 - Use a professional interpreter or another health care provider fluent in the patient's language.
 - The patient's family, friends or children should not be used as interpreters when asking about domestic violence.
- D. Screen verbally, in addition to any written questionnaire forms used.
- E. Document that screening for domestic violence was done.
 - Document that domestic violence is or has been present, has never occurred, or is suspected even though the patient denies it.
 - Document the date and the results of the screening in the life record of the patient's chart as well as in the progress notes.
- F. Routinely discuss with patients confidentiality limits regarding mandatory reporting and the requirement to report child abuse. (see Section V, "Mandatory Reporting").

If patient is positively screened for suspected or known domestic violence proceed with the following guidelines:

II. ASSESSMENT

A. Essential Assessment

1. Obtain history of present complaint.
2. Physical examination: Request that patient disrobes for a more thorough exam. Provider should examine for evidence of further injuries or scars.

3. Address the following four issues before the patient leaves your site:

- Immediate risk: “If you return home, will you be in immediate physical danger?”
- Children: “Is perpetrator (or patient) hurting or threatening patient’s children?”
- State of mind toward situation and readiness for change: “What type of assistance would you like?” “Are there any changes you would like to make?” “What steps would help you towards those goals?” “What actions are you ready to take?”
- Suicide: “Have you had suicidal thoughts in response to your situation?”

B. Further Assessment

Further assessment may be done immediately or over multiple visits. It may be done (and, it is even preferable for it to be done) by different members of a multidisciplinary team at a particular site and/or in conjunction with community domestic violence experts and counselors.

1. Assessing patient’s general view toward situation (state of mind): How has the abuse affected you? What do you do to cope with the abuse? What would you like to see happen for yourself (and for your children)?
2. Safety strategies patient has used: Currently, how do you protect yourself and your children? What safety strategies have you tried? Have you sought outside assistance for domestic violence? From whom or where? Have you ever tried to leave in the past? What happened when you tried to leave?
3. History of past injuries: Have you ever been treated for injuries related to the violence? Have you ever been hospitalized? Have the police ever been called during a domestic violence incident? What happened as a result?
4. Degree of abuser's control over patient: Does your partner ever try to control you by threatening to hurt you or your family? Does your partner ever try to restrict your freedom or keep you from doing things that are important to you? Do you have your own money or financial support? Do you feel controlled or isolated by your partner?
5. Effects on health: What types of medical and psychological effects have resulted from the abuse (e.g., chronic pain symptoms, worsening medical conditions, psychological distress, anxiety, sleep disorders, miscarriages or substance abuse)?
6. Effects of domestic violence on children: Have your children shown any signs of physical injuries or sexual abuse that could be related to your partner's abuse? Have your children had any eating or sleeping disorders, somatic complaints, bad dreams, aggressive behavior, school problems, depressions, suicidal thoughts or attempts? What will enhance your children’s safety while protecting yourself?
7. Further assessment of suicide/ homicide: Have you ever attempted suicide in the past? Are you having thoughts of suicide now? Have you thought about how you would do it? Have you ever thought of killing or harming your partner? Have you thought about how you would do it?

III. INTERVENTION

A. Convey the following messages:

- There is no excuse for domestic violence.
- No one deserves to be abused.
- Violence is not your fault. Your partner is responsible and can stop the violence.
- You are not alone. There are people you can talk to for support, shelter and legal advice.
- It must be very difficult for you to change your situation.

B. Provide information on domestic violence:

- Domestic violence is common.
- Most violence continues over time and often increases in frequency and severity.
- Violence in the home can have long-term, damaging effects on children, particularly if they are physically hurt and/or witnesses to the abuse.
- Domestic violence is a crime in the United States even if you are here without legal documentation.
- There are social and legal services available to you including counseling, shelters, police assistance and restraining orders.
- This information should be provided verbally and in written form if patient will accept it.

C. Assist the patient in making a safety plan:

1. Ask the following questions:

- Is your partner in the clinic now?
- What do you want to do?
- Can you stay with friends/family ? Do you want to stay at a shelter?
- Do you want an emergency protection order? Do you want a restraining order?
- Do you want legal assistance such as assistance with custody or visitation issues?
- Do you want immigration assistance? (Note: Presently in San Francisco there are resources for battered women to apply for legal status without having to rely on coercive husband).
- Do you want someone to further discuss your safety plans with you?

2. Contacting the police:

- Do you want police intervention? If the patient wants official police intervention, assist her/him in filing an official report with the local police department.
- Health Practitioners should assist the patient in making the report.
 - If perpetrator is posing immediate danger to patient, clinicians or the safety of others, **call 911.**

- If perpetrator is not posing immediate danger and patient wants police assistance, **call police dispatch at 553-0123**.
- Health care personnel should remain with the patient during the police interview, if the patient so desires.
- Ensure patient is in safe place while awaiting police.
- Document in the medical record that an official police report was made (include date, time, and officer name and badge number).
- Urge the patient to call the **Family Violence Project at 552-7550** to obtain an advocate to help her or him navigate the criminal justice system.
- *A separate report of injuries must be submitted by the health care provider to law enforcement, as required by California law (see Section V pg. 9)*

3. Safety in Clinic:

- Clinics should discuss and adapt safety strategies. Clinics with institutional police may have different policies than those without police.

4. If the patient is returning home or to previous living arrangement:

- Determine a safe way to contact patient in future (by phone, mail, friend, etc.) Use “DV Contact Form”, (Appendix J).
- Suggest patient gather important papers, (e.g., birth certificates and other documents of identification), some money and clothing for her/himself and children (if any). Tell patient to keep these items in an accessible, hidden place or at a friend's home in case she/he has to leave home in a hurry. (See Appendix D for details on safety planning).

5. Assist the patient with obtaining help to carry out her/his safety plan (See Appendix K for patient resources).

D. Referrals:

All known or suspected victims of current domestic violence should be referred to a CPHS social worker and/or public health nurse if the patient will accept a referral. All PHN referrals should be accompanied by DV Contact Form in (Appendix J).

- Refer the patient to available community resources (see Appendix K).
- Offer a written list of resources at each visit (from blue domestic violence folder).
- If patient thinks it would be dangerous to take a list of resources offer the phone number of Woman, Inc. for women patients and CUAV for gay patients on small piece of unlabeled paper.
- When the patient is willing, assist her/him in calling a domestic violence hotline during the health care visit.
- Tell the patient she/he can always call or come back for support or more information.

