NOTE: Photocopy for office use to document patient injuries.

VOLUNTARY DOMESTIC VIOLENCE SCREENING/STATISTICAL FORM

Date: ______________________

Location of reporting facility:

County ________________________

Type of Reporting Facility:

- ☐ Emergency Dept.
- ☐ Walk-in Clinic
- ☐ Home Health
- ☐ Private Practice
- ☐ Ambulatory Surgical
- ☐ Other: ____________ (specify)

Domestic Violence Screen:

- ☐ DV + (Positive)
- ☐ DV ? (Suspected)

Photographs:

YES	NO	
☐	☐	Consent to be photographed?
☐	☐	Photographs taken?

Referrals:

- ☐ Hotline number given
- ☐ Legal referral made
- ☐ Shelter number given
- ☐ Police
- ☐ In-house referral made: Describe ________________________________
- ☐ Other referral made: Describe ________________________________

PATIENT INFORMATION

County of Residence: ______________

Zip Code: ______________________

Age of Patient: ____________________

Sex:

- ☐ Female
- ☐ Male

Patient Pregnant:

- ☐ Yes
- ☐ No

Race: (Check one)

- ☐ White
- ☐ Black
- ☐ American Indian/Alaskan Native
- ☐ Asian/Pacific Islander
- ☐ Other
- ☐ Unknown

Hispanic:

- ☐ Yes
- ☐ No
- ☐ Unknown

Patient Safety Assessment Tool:

YES	NO	
☐	☐	Has there been physical violence?
		By whom? Patient ___ Abuser___ Both___
☐	☐	Have there been threats of physical violence?
		By whom? Patient ___ Abuser___ Both___
☐	☐	Has physical violence increased in severity?
☐	☐	Have there been threats of homicide?
		By whom? Patient ___ Abuser___ Both___
☐	☐	Have there been threats of suicide?
		By whom? Patient ___ Abuser___ Both___
☐	☐	Is there a gun in the patient's home?
☐	☐	Is alcohol or substance abuse involved?
		By whom? Patient ___ Abuser___ Both___
☐	☐	Has the abuser physically abused children?
☐	☐	Have the children witnessed violence in the home?
☐	☐	Is the abuser here now?
☐	☐	Is the patient afraid of their abuser?
☐	☐	Is the patient afraid to go home?
☐	☐	Did you discuss a safety plan with the patient?

Patient is the Abuser's:
(Relationship of patient to the abuser)

- ☐ Wife
- ☐ Ex-wife
- ☐ Girlfriend
- ☐ Ex-Girlfriend
- ☐ Husband
- ☐ Ex-Husband
- ☐ Boyfriend
- ☐ Ex-Boyfriend
- ☐ Father*
- ☐ Mother*
- ☐ Child*
- ☐ Sibling
- ☐ Other relative:
  Specify________________
  (i.e. Aunt, Uncle)
- ☐ Other:
  Specify________________
  (i.e. Stepmother, Stepfather)
- ☐ Unknown

***Required Reporting - See back page.**

Weapons Used:
(Check all that apply)

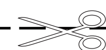
- ☐ Blunt Object
- ☐ Cutting and Piercing Instrument
- ☐ Fire
- ☐ Firearms/Explosives
- ☐ Physical abuse using mouth, hands and /or feet
- ☐ Other:
  Specify______________
  (i.e. cigarette burns)
- ☐ Weapon Unknown

Overall severity assessment indicator:

- ☐ Did not need medical treatment
- ☐ Not hospitalized but needed medical treatment
- ☐ Hospitalized in fair or satisfactory condition
- ☐ Hospitalized in poor or critical condition
- ☐ Death

24-HOUR DOMESTIC VIOLENCE HOTLINE

(800) 332-7385



* Provided in cooperation with Tennessee Department of Health

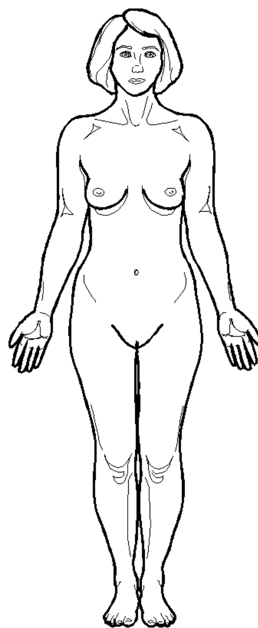
VOLUNTARY DOMESTIC VIOLENCE SCREENING/STATISTICAL FORM

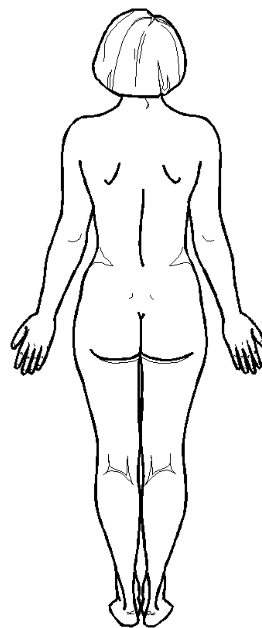
Indicate location and type of trauma.

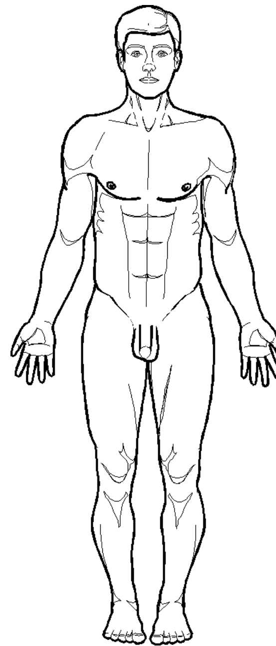
	Abrasions	Burns	Bleeding	Contusions	Fracture	Lacerations	Loss of Function	Painful Areas
Head								
Ears								
Nose								
Cheeks								
Mouth								
Neck								
Shoulders								
Arms								
Hands								
Chest								
Back								
Abdomen								
Genitalia								
Buttocks								
Legs								
Feet								

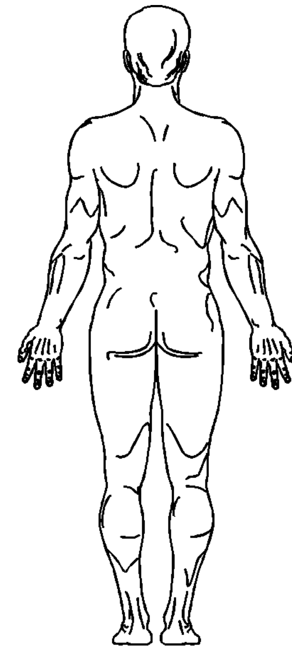
Other: ______________________________

Indicate the location of trauma on the diagram below:









Required Reporting in Addition to this Form:	**Reporting Authority:**
Child neglect/abuse/sexual abuse	Juvenile Judge, Local Police or County Sheriff, District Attorney General, Department of Children Services, Department of Health, and Medical Examiner (If death involved)
Adult/Elder Abuse	Department of Human Services
Suspicious Fire Deaths	Medical Examiner, District Attorney General, and Local Police or County Sheriff
Death by Other Violent Circumstances	Medical Examiner, District Attorney General, and Local Police or County Sheriff
Deadly Weapons Injuries	Local Police or County Sheriff and District Attorney General