

# Appendix I

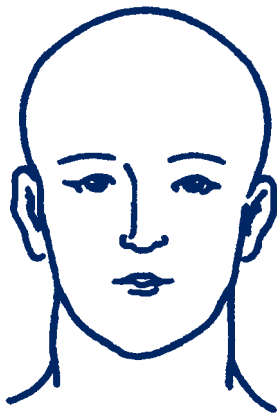
## Family Violence Identification/Documentation Form

Patient Name \_\_\_\_\_ Patient ID# \_\_\_\_\_

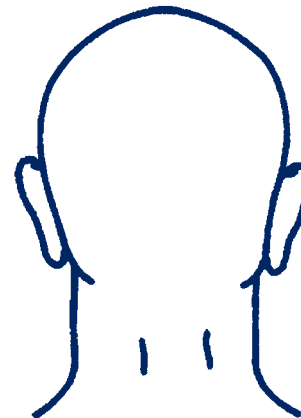
Provider Name \_\_\_\_\_ Time/Date \_\_\_\_\_

FV Screen  FV+ (Positive)  FV? (Suspected)

Patient Pregnant  Yes  No



- Face
- Eyes
- Nose
- Mouth
- Ears
- Neck



- Scalp
- Ears
- Neck

Measure, describe and show abrasions, lacerations, areas of pain and tenderness, sites of trace evidence, tattoos, scars and birthmarks

### Assess Patient Safety

- Yes  No Is abuser here now?
- Yes  No Is patient afraid to go home?
- Yes  No Has partner physically abused children?
- Yes  No Is there a gun in the home?
- Yes  No Have children witnessed the violence?
- Yes  No Threats of homicide?
- Yes  No Threats of suicide?
- Yes  No Is patient afraid of their partner?
- Yes  No Has the violence increased in severity?
- Yes  No Alcohol or substance abuse?
- Yes  No Has a safety plan been discussed?

Describe \_\_\_\_\_

By whom \_\_\_\_\_

By whom \_\_\_\_\_

### REFERRALS

- Family violence referral agency number given
- Police called
- Legal referral made
- Refuge number given
- In-house referral made
- Other referral made

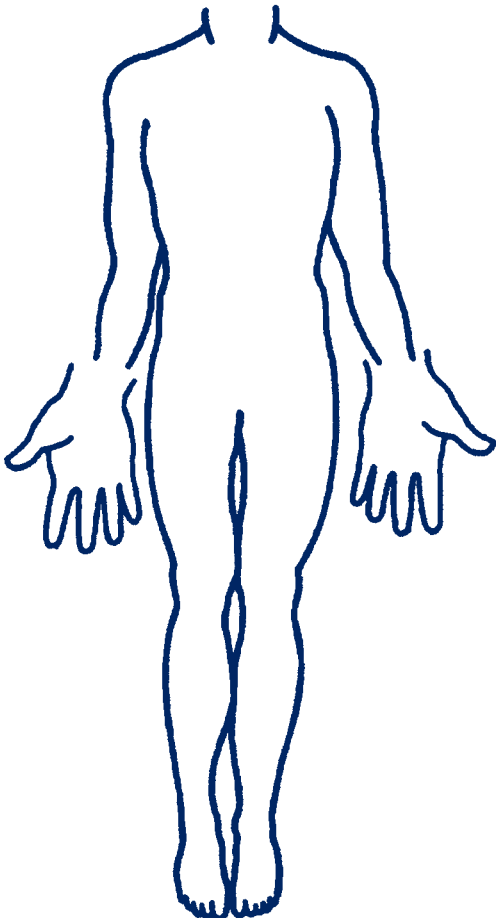
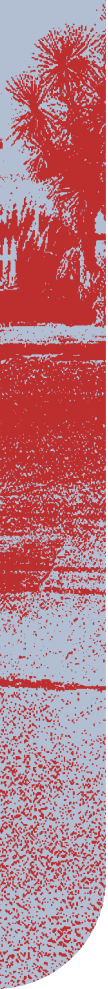
### REPORTING

- CYF Referral

### PHOTOGRAPHS

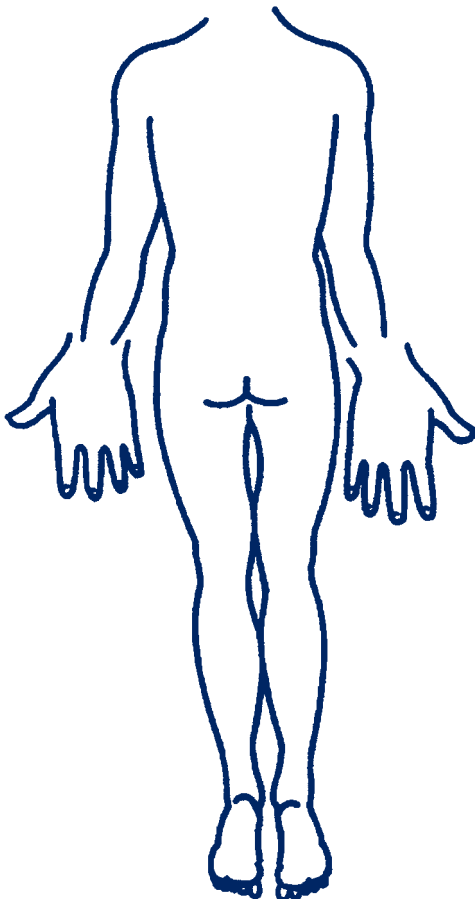
- Yes  No Consent to be photographed
- Yes  No Photographs taken

*Attach photographs and consent form*



## FRONT

- Shoulders
- Breast
- Thorax
- Upper Arm
- Lower Arm
- Hands
- Abdomen
- Upper Leg
- Lower Leg
- Feet



## BACK

- Shoulders
- Back
- Upper Arm
- Lower Arm
- Hands
- Buttocks
- Upper Leg
- Lower Leg
- Feet