

Preventing Domestic Violence: Clinical Guidelines on Routine Screening

This publication was made possible
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CONRAD N. HILTON FOUNDATION
and the
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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Family Violence Prevention Fund

Founded in 1980, the Family Violence Prevention Fund (FUND) is a leading national organization devoted to developing pioneering domestic violence prevention strategies and public policy responses in the fields of health care, criminal justice, workplace, public education, and child welfare. The central mission of the FUND is to stem the epidemic of violence in our homes.

The Family Violence Prevention Fund's National Health Resource Center on Domestic Violence was developed to strengthen the health care response to domestic violence by providing resources, training materials, and technical assistance to health care professionals and to other providers serving victims of domestic violence. Information, materials and program specialists are available through our toll-free number 1-888-Rx-ABUSE.

The FUND's programs also include: the first ever national public education campaign against domestic violence designed to promote prevention and intervention, called *There's No Excuse For Domestic Violence*; our Judicial Education Program, implemented in more than 20 states to ensure that judges treat domestic violence as a serious crime and hold batterers accountable for their violent acts; the Child Welfare Program, which includes several curricula for child welfare workers; and the National Workplace Resource Center on Domestic Violence, which develops partnerships with employers and unions throughout the country to respond effectively to the needs of abused women in the workplace. The FUND also provides ongoing leadership on public policy through its federal policy efforts on Capitol Hill, as well as its Battered Immigrant Women's Rights Project. The FUND is also working in various African American, Filipino and Latino communities to develop community-based responses to domestic violence.

For more information about the FUND, send an e-mail message to fund@fvpf.org or visit our website: <http://www.fvpf.org>.

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The Family Violence Prevention Fund (FUND) wishes to thank the following individuals for their time and rigorous attention to the development of these guidelines. Their expertise, experience and guidance were invaluable.

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*If you would like more information about improving
the health system's response to domestic violence contact:*

The Family Violence Prevention Fund's
National Health Resource Center on Domestic Violence
888/Rx-ABUSE

Screening for domestic violence provides a critical opportunity for disclosure of domestic violence and provides a woman and her health care provider the chance to develop a plan to protect her safety and improve her health. Recent experience with AIDS, smoking cessation and improved outcomes in breast cancer and cardiovascular disease support the efficacy of early identification and intervention. The prevalence and the health, social and economic costs of domestic violence require equivalent attention and equally effective action by the health care system.

For five years, the Family Violence Prevention Fund (FUND), a national domestic violence advocacy organization has promoted routine screening for domestic violence by health care providers. Concurring with this policy are the American Medical Association, the American Nurses Association and a number of other national health care organizations that recommend that health care practitioners screen for domestic violence.¹⁻³

As screening practice has become more widespread, and as data have been collected that support the efficacy of screening for domestic violence, the need for a set of clear guidelines for screening practice has become apparent. Providers are seeking this information in order to improve patient care, managed care plans and medical organizations in order to promote better practice across their organizations, and researchers and analysts in order to be able to better assess the state of domestic violence practice.

In this document, the FUND presents its recommendations for how screening should occur within the health care system. To develop this policy, the FUND conducted an extensive literature review and held a conference with expert health practitioners in the field of domestic violence screening, intervention and prevention and advocates in the domestic violence community (see page ii for Advisory Committee members).

The FUND recommends that all health care institutions and practitioners follow these guidelines which include both a general policy statement and health setting specific recommendations. The FUND is currently working with national health and medical associations and state organizations to jointly encourage the widespread implementation of these guidelines.

Because it is critical that providers understand how to respond to domestic violence victims once they are identified, policies and protocols on domestic violence must also include clinical guides on effective assessment, intervention, documentation and referral. The FUND recommends that providers pursue training and assistance on these skills prior to implementing screening. Model training materials, departmental guidelines, protocols and other tools that can assist you are available through the FUND and many other organizations.

RATIONALE

Domestic violence is a health care problem of epidemic proportions. It is estimated that between 20% and 30% of all women in the United States have been abused by an intimate partner at some point in their adult lives.⁴⁻⁶ In addition to the immediate trauma caused by abuse, domestic violence contributes to a number of chronic health problems including chronic pain in any organ system,¹ depression^{1,3} and alcohol and substance abuse.^{1,3,7,8} In addition, the management of other chronic illnesses such as asthma, seizure, diabetes and hypertension may be problematic in women who are being abused.

