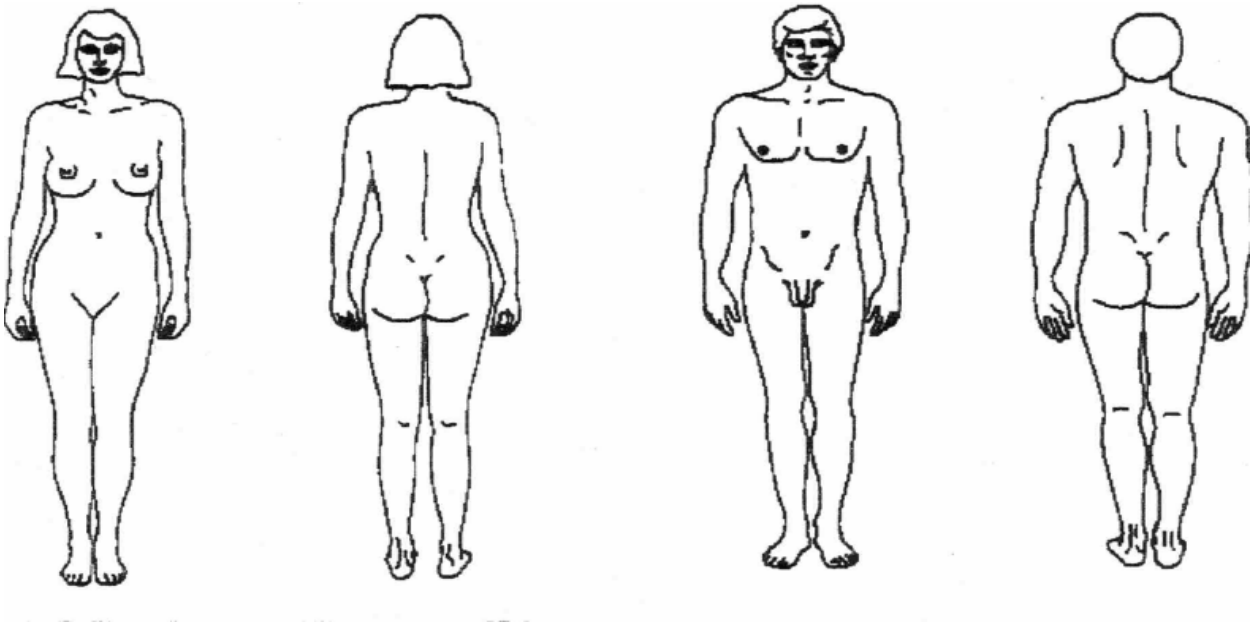
Date _____

Patient Label or
Name/MR #

DOMESTIC VIOLENCE DOCUMENTATION FORM

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



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**	**Perpetrator has weapon?**
_ Yes	**_ No**	**Alcohol or substance abuse by perpetrator?**
_ Yes	**_ No**	**Was safety plan discussed?**

Provider Name _____

Signature _____

REFERRALS

_ Hotline number given
_ Legal referral made
_ Shelter number given
_ Social work referral
Describe: _____
_ PHN referral
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 for the California Department of Health Services