E. Sexual Assault Intervention:

- In the case of sexual assault urge the patient to accept a referral to the **Rape Crisis Center at 206-3222** for advocacy, counseling and evidentiary collection. Currently, San Francisco Law Enforcement recommends that evidentiary collection can be useful for up to 120 hours after assault.
- If the patient does not wish to go to the Rape Crisis Center but you would like advice on examination, documentation and treatment call the Rape Crisis Center for advice.

IV. DOCUMENTATION

Health care providers should complete a legible medical record for each known or suspected victim of domestic violence. This record should include the following:

- A description of domestic violence history, including present complaints or injuries, past experiences of physical/sexual abuse and frequency of abuse. Include date, time and location of domestic violence incidents.
- Whenever appropriate use the patient's own words in quotation marks.
- A description of patient's injuries, including type, location, size, color and age. Document injuries on a body map (See Appendix E for sample Body Map).
- Alleged perpetrator's name, address, and relationship to patient (and children, if any), if patient is willing to provide this information.
- A description of other health problems, physical or mental, which may be related to the abuse.
- Whenever possible, following patient's consent, take photographs of patient's injuries (see Appendix F for photograph consent form). Take Polaroid photographs of all injuries, including:
 - One full body shot (to link injuries with identified victim).
 - One mid-range to show torso injuries.
 - Close-ups of all wounds and bruises.
- Preserve any physical evidence (e.g., damaged clothing, jewelry, weapons, etc.) that can be used for prosecution. (see Appendix F for Receipt of Evidence form).
- Document details of intervention made and all actions taken.
- In the case of rape/sexual assault contact Rape Crisis Center at 206-3222 for advice on transferring patient for appropriate forensic exam.
- This documentation process may take place over more than one visit as further history is revealed. Different members of the multidisciplinary team may document different aspects of the abuse.

DOCUMENT POSITIVE OR SUSPECTED DOMESTIC VIOLENCE THAT IS OCCURRING PRESENTLY OR HAS OCCURRED IN THE PAST ON THE "PROBLEM LIST" IN THE PATIENT'S CHART. (E.G., "DOMESTIC VIOLENCE SUSPECTED - PRESENT" OR "DOMESTIC VIOLENCE POSITIVE - IN PAST RELATIONSHIP")

V. **MANDATORY REPORT OF INJURY IN SAN FRANCISCO**
(SEE APPENDICES G, H, I)

Health Practitioners are required by California State Law (Penal Code Section 11160 et. seq.) to report certain cases of domestic violence to law enforcement. *This is different from a patient's voluntary formal police report to police and/or request for police assistance.*

1. Report to the local law enforcement agency when providing medical services to a patient who has a physical condition that you know or reasonably suspect is a result of a firearm or assaultive or abusive conduct.
2. Discuss reporting requirements and solicit cooperation from the patient. Patient consent, however, is not required.
3. Reporting health care provider should telephone a report of domestic violence as soon as possible to the San Francisco Police Department by calling 553-9220 to leave a voice mail message. The police will record your message. Document in the medical record that the call was made.
4. Reporting health care provider should complete *REPORT OF INJURIES BY A FIREARM OR ASSAULTIVE OR ABUSIVE CONDUCT* form. (See Appendices G, H & I for form, reporting procedure and other relevant information.) Mail this form within 2 working days to:

San Francisco Police Department Domestic Violence Unit 850 Bryant Street San Francisco, CA 94103

File a copy of report in “correspondence” section of the chart.

5. **If you or the patient want police intervention or follow-up, you must call 911 for emergencies or 553-0123 to make an official police report. Your mandatory report is not an official police report.**
6. **Abuse of a minor and elder/dependent adult abuse require different reporting procedures:**
 - ◆ *For patients under the age of 18, report in accordance with Child Abuse & Neglect Reporting (Article 2.5 of Penal code, commencing with Section 11164), even if alleged perpetrator is also a minor.*
 - ◆ *For patients age 65 and older and for dependent adults, report in accordance with Elder Abuse and Dependent Adult Civil Protection Act (Chapter 11 of Part 3, Division 9 of Welfare and Institutions Code, commencing with Section 15600).*

Child and elder mandatory reports may result in further investigation by Child Protective Services or Adult Protective Services.

7. ***Note: Reporting is not a substitute for thorough documentation of the abuse in the medical records.***

VI. CONTINUITY OF CARE

A. At each visit, for patients with known or suspected domestic violence:

1. Ask about history of violence since last visit.
2. Ask about coping strategies.
 - emotional status?
 - called hotline?
 - told any family or friends?
 - attempts to leave?
3. Ask about any abuse of children since last visit.
4. Give messages of support and your concern.
5. Reiterate options to patient (Emergency Protective Order, Temporary Restraining Order, friend's home, shelter, hotline, support groups).

B. For patients with no suspected domestic violence when screened at your site in the past:

There are no studies that address appropriate rescreening intervals. You might consider rescreening the patient at the following times (whichever occurs first):

- patient starts intimate relationship with new partner.
- patient presents with symptoms or signs of domestic violence.
- periodic intervals (at provider's discretion).

Roles & Responsibilities*

Clerical Staff:

- ★ Does not screen for domestic violence.
- ★ Privately and immediately reports suspicion of domestic violence, a witnessed act of domestic violence or a patient’s mention of domestic violence to the head nurse or primary provider if patient is coming to clinic for medical visit and to social worker if patient is coming to a social work visit.
- ★ Alerts institutional police if concerned about immediate patient or clinic safety issues.

Social Worker:

- ★ Screens routinely for domestic violence as outlined in this protocol.
- ★ Refers any patient with injuries to urgent medical appointment for evaluation, documentation, treatment and health care mandatory reporting.
- ★ Urges patients with history of known or suspected domestic violence to accept referral to a primary medical provider.

Public Health Nurse:

- ★ Screens routinely for domestic violence as outlined in this protocol.
- ★ Urges patients with history of known or suspected domestic violence to accept referral to a primary medical provider (if patient doesn’t have one).
- ★ Evaluates, documents and reports domestic violence as outlined in the protocol. If working with primary medical provider, only one provider should complete mandatory report.

