DOMESTIC VIOLENCE (DV) SCREENING

Name: _____ Date: _____

This information is part of your health care record. Your responses will not be released to anyone without your written consent, except as otherwise provided by law. If you do not feel comfortable talking today, you can call a hotline number anytime at:

NYS Adult Domestic Violence Telephone #
1-800-942-6906
TTY for the Hearing Impaired – English
1-800-818-0656
En Español Voice Telephone #
1-800-942-6908
TTY for the Hearing Impaired – Spanish
1-800-780-7660

NYC Bilingual Domestic Violence Hotline
Call 311 or 1-800-621-4673
Hearing Impaired
1-800-810-7444

Violence Intervention Program
(212) 410-9080

Please answer the following questions:

1.	**Do you feel safe at home?**	☐ **Yes**	☐ **No**
2.	**We all have disagreements – when you and your partner or a family member argue, have you ever been physically hurt or threatened?**	☐ **Yes**	☐ **No**
3.	**Do you feel your partner or a family member controls (or tries to control) your behavior too much?**	☐ **Yes**	☐ **No**
4.	**Does he or she threaten you?**	☐ **Yes**	☐ **No**
5.	**Has your partner (or other family member) ever hit, pushed, shoved, punched or kicked you?**	☐ **Yes**	☐ **No**
6.	**Have you ever felt forced to engage in unwanted sexual acts/contact with your partner or other family member?**	☐ **Yes**	☐ **No**

Physician use only

DV Screen

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

DOMESTIC VIOLENCE DOCUMENTATION FORM

Date: _____ **Patient ID#:** _____

Patient Name: _____

Provider Name: _____

Patient Pregnant? ☐ **Yes** ☐ **No**

DV Screen

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

Examination Findings:

_____

_____

_____

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?

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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

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Photographs

☐ Yes ☐ No Consent to be photographed?
☐ Yes ☐ No Photographs taken?
Attach photographs and consent form

Produced by:
The Family Violence Prevention Fund