The health care system is positioned to play a pivotal role in domestic violence prevention. Virtually every American woman interacts with the health care system at some point in her life — whether it is for routine health maintenance, pregnancy, childbirth, illness, injury or by bringing her child for health care services. For the estimated 1.5⁴ to the 3.9³⁴ million women who are physically abused by their partners every year, the health care system can be a primary resource.⁹ In fact, according to a report released in November 1998 by the National Institute of Justice and the Centers for Disease Control and Prevention, women make 693,933 visits to the health care system per year as a result of injuries due to physical assault.⁴ The majority of these visits were for treatment of injuries that were inflicted by the women's intimate partners. The scope of this study only measured the impact of specific injuries directly related to physical assault; experts believe these numbers would be significantly higher if data were available which documented visits for other health problems related to domestic violence and the effect of domestic violence on the management of other illnesses.

Although domestic violence directly or indirectly brings millions of women to the health care system every year, health care providers often treat these women without inquiring about abuse, therefore never recognizing or addressing the underlying cause of their health problems.^{6,10-15} Even when domestic violence results in injuries that were obviously inflicted by another person, health care providers often record the injuries and treat the presenting problem without inquiring about the cause of the injuries. An article printed in the *Journal of the American Medical Association* in August 1999 found that less than 10 percent of primary care physicians routinely screen for domestic violence during regular office visits.³⁵

Historically, the health care system has played an important role in identifying and preventing widespread public health problems. We believe the models developed to prevent other chronic health problems may effectively be applied to domestic violence. Routine screening, with its focus on early identification and its capacity to reach patients whether or not symptoms are immediately apparent,¹⁶ is a primary starting point for this improved approach to medical practice for domestic violence. Health care professionals currently screen routinely for a number of common conditions, where the prevalence is less than or similar to that of domestic violence.¹⁷

Routine and multiple screenings by skilled health care providers, when conducted face-to-face, markedly increase the identification of domestic violence.¹⁸⁻²⁰ Routine screening, as opposed to indicator-based screening, will increase opportunities for identification and intervention with patients presenting with symptoms not generally associat-

ed with domestic violence. When victims of domestic violence or those at risk for domestic violence are identified early, providers are able to intervene to help patients understand their options, live more safely within the relationship or safely leave the relationship. Expert opinion suggests that such interventions may lead to reduced morbidity and mortality.²¹

Screening provides women a valuable opportunity to tell their providers about their experiences with abuse. Battered women report that one of the most important parts of their interactions with their physicians was being listened to about the abuse.²²

Published literature also provides guidance for how effective screening should take place, demonstrating the importance of conducting inquiries in private settings and using straightforward, nonjudgmental questions, preferably asked verbally by a health care practitioner.^{18,23,24}

RECOMMENDED PRACTICE

Anecdotal evidence, expert opinion and a growing body of data support the efficacy of routine screening in identifying women who are victims of domestic violence or at risk for domestic violence.^{19,25}

The FUND recommends:

- ▶▶ Routine screening for domestic violence victimization for all female patients over the age of fourteen in primary care, obstetrics/gynecology and family planning, emergency department, in-patient, pediatrics and mental health settings. Routine screening means that inquiry about domestic abuse occurs with all women over the age of fourteen, whether or not symptoms or signs are present and whether or not the provider suspects abuse has occurred.
- ▶▶ That all practitioners and health organizations within these settings implement culturally competent programs to ensure routine screening of all female patients.
- ▶▶ That screening be carried out in private settings and through the use of straightforward, nonjudgmental questions in a culturally competent manner, preferably asked verbally by the practitioner in ways that increase safety of abused patients and respect their autonomy.^{18,23,24}
- ▶▶ Confidential documentation of screening outcomes.

The FUND is convinced that the prevalence of domestic violence, and the data demonstrating the efficacy of screening in increasing identification of domestic violence, strongly support these recommendations for routine screening in the identified populations and settings.

Practitioners and health care organizations should develop policies appropriate to their patient populations and settings (rural, urban, multi-ethnic, etc.) that ensure ongoing training for providers on how to implement these screening guidelines as well as policies for assessment, intervention, comprehensive and confidential documentation, and referral management if abuse is identified.

