DOMESTIC VIOLENCE ABUSE ASSESSMENT

Date ________________ Patient ID# ________________

Patient Name ______________________________

Patient Pregnant? ___ yes ___ no

R = ROUTINELY SCREEN

Because violence is so common in women's lives, I've begun to ask about it routinely.

A = ASK DIRECT QUESTIONS

___ yes ___ no Do you feel safe at home?

___ yes ___ no Are you in a relationship in which you have been hurt or threatened?

___ yes ___ no Have you ever been hit, kicked, or punched by someone close to you? ____ # of times in past yr.

___ yes ___ no I notice you have a number of bruises; did someone do this to you?

D = DOCUMENT YOUR FINDINGS

Patient report (Use patient's own words) - Description of assault (struck with fists or object, kicked, thrown, etc.)

___ yes ___ no **Abuse Confirmed.**

If yes, name of alleged perpetrator and relationship to patient

___ yes ___ no **Abuse Suspected. State reasons.**

A = ASSESS CLIENT SAFETY

___ yes ___ no Is patient afraid to go home?

___ yes ___ no Increase in severity/frequency of abuse?

___ yes ___ no Threats of homicide or suicide?

___ yes ___ no Weapon present?

R = REVIEW OPTIONS AND REFERRALS

___ yes ___ no Need immediate shelter?

___ yes ___ no Hotline numbers/resources given?

___ yes ___ no Referred to staff?

___ yes ___ no Referred to outside source?

___ yes ___ no Follow-up appointment? ________ date

___ yes ___ no Can patient be called at home? If no, is there a safe number where patient can be reached? ________________

Provider Evaluation

Provider Signature ______________________

Check Physical Findings

	Contusion	Abrasion	Laceration	Bleeding	Tenderness
Head					
Ears					
Nose					
Cheeks					
Mouth					
Neck					
Shoulder					
Arms					
Hands					
Chest					
Back					
Abdomen					
Genitals					
Buttocks					
Legs					
Feet					

___ yes ___ no Photographs taken?

Indicate Where Injury Was Observed: