



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

Referrals

- Hotline number given
- Legal referral made
- Shelter number given
- In-house referral made Describe: _____
- Other referral made Describe: _____

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

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