FUTURE CONSIDERATIONS

The FUND also believes that a broader recommendation for universal screening of all patients (men and women) in all settings may eventually be demonstrated to be appropriate. However, practice in these broader areas is still in its infancy, and there is little definitive research on which to draw conclusions. To appropriately address the question of whether a recommendation for universal screening is warranted, the FUND recommends:

- ▶▶ A research focus on the collection and analysis of data on the efficacy of a universal screening policy for domestic violence victimization.
- ▶▶ Interested providers consider adopting a universal screening policy for domestic violence victimization, particularly if this practice can be tied to research and data collection to demonstrate efficacy.

Expert opinion and initial studies suggest that the prevalence of domestic violence among lesbians, gay, bisexual, transgender individuals (LGBT) may be comparable to that of domestic violence against heterosexual women. Before recommending appropriate screening practices responding to these communities, it is critical to ensure that the guidelines address the unique issues related to the delivery of quality health care for LGBT individuals. The FUND is working with experts in the field of LGBT health care to develop appropriate guidelines.

In the pediatric setting, screening for domestic violence is clearly appropriate, but raises important and complex questions including when and how mothers of pediatric patients should be screened. Screening mothers in pediatric settings will reach women who may be victims of domestic violence and who come in contact with health care providers only through their children's care. Screening mothers in this setting will also indicate to providers whether the pediatric patient may be at risk for direct abuse or as a child witness to domestic violence. The FUND is working with experts in pediatrics, family practice and adolescent medicine to develop a set of recommendations for screening in these settings.

On the following pages, practitioners will find a general screening policy on setting specific recommendations. Each addresses who should be screened, which providers should carry out the screening, the recommended frequency of screening and the environment in which screening should take place.

The formal recommendations that follow provide guidance for practitioners and organizations on who should be screened as well as when, where, how and by whom screening should be carried out.

General Screening Policy

This is a general policy on screening women for domestic violence within the health care system. A more detailed set of recommendations for screening for domestic violence in specific health care settings follows.

■ *Who should be screened routinely for domestic violence?*

- All females aged fourteen years and older.

■ *Who should screen for domestic violence?*

At a minimum, screening should be conducted by a health care provider who:

- Has been educated about the dynamics of domestic violence, the safety and autonomy of abused patients and cultural competency
- Has been trained how to ask about abuse and to intervene with identified victims of abuse
- Is authorized to record in the main body of a patient's medical record.

Ideally, screening should be conducted by a health care provider who either:

- Establishes a relationship or some trust with the patient, OR
- Has a clearly defined role in an urgent care or emergency setting.

■ *How should screening occur?*

At a minimum, screening for domestic violence should:

- Be part of a face-to-face health care encounter
- Be direct and nonjudgmental
- Take place in private; no friends or relatives of the patients should be present during the screening and preferably no children over two should be present
- Be confidential; patients should be told of the confidentiality of the conversation and told of the limits of that confidentiality, including the limits of confidentiality of medical records

- Use professional interpreters when needed, rather than a patient’s friend or family member.

Ideally, screening for domestic violence should *also*:

- Be included as part of a written health questionnaire
- Be conducted in the patient’s primary language with use of professional interpreters when appropriate.

■ *When should screening occur?*

- As part of routine health history (or “review of systems”)
- As part of the standard health assessment
- During an initial visit for a new chief complaint
- During every new patient encounter
- At every new intimate relationship
- During every periodic comprehensive health visit.

■ *Where should screening occur?*

Trained health care providers should provide domestic violence screening as part of routine patient care in the following settings:

- Primary care
- Urgent care
- Ob/Gyn and Family Planning
- Mental health
- Inpatient.

■ *How should a screening policy be implemented?*

All health care providers who screen for domestic violence should receive appropriate training on how to ask about abuse, how to respond when it is identified, and on issues of cultural competency and principles of increasing safety and respecting autonomy of battered patients.

