



Name of Health Service:

[Grey box for Patient Details (UR)]

**Health worker to explain the following in own words:**

- In this health service, we are concerned about your health and safety, so we ask all women the same questions about violence at home;
- This is because violence is very common and we want to improve our response to families experiencing violence.

**Health worker to ask the following questions of ALL female patients on their own.**

- Are you ever afraid of your partner?  YES  NO
- In the last year, has your partner hit, kicked, punched or otherwise hurt you?  YES  NO
- In the last year, has your partner put you down, humiliated you or tried to control what you can do?  YES  NO
- In the last year, has your partner threatened to hurt you?  YES  NO

**If domestic violence has been identified in any of the above questions, continue to questions 5 & 6.**

- Would you like help with any of this now?  YES  NO
- This could be important information for your health care. Would you like us to send a copy of this form to your doctor?  YES  NO

Name of Doctor:

Address: .....

.....

.....

.....  
Signature of Client

.....  
Date

<p><b>DV Risk Status:</b></p> <p>Domestic Violence not identified <input type="checkbox"/></p> <p>Domestic Violence Identified, help refused <input type="checkbox"/></p> <p>Domestic Violence Identified, help provided <input type="checkbox"/></p> <p><b>Provided with:</b></p> <p>Contact phone numbers for DV <input type="checkbox"/></p> <p>Written information for DV <input type="checkbox"/></p> <p>Referral to hospital-based service <input type="checkbox"/></p> <p>Referral to community DV service <input type="checkbox"/></p> <p>Referral to GP <input type="checkbox"/></p> <p>Other _____</p>	<p><b>Screening Not Completed due to:</b></p> <p>Presence of partner <input type="checkbox"/></p> <p>Presence of family members / friends <input type="checkbox"/></p> <p>Absence of interpreter <input type="checkbox"/></p> <p>Woman refused to answer the questions <input type="checkbox"/></p> <p><b>Additional Comments:</b></p> <p>Signature of Health Professional _____</p> <p>Date _____</p>
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DVI ASSESSMENT FORM

**IF THIS FORM WAS NOT COMPLETED PLEASE SCREEN ON NEXT VISIT**