Mental Health Consultant:

- ★ Screens for domestic violence as outlined in this protocol.
- ★ Refers any patient with injuries to urgent medical appointment for evaluation, documentation, treatment and health care mandatory reporting.

Nurses/MEA’s:

- ★ Does not screen routinely for domestic violence.
- ★ If symptoms or signs of domestic violence or affirmative answers to abuse questions on written intake forms AND patient is alone, screens for domestic violence as outlined in protocol. Then, pulls “blue folder” for NP or MD if positive or suspected domestic violence.

* This is for Maxine Hall Health Center. Each site should adapt this appendix.

- ★ If symptoms or signs of domestic violence or affirmative answers to abuse questions on written intake form AND patient is not alone, attempts to request that accompanying persons wait in lobby when putting patient in exam room. Then, privately informs NP or MD of suspicion of domestic violence. Pulls blue folder to hand to provider privately.
- ★ Asks patients with positive screening for domestic violence whether perpetrator is in clinic and informs provider of perpetrator's presence as promptly as possible.
- ★ Always documents patient's remarks about domestic violence in her/his own words in quotation marks.
- ★ Works with provider to obtain photographs of injuries and collect evidence
- ★ Works with provider to fill out mandatory reporting form.
- ★ Works with provider to assess safety, create safety plan and make referrals upon discharge.
- ★ Alerts institutional police if concerned about immediate patient or clinic safety.

Triage RN:

- ★ Does not screen routinely for domestic violence.
- ★ Screens all patients with symptoms or signs of domestic, violence as outlined in protocol.
- ★ Follows protocol for assessment, documentation, planning and reporting in consultation with provider.
- ★ Refers patient with known or suspected domestic violence to urgent care or primary care as deemed appropriate in consultation with provider.
- ★ Completes mandatory health care report when required by law (or helps to do so if patient will see an NP or MD immediately)
- ★ Alerts institutional police if concerned about immediate patient or clinic safety.

Medical Provider (NP or MD):

- ★ Screens routinely for domestic violence and treats patients as outlined in this protocol.
- ★ Determines whether perpetrator is in clinic if not already informed by RN/MEA.
- ★ Urges all patients with known or suspected domestic violence to accept referral to PHN and/or social worker.
- ★ If provider is not the primary provider for the patient, notifies primary provider of known or suspected domestic violence promptly.
- ★ Alerts institutional police if concerned about immediate patient or clinic safety.

Institutional Police Officer

- ★ Helps ensure safety of patient and staff especially when perpetrator is in clinic.
- ★ Helps providers contact SFPD when patient or provider would like SFPD assistance.
- ★ Is informed by providers of any potentially violent situations or persons in advance whenever possible.

Medical Records Staff:

- ★ Obtains provider permission for Xeroxing of records with “sensitive services” designation as per routine existing policy.
- ★ Attempts to obtain provider permission for Xeroxing records if domestic violence happens to be noted before copying in chart without “sensitive services” designation.
- ★ Replenishes “blue folders” with appropriate forms.

Custodial Staff:

- ★ Alerts “doctor of the day” or head nurse to any witnessed activity suspicious for domestic violence.
- ★ Alerts institutional police if concerned about patient or clinic safety.

WIC Staff: Not yet delineated

Symptoms and Signs of Domestic Violence

Screening for domestic violence on the basis of symptoms and signs will greatly underestimate the prevalence of domestic violence. Universal screening, therefore, should be done as outlined in the protocol.

I. History suggesting domestic violence:

- ★ Traumatic injury or sexual assault;
- ★ Suicide attempt or ideation;
- ★ Overdose;
- ★ Physical symptoms related to stress;
- ★ Vague complaints or non-specific complaints;
- ★ History inconsistent with injury;
- ★ Delay in seeking medical care;
- ★ Repeated visits
- ★ History of spontaneous abortion

II. Physical clues:

- ★ Any physical injuries;
- ★ Unexplained, multiple or old injuries

III. Behavioral clues:

- ★ Reluctance to speak in front of partner;
- ★ Evasive;
- ★ Overly protective or controlling partner

IV. Verbal clues:

- ★ Directly or indirectly brings up the subject of abuse

Approaches for Interviewing the Patient

Sample Questions:

- ★ “Has your partner ever hit you or hurt you in any way?”
- ★ “Do you ever feel frightened of your partner?”
- ★ “Has your partner ever forced you to have sex when you didn’t want to?”

Framing Questions:

If you feel uncomfortable raising the topic of domestic violence or if you think the patient seems uncomfortable you may choose to use a “framing statement” with your questioning. For example:

- ★ “I ask all women about violence in their relationships. Has your partner ever hit you or hurt you in any way?”
- ★ “I know I have been seeing you in clinic for a few years now. I have started to ask all my patients more about their relationships.” “What happens when you and your partner disagree?”

Open ended questions should always be followed by direct questions.

- ★ “Has your partner ever hit you or tried to hurt you?”

Sexual Abuse:

If the patient admits to physical abuse always ask about sexual abuse. Do not use the word “*rape*”. (Many patients define rape as forced sex by a stranger)

- ★ “Has your partner ever forced you to have sex when you didn’t want to?”

Suspected Domestic Violence:

If you are screening a patient and she/he denies domestic violence but you suspect domestic violence use this opportunity to offer messages of support. Anticipate the patient’s fears. For example:

- ★ “I am asking you about this because I am concerned for your safety.”
- ★ “Many people who are being hurt by their partners are afraid or ashamed to talk about it. I want you to know that I would like to talk about this if this ever happens to you.”

- ★ “No one deserves to be hurt or threatened by her/his partner.”
- ★ “There is help here and in other places for people who are being hurt by their partners.”
- ★ “Sometimes people are afraid to talk about this because they think their family and friends will find out . Let me explain the privacy of your care.”
- ★ “Patients do not have to have police intervention unless they want it”.
- ★ “We can help you even if you don’t have legal documentation.”
- ★ “If this ever happens to you please let us help you. We would never ask you to do anything you are not ready to do.”

Encourage patient to take resource list “in case you ever need it.” Highlight hotline numbers for the patient.