Screening can be facilitated by the use of forms or other assessment tools such as the five-question Abuse Assessment Screen.²⁵ Chart prompts are another effective tool to remind providers to screen and have been shown to increase screening rates.²⁶

Screening for Domestic Violence

Primary Care

Within the managed care system, women are increasingly being seen in a primary care or obstetrician/gynecologist setting, which serves as their entry point into the health care system. The primary care visit offers a woman the chance to have a private conversation with her health care provider, where screening can be done in a less hectic setting than in the emergency department. The primary care setting also offers an opportunity to screen both women who present for routine health maintenance and those who are presenting for specific health complaints.

■ *Who should be screened for domestic violence?*

- ➔ All females aged fourteen years and older.

■ *Who should screen for domestic violence?*

At a minimum, screening should be conducted by a health care provider who:

- ➔ Has been educated about the dynamics of domestic violence, the safety and autonomy of abused patients and cultural competency,
- ➔ Has been trained how to ask about abuse and to intervene with identified victims of abuse,
- ➔ Has the opportunity to speak to the patient in a private setting,
- ➔ Is authorized to record in the main body of a patient's medical record.

Ideally, screening should be conducted by a health care provider who:

- ➔ Establishes a relationship or some trust with the patient.

■ *How should screening occur?*

At a minimum, screening for domestic violence should:

- ➔ Be part of a face-to-face health care encounter,

- Be direct and nonjudgmental,
- Take place in private; no friends or relatives of the patients should be present during the screening and preferably no children over two should be present
- Be confidential; patients should be told of the confidentiality of the conversation and told of the limits of that confidentiality
- Use professional interpreters when needed, rather than a patient's friend or family member.

Ideally, screening for domestic violence should also:

- Be included as part of a written health questionnaire
- Be conducted in the patient's primary language.

■ *When should screening occur?*

- As part of routine health history (or "review of systems")
- As part of health assessment
- During an initial visit for a new chief complaint
- During every new patient encounter
- At every new intimate relationship
- During every periodic comprehensive health visit.

■ *What should patients be screened for?*

- At the first visit, female patients should be screened for any domestic violence that occurred anytime in their lives
- Annually, women should be screened for abuse over the past year.

Screening for Domestic Violence

Emergency Department / Urgent Care

The extremely high prevalence of domestic violence and severity of injuries due to domestic violence justify universal screening in emergency departments. According to a report issued in November 1998 by the National Institute of Justice and the Centers for Disease Control and Prevention, women make 547,000 visits to the emergency department every year for treatment of injuries resulting from physical assault.⁴ Most of these assaults were committed by the women's intimate partners. The emergency department is a setting where women who are at high risk for immediate physical danger are likely to present. Of 4,448 women presenting in 10 emergency departments in two cities, 37% reported that they had been abused by a partner at some time, 10% reported they were currently in a battering relationship, and 4% said their current visit to the emergency department was for abuse by an intimate partner.⁹ Of 3,455 women who completed surveys in 11 community emergency departments, 2.2% were there for acute trauma resulting from domestic violence, 14.4% had experienced domestic violence in the past year and 36.9% had been victims of domestic violence at some point in their lives.⁶

■ *Who should be screened for domestic violence?*

- ➔ All females aged fourteen years and older.

■ *Who should screen for domestic violence?*

At a minimum, screening should be conducted by a health care provider who:

- ➔ Has been educated about the dynamics of domestic violence, the safety and autonomy of abused patients and cultural competency
- ➔ Has been trained how to ask about abuse and to intervene with identified victims of abuse
- ➔ Has the opportunity to speak to the patient in a private setting
- ➔ Is authorized to record in the main body of a patient's medical record.

Ideally, screening should be conducted by a health care provider who either:

- Establishes a relationship or some trust with the patient, OR
- Has a clearly defined role.

■ *How should screening occur?*

At a minimum, screening for domestic violence should:

- Be part of a face-to-face health care encounter
- Be direct and nonjudgmental
- Take place in private; no friends or relatives of the patients should be present during the screening and preferably no children over two should be present
- Be confidential; patients should be told of the confidentiality of the conversation and told of the limits of that confidentiality
- Use professional interpreters when needed, rather than a patient's friend or family member.

Ideally, screening for domestic violence should also:

- Be included as part of a written health questionnaire
- Be conducted in the patient's primary language.

■ *When should screening occur?*

- At every emergency department visit.

■ *What should patients be screened for?*

- Abuse over the past year.

