

DO NOT COPY WITHOUT  
EXPRESS PATIENT PERMISSION

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

## Domestic Violence Documentation Form

### STEP 1 – Establish privacy to ask screening question.

Safety is the first priority. ONLY complete this form if YOU CAN assure the patient safety, privacy and confidentiality. The patient must be alone, without partner present.

Is it safe to screen the patient at this time? ☐ Yes ☐ No **If no, STOP HERE**

### STEP 2 – Ask the patient screening questions:

“Because abuse is so common in people’s lives, we are now asking all of our female patients,

Are you in a relationship in which you are being hurt or threatened? \_\_\_ Yes \_\_\_ No

Do you feel safe at home? \_\_\_ Yes \_\_\_ No

If the patient answers YES to either question, proceed to **STEP 3** below.  
If both answers are NO, Go to **STEP 5**

### STEP 3 - ASSESS the patient’s account of abuse and safety:

What is the first time your partner hurt you? \_\_\_\_\_

What is the worst abuse that has happened to you with your partner? \_\_\_\_\_

When is the last time your partner hurt you? \_\_\_\_\_

What happened? \_\_\_\_\_

**Yes      No**

\_\_\_\_ Are you afraid of your partner or any family member? If yes, who: \_\_\_\_\_

\_\_\_\_ Is abuse getting worse and more frequent?

\_\_\_\_ Does your partner use alcohol or drugs?

\_\_\_\_ Have you been forced to do anything sexual that you did not want to do?

\_\_\_\_ Does your partner have a weapon (gun or knife)?

\_\_\_\_ Have you been threatened with any weapon?

\_\_\_\_ Has your partner threatened to kill you?

\_\_\_\_ Has your partner threatened or attempted suicide?

\_\_\_\_ Have you told anyone else about the abuse? Who? \_\_\_\_\_

\_\_\_\_ Do you have any health problems from the abuse? If yes, what? \_\_\_\_\_

\_\_\_\_ Are you afraid to go home today?

Where is your partner now? \_\_\_\_\_

Inform the Patient. “If we have reason to believe that children are being abused, Florida law requires us to report it to state authorities. We must do this to ensure the safety of children. You have the choice NOT to answer any or all of the following questions.”

\_\_\_\_ Not applicable      If there are children, has your partner hurt them?

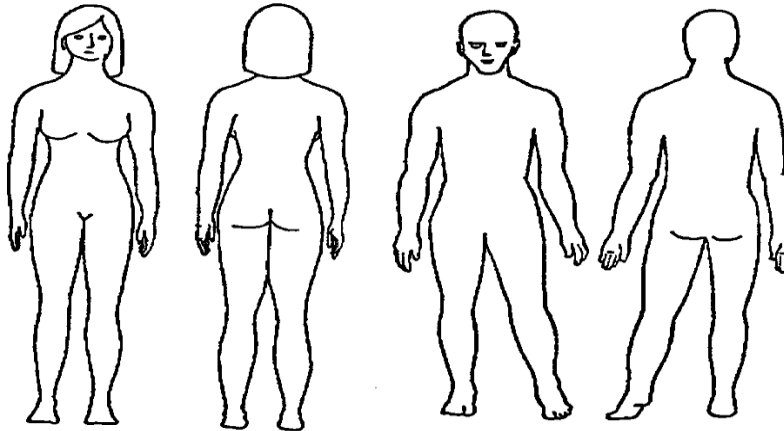
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Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

If Patient has responded yes to above questions and in your professional judgement the patient's safety is an issue, strongly encourage the patient to talk to advocate during visit. Provide safe place for phone call. Review Safety Plan with the patient by staff or advocate.

**STEP 4 - ASSESS Patient's physical injuries, past and present.**



**Observations/Comments/Interventions:**

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**STEP 5** If the patient responds NO to screening. (Check one)

- \_\_\_\_ The patient responds NO to screening, and you do not suspect abuse. Sign & date form.  
\_\_\_\_ The patient responds NO to screening, and you still suspect abuse.

Inform the patient that you are providing information in the event she or a friend may need it in the future. Provide and review: the power and control wheel, cycle of violence, characteristics, why victims stay, safety plan and phone number for state hotline and nearest domestic violence program number.

**STEP 6 – Information, referrals or reports made**

**Yes      No**

- |      |      |   |
|------|------|---|
| ____ | ____ | 1. Patient given domestic violence information including safety planning. |
| ____ | ____ | 2. Reviewed domestic violence information including safety planning.      |
| ____ | ____ | 3. State Hotline and Shelter Hotline number given to the patient.         |
| ____ | ____ | 4. Patient called hotline during visit.                                   |
| ____ | ____ | 5. Patient seen by advocate during visit.                                 |
| ____ | ____ | 6. Report made. If yes, to whom: _____                                    |
| ____ | ____ | 7. Other _____  |

Representative \_\_\_\_\_ Title \_\_\_\_\_ Date: \_\_\_\_\_