Safety Planning

When a patient has been identified as a victim or suspected victim of domestic violence it is important to speak with the patient about immediate and future safety. The severity of current abuse or past injury is not always an accurate predictor of future violence. Patients may minimize the danger they face. Assisting the patient in making a safety plan can increase the patient's awareness of options for increasing her/his safety. Also, safety planning will help the provider assess the situation and better support the patient.

A patient may choose different options such as returning to the abuser, evicting the abuser or leaving the abuser. A patient may choose to remain in a relationship with the perpetrator for many different reasons. Provide messages of support and discuss the dangerous, harmful consequences of domestic violence but respect the patient's choice and work with the patient to help increase safety as much as possible. Also, remember that leaving a violent relationship may be a very dangerous time for the victim.

A. If patient decides to leave, stay elsewhere temporarily or bar perpetrator from patient's place of residence:

- ★ Does patient have a supportive friend or family member with whom she/he can stay?
- ★ Does patient have a friend or relative who will stay with her/him whose presence would deter violence?
- ★ Does patient want to call the police, to file an official police report and/or obtain an emergency protective order or temporary restraining order?
- ★ Does patient want to go to a battered women's shelter, homeless shelter or use other housing assistance programs such as hotel vouchers from social services or advocacy programs?
- ★ Does patient want to move secretly to another community or state? Are there means to help arrange transportation to out-of-state shelter?
- ★ If perpetrator is removed or barred from living situation discuss safety measures such as changing locks on doors and windows, installing alarms and smoke detectors, teaching children to make collect calls in case perpetrator kidnaps them, and telling caretakers of children (school/babysitters) who has permission to pick up children.

B. If patient is planning to stay in relationship:

- ★ What kind of strategies have worked in the past to minimize injuries? Does patient think these strategies would continue to work?
- ★ Can patient anticipate escalation of violence and take any precautions?

- ★ Would patient call the police if perpetrator becomes violent? If patient couldn't get to phone could she/he work out a signal with a neighbor to call police and/or teach her/his children to call 911?
- ★ Does patient have a support network of friends or family that live nearby and would provide help if needed?
- ★ Does perpetrator have or use weapons? Can they be removed from perpetrator or can ammunition be separated from weapon?

C. Escape Plan

For many people, deciding to leave an abusive relationship is one of the most difficult decisions they will ever make. Arranging an "escape plan" can help a patient feel less need to return to an abusive relationship after leaving.

- ★ Encourage patient to keep the following items in a safe but easily accessible place:
 - As much cash as possible, a checkbook, an ATM card and credit cards.
 - Loose change for pay phones.
 - A small bag of extra clothing for the patient and any children.
 - Medications
 - Extra keys to car, apartment or house.
 - Documents:
 - Bank accounts
 - Insurance policies
 - Marriage license
 - Abuser's date of birth
 - Social Security numbers (perpetrator's, patient's, and any children's)
 - Birth certificates (the patient's and the children's)
 - List of important phone numbers (family and friends)
 - Sentimental valuables
 - "Green card"
 - Passports
 - Work authorization and any other immigration documents
 - Medical card
 - Driver's license and title to car with proof of insurance

Remember to always give messages of support, hotline numbers and to refer patient to an advocate to discuss options further.



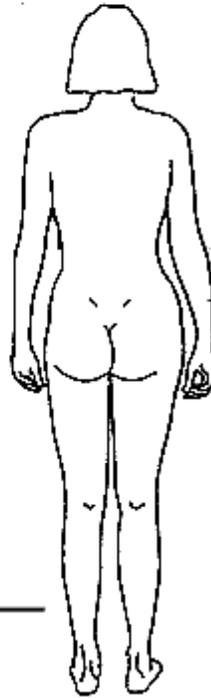
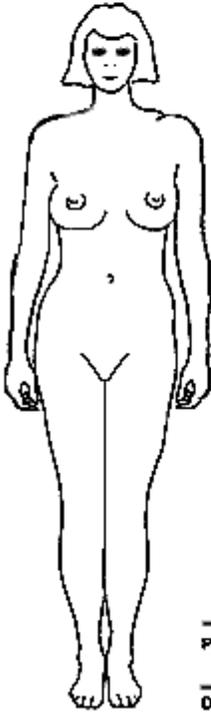
SAN FRANCISCO
GENERAL HOSPITAL

NAME
DOB
MRN

INJURY LOCATION RECORD - Female

INDICATE ALL INJURIES
USING LEGEND

LEGEND	
AB	ABRASION
AMP	AMPUTATION
BI	BITE
BL	BLEEDING
BR	BRUISING
B	BURN
F	FOREIGN BODY
FR	FRACTURE
G	GUN SHOT WOUND
L	LACERATION
P	PAIN
PU	PUNCTURE
R	REDDENED
S	STAB WOUND
SW	SWELLING DEFORMITY



PHYSICIAN'S SIGNATURE

IC CODE

DATE

STAPLE PHOTO HERE

STAPLE PHOTO HERE

PHOTOGRAPHER: Affix addressograph label to back of photo.
Write on front of photo: your name, date and time taken.



SAN FRANCISCO
GENERAL HOSPITAL

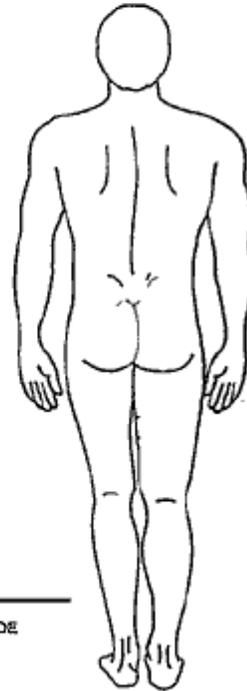
NAME
DOB
MRN

INJURY LOCATION RECORD - Male



INDICATE ALL INJURIES
USING LEGEND

LEGEND	
AB	ABRASION
AMP	AMPUTATION
BI	BITE
BL	BLEEDING
BR	BRUISING
B	BURN
F	FOREIGN BODY
FR	FRACTURE
G	GUN SHOT WOUND
L	LACERATION
P	PAIN
PU	PUNCTURE
R	REDDENED
S	STAB WOUND
SW	SWELLING DEFORMITY



PHYSICIAN'S SIGNATURE

ID CODE

DATE

STAPLE PHOTO HERE

STAPLE PHOTO HERE

PHOTOGRAPHER: Affix addressograph label to back of photo.
Write on front of photo: your name, date and time taken.