Screening for Domestic Violence

Obstetrics/Gynecology & Family Planning

The American College of Obstetricians and Gynecologists recommends that every woman and girl presenting to an Ob/Gyn provider be screened for domestic violence. Because the prevalence of domestic violence in the Ob/Gyn setting is high and because many women use their Ob/Gyn provider as their primary provider of health care and do not access other providers in the health care system, screening in this setting is critical.^{20,25,27} Like primary care, Ob/Gyn and family planning settings offer a woman the chance to have a private conversation with her health care provider, where screening can be done in a less hectic setting than in the emergency department, for example.

It is estimated that between 7% and 17% of pregnant women in this country are battered by their partners.²⁸⁻³⁰ Of 225 pregnant and 142 nonpregnant women presenting to an urban New England urgent care obstetrics and gynecology unit, 184 (46%) reported a history of physical or sexual abuse, and 38 (10%) reported recent abuse.¹⁰ Recent clinical studies have proven the effectiveness of a two minute screening for early detection of abuse to pregnant women. Additional longitudinal studies have tested a 10-minute intervention that was proven highly effective in increasing the safety of pregnant abused women.³¹

■ *Who should be screened for domestic violence?*

- ➔ All females aged fourteen years and older.

■ *Who should screen for domestic violence?*

At a minimum, screening should be conducted by a health care provider who:

- ➔ Has been educated about the dynamics of domestic violence, the safety and autonomy of abused patients and cultural competency
- ➔ Has been trained how to ask about abuse and to intervene with identified victims of abuse
- ➔ Has the opportunity to speak to the patient in a private setting
- ➔ Is authorized to record in the main body of a patient's medical record.

Ideally, screening should be conducted by a health care provider who:

- Establishes a relationship or some trust with the patient.

■ *How should screening occur?*

At a minimum, screening for domestic violence should:

- Be part of a face-to-face health care encounter
- Be direct and nonjudgmental
- Take place in private; no friends or relatives of the patients should be present during the screening and preferably no children over two should be present
- Be confidential; patients should be told of the confidentiality of the conversation and told of the limits of that confidentiality
- Use professional interpreters when needed, rather than a patient's friend or family.

Ideally, screening for domestic violence should also:

- Be included as part of a written health questionnaire
- Be conducted in the patient's primary language.

■ *When should screening occur?*

- At every prenatal and postpartum visit
- At every new intimate relationship
- At every routine gynecological visit
- At family planning visits
- At STD clinics/visits
- At abortion clinics/visits.

■ *What should patients be screened for?*

- Screening should be for current and past domestic violence that occurred anytime in a woman's life.

Screening for Domestic Violence

Mental Health

In mental health services, including substance abuse settings, universal domestic violence screening of women and girls should be routine. The American Psychological Association recommends that “routine screening for a history of victimization be included in standard medical and psychological examinations.”³ Abuse has significant, lasting mental health effects that, if undetected, would hinder care. Domestic violence is a significant risk factor for depression, PTSD, anxiety and substance abuse in women.³ In one study of women presenting to an emergency room, 29% of the women who had been in abusive relationships had attempted suicide, whereas, only 4% of the women who had never had an abusive relationship had attempted suicide.¹²

■ *Who should be screened for domestic violence?*

- ➔ All female patients aged 14 years or older.

■ *Who should screen for domestic violence?*

At a minimum, screening should be conducted by a health care provider who:

- ➔ Has been educated about the dynamics of domestic violence, the safety and autonomy of abused patients and cultural competency
- ➔ Has been trained how to ask about abuse and to intervene with identified victims of abuse
- ➔ Has the opportunity to speak to the patient in a private setting
- ➔ Is authorized to record in the main body of a patient’s medical record

Ideally, screening should be conducted by a health care provider who:

- ➔ Establishes a relationship or some trust with the patient

■ *How should screening occur?*

At a minimum, screening for domestic violence should:

- ➔ Be part of a face-to-face health care encounter
- ➔ Be direct and nonjudgmental
- ➔ Take place in private; no friends or relatives of the patient should be present during the screening and preferably no children over two should be present
- ➔ Be confidential; patients should be told of the confidentiality of the conversation and told of the limits of that confidentiality
- ➔ Use professional interpreters when needed, rather than a patient's friend or family.

Ideally, screening for domestic violence should also:

- ➔ Be included as part of a written health questionnaire
- ➔ Be conducted in the patient's primary language.

