DOMESTIC VIOLENCE ASSESSMENT

Date ___________________ Patient ID # _____________________

Patient Name ____________________________________

Patient pregnant _____ yes _____ no

R= Routinely Screen
"Because violence is so common in peoples' lives, I've begun to ask about it routinely."

A=Ask Direct Questions
_____ yes _____ no Are you afraid 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 the past year.
_____ yes _____ no I notice you have a number of bruises; did someone do this to you?

D=Document Your Findings
Patient report: Patient's description of assault (use patient's own words)

____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________

_____ yes _____ no Domestic Violence confirmed by patient.

If yes, name and relationship of perpetrator:

____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________

_____ yes _____ no Domestic Violence suspected.

State reasons:

____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________
____________________________________________________________________________________________________

A=Assess Patient Safety
_____ yes _____ no Is client afraid to go home?
_____ yes _____ no Increase in severity/frequency of abuse?
_____ yes _____ no Threats of homicide or suicide?
_____ yes _____ no Weapon present?
_____ yes _____ no Do you want police intervention?

R=Review Options and Referrals
_____ yes _____ no Need immediate shelter?
_____ yes _____ no Hotline number/community resources given?
_____ yes _____ no Referred to AWARE staff?
_____ yes _____ no Referred to outside source?
_____ yes _____ no Follow-up appointment made?

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

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_____ yes _____ no Photographs taken?