(Place patient label here).

Consent to Photograph

(In the event a photograph is taken, be sure to complete this form, including the patient's signature)

The undersigned hereby authorizes _____ and the attending
(Name of Agency)

clinician to photograph or permit other persons in the employ of this facility to photograph

_____ while under the care of this facility, and agrees
(Name of Patient)

that the negatives or prints be stored in patient's medical records, sealed in a separate envelope, in the event they may be needed later for evidence. These photographs will be released to the police or prosecutor only when the undersigned gives permission to release the medical records. The undersigned does not authorize any other use to be made of these photographs.

Date _____

Patient's Signature _____

Street Address _____

City _____

State, Zip _____

Witness _____

Parent or Legal
Guardian _____

(Place patient label here).

Receipt For Evidence

(Upon receipt of any evidence, fill out all necessary information below.)

Date: _____

Received From: _____

Medical Facility: _____

■ Photograph of or items from:

Name: _____

Address: _____

City, State, Zip: _____

■ Items (List) _____

Signed: _____

Police Officer:

Name (Print or Type) _____

Department Badge # _____

Prosecutor's Office:

Name _____

Title _____

Reporting Procedure

When health care provider provides medical services to a patient suffering from a physical injury known or suspected to be a result of domestic violence she or he should do the following:

- ★ Inform the patient of clinician's duty to report.
- ★ Inform patient that if she/he wants police intervention or follow-up, she/he must call 911 for emergencies or 553-0123 for non-emergency situations to make an official police report.
- ★ Make a telephone report to the Domestic Violence Unit of the SFPD by calling 553-9220 to leave a voice mail message as soon as possible.
- ★ Complete a **“Report of Injuries By a Firearm or Assaultive or Abusive Conduct”** form (see included form) and send within two working days to the Domestic Violence Unit:

San Francisco Police Department
Domestic Violence Unit
850 Bryant Street
San Francisco, CA 94103

- ★ When two or more health care providers have knowledge of a known or suspected instance of violence requiring reporting, only one person is required to submit the report.
- ★ All health care providers involved are equally responsible to see that the report is made according to State requirements.
- ★ File a copy of the report in the patient's medical record in the correspondence section.
- ★ Maximize role of patient's input; advocate for the patient's needs with authorities.
- ★ Keep the report confidential; it cannot be accessed by friends, family, or other third parties without the patient's consent.

NOTE TO LAW ENFORCEMENT: PATIENT'S WHEREABOUTS MUST BE DELETED FROM ANY REPORT REQUIRED TO BE DISCLOSED TO SUSPECT OR SUSPECT'S ATTORNEY.

REPORT OF INJURIES BY A FIREARM OR ASSAULTIVE OR ABUSIVE CONDUCT
(Pursuant to Penal code Section 11160 et. seq.)

1. PATIENT'S NAME (if known): _____

2. PATIENT'S WHEREABOUTS: Specify where and when patient can be safely contacted (specify any special instructions for contacting patient): _____

3.a. REASON FOR REPORT (check all that apply):

- firearm
- assaultive or abusive conduct

4.a. RELATIONSHIP OF SUSPECTED PERPETRATOR TO PATIENT

- domestic / intimate partner
- other (please specify)

b. DESCRIBE NATURE AND EXTENT OF INJURY:

b. NAME OF ANYONE PATIENT ALLEGES INFLECTED THE WOUND OR INJURY

c. DATE OF INJURY (if known)

5. OTHER COMMENTS (include any special needs of patient, i.e., interpreter)

6. WAS PATIENT REFERRED TO SUPPORT SERVICES?

- YES
- NO

<i>Date</i>
<i>Health practitioner's name</i>
<i>Health practitioner's title</i>
<i>Health practitioner's medical facility</i>
<i>Health practitioner's phone number</i>
<i>Law enforcement agency contacted</i>
<i>Date/time of telephone report</i>
<i>Name and serial no. of official contacted, if not reporting line</i>

NOTE:

The SFPD will not follow up on this report, but will record practitioner compliance with law. If patient wants police follow up, call the police (415) 553-0123 for non-emergencies or 911 for emergencies and request an official police report.

MAIL THIS FORM TO:

**San Francisco Police Department
Domestic Violence Unit, Room 561
850 Bryant Street
San Francisco, CA 94103**

CALL: (415) 553-9220 (Reporting Line)

THIS FORM IS NOT A SUBSTITUTE FOR COMPLETE DOCUMENTATION IN THE MEDICAL RECORD

SUMMARY OF REPORTING REQUIREMENTS

See complete text of law in Penal Code Section 11160 et. seq.

Any health practitioner employed in a health facility, clinic, physician's office, local or state public health department operated clinic or facility is required to make a report if s/he provides medical services for a physical condition to a patient who s/he knows or reasonably suspects is:

- suffering from any wound or other physical injury inflicted by his or her own act or inflicted by another where the injury is by means of a firearm and/or
- suffering from any wound or other physical injury, that is the result of assaultive or abusive conduct.

Assaultive or abusive conduct is defined to include 24 criminal offenses, among which are murder, manslaughter, torture, battery, sexual battery, incest, assault with a deadly weapon, rape, spousal rape, and abuse of spouse or cohabitant.

Health practitioner is defined to include practitioners such as a physician, surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, optometrist, MFCC, MFCC trainee or registered intern, emergency medical technician I or II, paramedic, public health employee who treats minors, coroner, person who performs autopsies, and a religious practitioner who diagnoses, examines, or treats children. (This is not a complete definition, see Penal Code §11165.8)

The health practitioner is required to make a report by telephone immediately or as soon as practically possible and send a written report to a local law enforcement agency within two working days.

CONFIDENTIALITY

Health care facilities must keep reporting forms confidential. Family, friends and other third parties should not have access without patient consent.

LIABILITY

Civil and criminal immunity is provided by health practitioners who make required or authorized reports pursuant to these provisions.

PENALTY

Violation of this law is a misdemeanor.