■ *When should screening occur?*

- ➔ As part of every initial assessment
- ➔ At each new intimate relationship
- ➔ Annually, if receiving ongoing or periodic treatment.

■ *What should patients be screened for?*

- ➔ At the first visit, patients should be screened for any domestic violence that occurred anytime in the woman's life
- ➔ Annually, women should be screened for abuse over the past year.

Screening for Domestic Violence

Inpatient

The inpatient setting provides an opportunity to screen for domestic violence in a setting in which a woman is safely outside the home for a duration of time. One prevalence study of an inpatient female population found a 26% lifetime prevalence of domestic violence.³²

■ *Who should be screened for domestic violence?*

- ➔ All females aged fourteen years and older.

■ *Who should screen for domestic violence?*

At a minimum, screening should be conducted by a health care provider who:

- ➔ Has been educated about the dynamics of domestic violence, the safety and autonomy of abused patients and cultural competency
- ➔ Has been trained how to ask about abuse and to intervene with identified victims of abuse
- ➔ Has the opportunity to speak to the patient in a private setting
- ➔ Is authorized to record in the main body of a patient's medical record.

Ideally, screening should be conducted by a health care provider who:

- ➔ Has established a relationship or some trust with the patient.

How should screening occur?

At a minimum, screening for domestic violence should:

- ➔ Be part of a face-to-face health care encounter
- ➔ Be direct and nonjudgmental

- Take place in private; no friends or relatives of the patient should be present during the screening and preferably no children over two should be present
- Be confidential; patients should be told of the confidentiality of the conversation and told of the limits of that confidentiality
- Use professional interpreters when needed, rather than a patient's friend or family member.

Ideally, screening for domestic violence should also:

Be included as part of a written health questionnaire

Be conducted in the patient's primary language.

When should screening occur?

- As part of admission to the hospital
- As part of discharge from the hospital.

What should patients be screened for?

- Abuse over the past year.



Glossary of Terms

- Cultural Competency:** The standard terminology currently used in health care. It refers to the process by which the provider combines the general knowledge with specific information provided by the victim about his/her culture, incorporates an awareness of one's biases, and approaches the definition of culture with a critical eye and open mind.
- Domestic Violence:** A pattern of coercive behaviors that may include repeated battering and injury, psychological abuse, sexual assault, progressive social isolation, deprivation and intimidation. These behaviors are perpetrated by someone who is or was involved in an intimate relationship with the victim.
- Routine Screening:** Routine inquiry, either written or verbal, by health care providers to patients about personal history with domestic violence. Unlike indicator-based screening, routine screening means screening conducted routinely on all individuals or specified categories of individuals in a specified situation.

APPENDIX B

Suggested Screening Questions

FRAMING QUESTIONS:

- ➔ Because violence is so common in many people's lives, I've begun to ask all my patients about it.
- ➔ I'm concerned that your symptoms may have been caused by someone hurting you.
- ➔ I don't know if this is a problem for you, but many of the women I see as patients are dealing with abusive relationships. Some are too afraid of uncomfortable to bring it up themselves, so I've started asking about it routinely.
- ➔ Some of the lesbian women and gay men we see here are hurt by their partners. Does your partner ever try to hurt you?

DIRECT VERBAL QUESTIONS:

- ➔ Are you in a relationship with a person who physically hurts or threatens you?
- ➔ Did someone cause these injuries? Was it your partner/husband?
- ➔ Has your partner or ex-partner ever hit you or physically hurt you? Has he ever threatened to hurt you or someone close to you?
- ➔ Do you feel controlled or isolated by your partner?
- ➔ Do you ever feel afraid of your partner? Do you feel you are in danger? Is it safe for you to go home?
- ➔ Has your partner ever forced you to have sex when you didn't want to? Has your partner ever refused to practice safe sex?

FOR HISTORY INTAKE FORMS/NEW PATIENT QUESTIONNAIRES:

Option 1:

- ➔ Have you ever been hurt or threatened by your boyfriend/husband/partner?

-OR-

- ➔ Have you ever been hit, kicked, slapped, pushed or shoved by your boyfriend/husband/partner?

-OR-

- ➔ Have you ever been hit, kicked, slapped, pushed or shoved by your boyfriend/husband/partner during this pregnancy?

