

## 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.)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Provider Evaluation

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

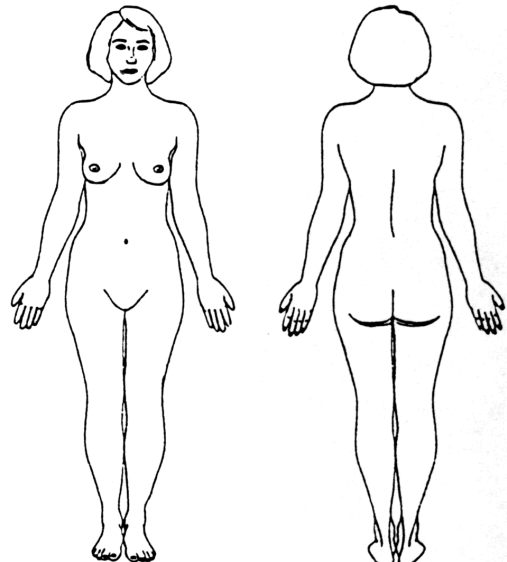
yes  no Can patient be called at home? If no, is there a safe number where patient can be reached? \_\_\_\_\_

Provider 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					

Indicate Where Injury Was Observed:



yes  no Photographs taken?