IMPORTANT CONSIDERATIONS IN DOMESTIC VIOLENCE CASES

SENSITIVITY AND AWARENESS

Reassurance to patient that s/he is not alone and does not deserve to be treated this way. Be careful not to imply patient is to blame (i.e. by asking what prompted the abuse or suggesting couple's counseling).

Be aware of the following:

- Patient may be scared of seeking care because they do not want police involvement.
- Some patients may fear reporting for other reasons (i.e., immigration status).
- There are many potential barriers to leaving an abusive situation (i.e. threats from the batterer, fear of financial instability, failure of police and others to effectively intervene, hope the relationship can work out).

PATIENT SAFETY

The patient's safety should be the primary focus. If the batterer finds out that the patient revealed the abuse, the patient may be in great danger. (Note: separation is often the most dangerous time for victims.) Address directly the risk of retaliation by the batterer and discuss how the patient might protect her/himself from further abuse. Indicate on the reporting form any special concerns regarding how the report should be handled to maximize patient safety.

OPEN COMMUNICATION

Discuss with patient your legal obligation to report and explain what consequences may follow up from reporting. Providers should find out how local police will respond to reports and communicate this to the patient. Ask the patients if s/he wants to be present during the telephone report to the police.

REFERRALS

Provide patient with referrals to domestic violence services. Ask if s/he wants assistance in contacting a local agency.

DOCUMENTATION IN MEDICAL RECORD

Include in medical record: patient's comments regarding injuries, identity of suspected perpetrator and past domestic violence, descriptions of injuries and body map, copy of reporting form, photographs of the injuries, any evidence collected.

Common Questions and Answers About Mandatory Reporting Requirements for San Francisco Health Practitioners

This information is intended to be a general reference guide for questions about mandatory reporting. Information presented herein should not be construed as legal advice. Specific questions regarding interpretation of the law should be referred to your local district attorney.

1. If I provide counseling or social work services to a patient who has domestic violence injuries, but do not provide medical treatment, do I have to report?

No. You only report if you are a health practitioner who provides medical services for a physical condition to a patient you know or reasonably suspect is suffering from a wound or physical injury due to assaultive or abusive conduct or a firearm.

2. If I am treating a patient for injuries or conditions unrelated to the battering, but am aware that the patient has other physical injuries due to domestic violence, do I have to report?

The language of the law is vague regarding this issue. The legislator who wrote this law, Assembly Member Jackie Speier, specified that her intent was that provider does not have to be treating the domestic violence injury in order for the reporting requirements to apply: the provider must be providing medical services for a physical condition, and the patient must have a domestic violence physical injury, but the former condition and latter injury do not have to be related. Until courts begin interpreting this statute, however, the answer to this question remains unclear.

3. What must be included in the health practitioner report made to the police?

The report must include the following:

- (A) The name of the injured person, if known.
- (B) The injured person's whereabouts.
- (C) The character and extent of the person's injuries.
- (D) The identity of any person the injured person alleges inflicted the injury.

4. How do I make my health practitioner report?

Telephone the San Francisco Police Department at 553-9220 as soon as possible and leave a voice mail message. Document in the Medical Records that the call was made. Within 48 hours, mail the confidential mandatory health care reporting form to:

San Francisco Police Department
Domestic Violence Unit
850 Bryant Street
San Francisco, CA 94103

5. What happens in San Francisco to the health practitioner report once it is made?

If you follow the instructions above, your report and compliance with the law will be noted and kept on file at the Domestic Violence Unit at the police department. According to current police department practices, there will be no police follow-up on your confidential report.

There may be exception to the above procedure. In Emergency Room cases, the police may already be involved. Either they were at the scene of the crime or they have been called to the hospital to conduct an investigation, make a report, and possibly make an arrest.

In addition, if you do not use the voice mail number and address specify above in number 4 police response may vary. For example, police intervention may occur regardless of patient wishes if you call a different police number.

6. How do I get the police to intervene or follow up on the case?

If you or the patient want police intervention or follow-up, you must call 911 for emergencies or 553-0123 to make an official police report. An officer will come to your location to make the report. Your medical mandatory report is not an official police report. Depending on the circumstances, the police report may lead to arrest, prosecution, and/or incarceration.

7. If a patient was injured by the batterer in another county, do I report to law enforcement that oversees the jurisdiction where the clinic is located, or to the police in the county in which she was injured?

The law states that a report must be made to “a local law enforcement agency.” Practically speaking, it may be that upon calling the local police, or sheriff, they will tell you that they cannot do anything and that you should call the law enforcement agency in the county in which he or she was injured.

8. Are we required to tell battered patients that we are going to make a report?

There is no legal requirement to inform patients of the report. However, ethically it would seem imperative. In order to best protect themselves, patients should be aware of any actions that may be taken by the police and any documentation that is being created.

9. Should we tell all patients prior to screening for domestic violence that we are required to make a report if domestic violence is suspected?

The law does not specify any particular procedure. On the one hand, informing patients of the reporting law prior to screening may enhance their autonomy; if patients believe they will be in more danger if a report is made, they can decide to refrain from discussing the abuse or even leave the facility. On the other hand, health care providers can provide life-saving care and information to patients they identify as being battered, and such pre-screening warnings may only provide obstacles to that end. Providers must not let their misgivings about reporting laws prevent them from routinely inquiring about domestic violence and providing appropriate care to patients. Each facility should have a discussion and form its own protocols around this issue.

10. If the battered patient does not want to report, do I still have to make one?

Legally, you are required to report whether or not the patient consents to a report, even though there may be countervailing ethical principles. You should find out why the patient does not want a report made, and

advocate on behalf of his or her needs and concerns with the authorities. (see questions 11 and 12 below for more discussion)

11. May reporting result in any negative repercussions for my patient?

Providers should be aware of the potential harmful consequences mandatory reporting presents for battered patients. Reporting may put battered patients at risk for retaliation if police intervene against patients' wishes. It may deter patients from seeking health care or being candid with their clinicians about the causes of their injuries. There may be an ineffective response to reports of abuse. Reporting without patient consent infringes on personal autonomy, and may also revictimize patients by controlling their life decisions. The abrogation of provider-patient confidentiality that may result from reporting is also harmful and may undermine the patients' trust in their providers. In San Francisco, many of these concerns may be alleviated as the police response is largely dictated by the request of the providers/patients (when providers follow the reporting protocol outlined on Section V, Mandatory Reporting in San Francisco).

12. What can I do to minimize some of the potential dangers to my client from reporting?

Most importantly, providers should provide ongoing, supportive care, address patient safety and guide the patient through available options. Institutions must support providers in meeting the needs of battered patients. Collaboration with domestic violence programs in developing policies, practices and trainings is essential to this process. Providers should learn how authorities respond to reports and discuss this with the patient. They should address the risk of retaliation and need for safety precautions in cases where there will be police intervention or follow-up. Providers should work with the patient and authorities to meet patient needs when handling the report and strive to maximize the patient's input into any future plan of action.

13. If the battered patient is a minor, under what law do we report?

Whenever the Child Abuse and Neglect Reporting Act applies, that reporting act supersedes the reporting act discussed here. If a minor is battered by an intimate partner, that falls within the definition of child abuse in the Child Abuse and Neglect Reporting Act, and should therefore be reported pursuant to that law.

14. If a patient's children are also being abused and I report to Child Protective Services, will CPS be sensitive to the needs of my patient?

Child Protective Service workers may not always be trained on adult domestic violence. Punitive state measures such as taking the child from the mother's care for her failure to protect her child may occur. Such measures do not always address the source of the problem-- the batterer-- and may be harmful to the mother and the child. Clinicians should go beyond simply filing reports; they might consult their ethics and risk management committees, and battered women's advocates on how to protect the child and also facilitate the mother's safety and empowerment.

This paper reflects Mandatory Reporting procedures for San Francisco County only. If you are outside of San Francisco County, please check your local Mandatory Reporting procedures and police response as they vary from county to county.

Prepared by Ariella Hyman of the San Francisco Legal Assistance Foundation for the San Francisco Family Violence Council's Health Committee.

D.V. CONTACT FORM

(*Leave copy in chart and send copy to PHN if referred to PHN.)

DATE _____ CENSUS TRACT# _____

NAME OF PATIENT _____

RELATIONSHIP OF PERPETRATOR TO PATIENT _____

DOES PERPETRATOR LIVE WITH PATIENT? YES _____ NO _____
SOMETIMES _____

PHONE NUMBER OF PATIENT _____

IS IT SAFE TO CONTACT PATIENT BY PHONE? YES _____ NO _____

SAFE TO CALL DURING WHICH HOURS? ANYTIME _____
ONLY BETWEEN HOURS OF _____ AND _____

PATIENT ADDRESS _____

SAFE TO VISIT PATIENT IN HOME? YES _____ NO _____
ONLY DURING FOLLOWING DAYS/TIMES _____

ALTERNATE VISIT SITE _____

SAFE EMERGENCY CONTACT (IF AVAILABLE):

NAME _____

RELATIONSHIP TO PATIENT _____

EMERGENCY CONTACT AWARE OF DOMESTIC VIOLENCE? YES _____ NO _____

PHONE NUMBER _____

ADDRESS _____

ADDITIONAL COMMENTS:

FAMILY VIOLENCE REFERRAL LIST

1. POLICE/DISTRICT ATTORNEY		
POLICE/MEDICAL EMERGENCY	911	Outreach & Advocacy Program ~@*# 553-1865
LOCAL POLICE	553-0123	Latino Family Alcoholism Counseling Ctr.* 826-6767
Domestic Violence Unit	553-9225	CHILDREN, YOUTH, AND FAMILY COUNSELING
Juvenile Sexual Assault Unit	558-5500	Child Crisis Service ∞ 970-3800
Sexual Assault Unit	553-1361	Larkin Street Youth Center *
District Attorney	553-1752	Homeless and Runaway Youth 800-669-6196
Family Violence Project	553-1865	Youth Crisis Line 800-843-5200
Victim Witness Assistance Program	553-9044	LINC (child witnesses of dv) 885-7636
2. REPORTING LINES		BATTERERS' COUNSELING
Domestic Violence Reporting Line	553-9220	MAN ALIVE * (PACOV) Spanish only 552-1361
S.F. DHS Child Abuse Reporting *@~	558-2650	MOVE (Men Overcoming Violence) 626-MOVE
Elder Abuse Hotline ∞ (APS)	557-5230	Center for Special Problems ~@* 292-1500
3. CRISIS		ELDERLY COUNSELING
National Domestic Violence Hotline ∞	800-799-7233	SF Institute on Elder Abuse Prevention 750-4188 (x222)
Woman, Inc.(24 hr.) ∞	864-4722	Network for Elders 647-5353
La Casa de las Madres *	877-503-1850	GAY/LESBIAN/BI/TG COUNSELING
Riley Center *@~	255-0165	CUAV ∞ 333-4357
Riley Center *@~ (offices)	552-2943	New Leaf *(ss) 626-7000
Riley Center *@~ (shelter)	831-3535	5. SUBSTANCE ABUSE
Asian Women's Shelter #@~χ§∞	877-751-0880	Women and Children's Family Services
Raphael House *	474-4621	Administrative *(ss) 447-1600
Women Against Rape Crisis Line ∞	647-RAPE	Client program (Pomeroy House) 282-8900
WOMEN'S CRISIS INTERVENTION		Primary Care Substance Abuse Svcs. 206-8866
San Francisco Suicide Prevention ∞	781-0500	Mobile Assistance Patrol (24hrs) 431-7400
Westside Community Crisis Clinic *	353-5050	4 th Avenue Detox 664-1868
SFGH Psychiatric ED.(24hr.) ∞	206-8125	6. LEGAL ASSISTANCE
HELPLINE *~@	English: 772-HELP	Bay Area Legal Aid 575-9630
	Spanish: 772-4444	COOPERATIVE Restraining Order Clinic∞ 864-1790
	Chinese: 772-7339	Cameron House @~§(ss) 781-0401
	TTY: 772-4440	Family Violence Project *~@ # 553-1865
YOUTH CRISIS INTERVENTION		Immigrant Assistance Line * 543-6767
Huckleberry House *~	621-2929	Legal Services for Children, Inc. ~@*# 863-3762
CHALK ∞	777-3399	SF Police Dept. / DV Unit * 553-9225
(Communities in Harmony		7. FOR FURTHER RESOURCES
Advocating for Learning and Kids)		SFDPH Comprehensive Violence Prevention Resource
(4pm-10pm, 7days week)		Directory:
YOUTH ABUSE/NEGLECT		http://www.dhs.ca.gov/ps/cdic/epic/html/dv_directory.htm
Comprehensive Child Crisis Services ∞	970-3800	or
Child/Adolescent Sex Abuse Resource ∞	206-8386	http://www.safetynetwork.org/
Telephone Aid in Living with Kids		
(T.A.L.K.) Line *	441-KIDS	Bay Area Women and Children's Center 474-2400
ELDER CRISIS INTERVENTION		(Comprehensive Resource List for
Friendship Line for the Elderly	752-3778	Low Income Families)
Consortium for Elder Abuse Prevention	447-8900 (x513)	
Senior Information and Referral	626-1033	Free Eats Web Site http://thecity.sfsu.edu/~freep .
GAY/LESBIAN/BI/TG CRISIS INTERVENTION		
Community United Against Violence ∞	333-HELP	
Woman, Inc. ∞	864-4722	
4. COUNSELING		
GENERAL COUNSELING		Code: * Spanish Speaking
Community Mental Health ("Access") *	255-3737	# Tagalog
Psychosocial Medicine	206-5189	@ Mandarin
		~ Cantonese
		χ Hindi
		§ Vietnamese
		∞ Multiple Language Capability/Translation Service
		Used
WOMEN COUNSELING		All Service Free Unless Noted:
Woman, Inc. ∞	864-4722	(ss) Sliding Scale
Cameron House @~§(ss)	781-0401	
Center for Special Problems ~@*(ss)	292-1500	
La Casa de las Madres *	877-503-1850	
Family Violence Project Community		
		Last updated March 2002
		For corrections, suggested changes or to receive updates
		contact Dr. Leigh Kimberg at kimb@itsa.ucsf.edu