-AND-

- ➔ Have you ever been raped or forced to engage in sexual activity against your will?

Option 2:

- ➔ Are you currently or have you ever been in a relationship where you were physically hurt, threatened, or made to feel afraid?

Option 3:

- ➔ Have you ever been forced or pressured to have sex when you did not want to?
- ➔ Have you ever been hit, kicked, slapped, pushed or shoved by your boyfriend/husband/partner?

Option 4:

ABUSE ASSESSMENT SCREEN³³

1. Have you ever been emotionally or physically abused by your partner or someone important to you? YES NO

2. Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone? YES NO

If YES, by whom? _____ Total number of times: _____

3. Since you've been pregnant, were you hit, slapped, kicked, or otherwise physically hurt by someone? YES NO

If YES, by whom? _____ Total number of times: _____

Mark the area of injury on a body map.
Score each incident according to the following scale:

- 1 = Threats of abuse including use of a weapon
- 2 = Slapping, pushing, no injuries and/or lasting pain
- 3 = Punching, kicking, bruises, cuts and/or continuing pain
- 4 = Beating up, severe contusions, burns, broken bones
- 5 = Head injury, internal injury, permanent injury
- 6 = Use of weapon; wound from weapon

If any of the descriptions for the higher number apply, use the higher number.

4. Within the last year, has anyone forced you to have sexual activities? YES NO

If YES, by whom? _____ Total number of times: _____

5. Are you afraid of your partner or anyone you listed above? YES NO

Option 5:

For use as a rubber stamp or printed on Intake Form:

SCREENING : <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DV+ <input type="checkbox"/> DV- <input type="checkbox"/> DV?
--

or

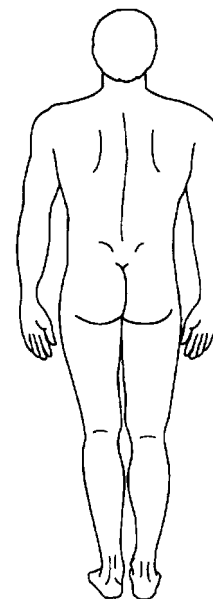
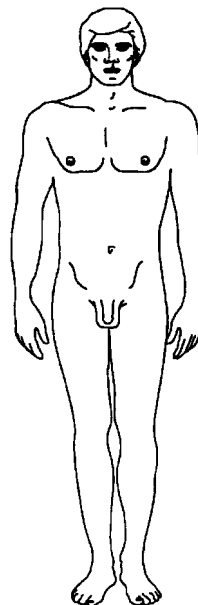
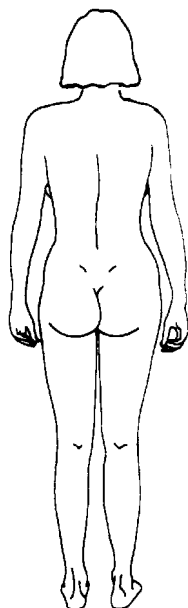
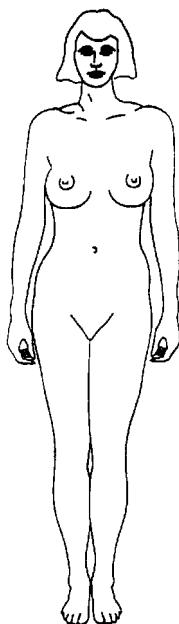
SCREENING : <input type="checkbox"/> DV+ <input type="checkbox"/> DV- <input type="checkbox"/> DV?

(Note: "DV?" means that domestic violence is suspected.)

DOMESTIC VIOLENCE SCREENING/DOCUMENTATION FORM

DV Screen <input type="checkbox"/> DV+ (Positive) <input type="checkbox"/> DV? (Suspected)
--

Date _____ Patient ID# _____
 Patient Name _____
 Provider Name _____
 Patient Pregnant? Yes No



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: _____

REPORTING

- Law enforcement report made
- Child Protective Services report made
- Adult Protective Services report made

PHOTOGRAPHS

- Yes No Consent to be photographed?
 - Yes No Photographs taken?
- Attach photographs and consent form*

Developed by the Family Violence Prevention Fund and Educational Programs Associates, Inc.

Endnotes

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