HEALTH COMMISSION

CITY AND COUNTY OF SAN FRANCISCO

RESOLUTION NO. 5-97

ENDORING THE POLICY OF ROUTINE DOMESTIC VIOLENCE SCREENING OF ALL WOMEN AND GIRLS IN ALL HEALTHCARE SETTINGS AND ENCOURAGING ALL HEALTHCARE PROFESSIONALS TO DEVELOP, ADOPT, AND IMPLEMENT ROUTINE DOMESTIC VIOLENCE SCREENING PROTOCOLS IN ALL HEALTHCARE SETTINGS, BOTH PUBLIC AND PRIVATE.

WHEREAS, domestic violence is increasingly recognized as a major public health concern in the United States; and,

WHEREAS, healthcare providers have a unique opportunity and responsibility to intervene in cases of domestic violence because they are often the first and sometimes the only professionals to whom an abused person will turn to for help; and,

WHEREAS, screening and responses to domestic violence differ from traditional responses to violence; and,

WHEREAS, since January 1992, the Joint Commission on Accreditation of Healthcare Organizations has required that all accredited hospitals implement policies and procedures in their emergency departments and ambulatory care facilities for identifying, treating and referring victims of abuse, as well as domestic violence educational programs for hospital staff; and,

WHEREAS, California State law requires that all licensed clinics adopt written policies and procedures to screen patients to detect partner abuse; and,

WHEREAS, training for healthcare providers and educators has proven to be very effective in improving the quality of care given to domestic violence patients; and,

WHEREAS, the Health Care Subcommittee of San Francisco's Family Violence Council has developed a *San Francisco Domestic Violence Protocol* for use in all healthcare settings in San Francisco to provide guidelines for healthcare professionals for responding to domestic violence, to improve the quality of care given in San Francisco to domestic violence patients and to assist health care professionals to comply with existing laws and standards; and,

WHEREAS, the *San Francisco Domestic Violence Protocol* outlines the elements of an effective response and has been developed by an interdisciplinary committee of healthcare and domestic violence professionals, including physicians, nurses, medical social workers, administrators, health educators and domestic violence prevention advocates; and,

HEALTH COMMISSION

CITY AND COUNTY OF SAN FRANCISCO

RESOLUTION NO. 5-97 (Cont'd.)

WHEREAS, the model for the *San Francisco Domestic Violence Protocol* has been pilot-tested by twelve hospitals throughout the country, including the Emergency Department-San Francisco General Hospital, ten health centers and clinics administered by the Department of Public Health and the Community Clinic Consortium and the Family Violence Prevention Fund and has proven effective in improving healthcare responses to battered patients; and,

WHEREAS, the *San Francisco Domestic Violence Protocol* includes routine screening of all women and adolescent girls for past and current abuse, the training of healthcare personnel and the availability of training materials; and,

WHEREAS, the San Francisco Police Department, the San Francisco Domestic Violence Consortium and the San Francisco Medical Society have reviewed and provided input on the *San Francisco Domestic Violence Protocol*; now therefore, be it

RESOLVED, that the Health Commission of the City and County of San Francisco hereby endorses the policy of routine domestic violence screening of women and girls in all health care settings, both public and private; and, be it

FURTHER RESOLVED, that the Health Commission directs the Department of Public Health to develop, adopt and implement protocols for routine domestic violence screening; and, be it

FURTHER RESOLVED, that the Health Commission urges other public and private providers to adopt routine domestic violence screening protocols, such as those contained in the *San Francisco Domestic Violence Protocol* promulgated by the Family Violence Council.

I hereby certify that the foregoing resolution was adopted by the Health Commission as its meeting of Tuesday, February 19, 1997.

Sandy Ouye Mori
Executive Secretary to
the Health Commission

*CITY & COUNTY OF SAN FRANCISCO
DEPARTMENT OF PUBLIC HEALTH
COMMUNITY PUBLIC HEALTH SERVICES*

SIGNATORY PAGE

DOMESTIC VIOLENCE PROTOCOL

APPROVED:

David Ofman, M.D., M.A.
Medical Director, Community-Oriented Primary Care

Date

Jan Murphy, MBA
Primary Care Administrator, CHN

Date

Mary Anne McGuire-Hickey, R.N., M.S
Director of Nursing

Date

Leigh Kimberg, M.D.
Domestic Violence Coordinator for
Community Public Health Services

Date

Kate Monico Klein
Coordinator of Women's Services

Date

Maureen O'Neil, LCSW
Social Work Supervisor

Date