Patient Label/hospital number_____

DOMESTIC VIOLENCE DOCUMENTATION

CONSENT FORM TO OBTAIN EVIDENCE *(Francais au verso)*

To: _____ And to: _____
(Name of Domestic Violence Nurse) (Name of Hospital)

I, _____ authorize you to:

(initial choices)
____ Complete Domestic Violence documentation
____ Collect articles of my clothing and/or physical samples for potential use as evidence
____ Photograph my injuries for potential use as evidence

I understand that I may consent to some, all or none of the above. Should I decline to consent to any of the above, I will not be denied medical treatment. I may withdraw my consent to any of the above at any time during the examination. I also understand that a child protection agency may be notified if there are children under the age of 16 witnessing violence in the home.

Hospitals are also required to release records when subpoenaed through a court order including warrants, in accordance with relevant privacy legislation.

Patient Name (please print)	(Signature of Patient)	(Date/Time)
Witness Name (please print)	(Signature of Witness)	(Date/Time)
Interpreter Name (please print)	(Signature of Interpreter)	(Date/Time)

CONSENT FORM TO RELEASE EVIDENCE

I, _____, authorize you to:

(Initial choices)
____ Inform _____ police that I have made a complaint of assault.
(Name of Police Services)

____ Release to the police the forensic report of the SA/DV Nurse, with the exception of the safety and discharge planning

_____ Release any clothing, physical samples, or photographs the SA/DV Nurse has collected

(Signature of Patient)	(Date/Time)
(Signature of Witness)	(Date/Time)
(Signature of Interpreter)	(Date/Time)

DATE: _____ **Signature/Designation** _____

Patient Label/hospital number_____

1. ADMINISTRATIVE INFORMATION

NAME:	**D.O.B.:**
SEX: ☐ Female ☐ Male	**AGE:**
Do you have children under the age of 16? ☐ No ☐ Yes # _____	Name: _____ Age: _____ Name: _____ Age: _____ Name: _____ Age: _____
Client referred by: ☐ Family ☐ Shelter ☐ VWAP ☐ Police ☐ Victim Services ☐ Hospital_____ ☐ Physician_____ ☐ Self ☐ Other _____	Accompanied by: ☐ Alone ☐ Agency_____ ☐ Family/Friend ☐ Other _____ ☐ Partner

Time Nurse Called:	Arrived:	Left:
Nurse's Name:		
Physician's Name:		Time Seen:
Police Officer's Name:		
Service: Division:	Badge #:	Occurrence #:_____ Event #:_____
CAS worker name: ☐ N/A	Agency:	Date/Time Notified:
Interpreter: ☐ Yes ☐ N/A	Arrived:	Left:
Interpreter Name:	Interpreter Agency:	
Support person called? ☐ No ☐ Yes	Support Agency:	

2. CURRENT ASSAULT HISTORY

Date and Time of Assault:	
Location: (check all that apply) ☐ Patient's home ☐ Friend's home ☐ Outside ☐ Relative's home ☐ Vehicle ☐ Assailant's home ☐ Other _____ Address:_____(if known)	Weapon used: ☐ None ☐ Gun ☐ Knife ☐ Unknown ☐ Weapon indicated but not seen ☐ Other _____
Assailant Information: ☐ Male ☐ Female Name: _____ Date of birth: _____ Age: ____ Use of drugs/alcohol: ☐ Yes ☐ No ☐ Don't know	Relationship to Victim: ☐ Spouse ☐ Common Law Partner ☐ Ex-Spouse ☐ Ex-Common Law Partner ☐ Girlfriend ☐ Boyfriend
Nature of present assault: (as reported by patient) ☐ Pushing ☐ Punching ☐ Slapping ☐ Kicking ☐ Biting ☐ Cutting ☐ Burning ☐ Hair pulling ☐ Strangulation (Complete addendum) ☐ Objects thrown ☐ Sexual Assault (Offer SAEK) ☐ Restraining (method)_____ Other: _____	

DATE: _____ **Signature/Designation** _____

2. CURRENT ASSAULT HISTORY (cont'd)

Loss of Consciousness: ☐ Yes ☐ No Describe: _____	Alcohol/Drugs Consumed by Patient: ☐ Yes ☐ No What/How much: _____ When:_____ Suspected drugging ☐ Yes ☐ No (Use DFSA addendum)
Describe any physical or mental impairment experienced prior to, during, or after the assault. When were these symptoms experienced? _____	
Did _____ threaten to kill you?	☐ Yes ☐ No
Did _____ threaten bodily harm to family/friends?	☐ Yes ☐ No
Did _____ threaten to use a weapon?	☐ Yes ☐ No
Did _____ use a weapon?	☐ Yes ☐ No Weapon type: _____
Are there any firearms in the home?	☐ Yes ☐ No ☐ Don't know
Does _____ have access to any firearms?	☐ Yes ☐ No ☐ Don't know
Does _____ presently reside in the home? If No, where is _____ now? _____	☐ Yes ☐ No
Has there been a recent separation or change in your relationship?	☐ Yes ☐ No
Has there been a recent change in _____employment?	☐ Yes ☐ No

3. PREVIOUS DOMESTIC VIOLENCE

Has _____ ever:	
▪ Attempted or threatened to commit suicide?	☐ Yes ☐ No ☐ Attempted
▪ Controlled or tried to control your daily activities?	☐ Yes ☐ No ☐ Attempted
▪ Isolated or tried to isolate you from friends/family?	☐ Yes ☐ No ☐ Attempted
▪ Stalked you?	☐ Yes ☐ No
▪ Made threats to family, friends or police?	☐ Yes ☐ No
In this relationship have you experienced:	☐ Yes ☐ No
• Emotional Abuse	☐ Yes ☐ No
• Financial Abuse	☐ Yes ☐ No
• Spiritual	☐ Yes ☐ No
• Sexual Abuse	☐ Yes ☐ No
Have you been assaulted at other times by _____? If Yes, when was the last time? _____	☐ Yes ☐ No
Were these prior assaults reported to police? If Yes, Which Police Service? _____	☐ Yes ☐ No
How long has the relationship been violent? _____	
Has the violence become more frequent?	☐ Yes ☐ No
Has the violence become more intense?	☐ Yes ☐ No
Has violence been committed against pets or property?	☐ Yes ☐ No
Have you had any injuries from previous assaults by _____?	☐ Yes ☐ No
Have you ever received medical treatment for injuries because you were assaulted by _____? If yes, where _____	☐ Yes ☐ No
Has _____ been charged with any prior criminal behaviour? If Yes: What:_____ When:_____	☐ Yes ☐ No ☐ Don't know

DATE: _____ **Signature/Designation** _____

3. PREVIOUS DOMESTIC VIOLENCE (cont'd)

Has the _____ disobeyed any court order? If Yes: How_____ When:_____	☐ Yes ☐ No ☐ Don't know
Are you afraid of _____'s friends/family/associates? If Yes: Who_____ Why:_____	☐ Yes ☐ No
Do you believe that _____is capable of severely injuring or killing you (your children)?	☐ Yes ☐ No ☐ Don't know
To the best of your knowledge has _____ been abusive in any past relationships?	☐ Yes ☐ No ☐ Don't know

4. OPTIONS

OPTIONS	DISCUSSED	CHOSEN
Physical Examination		
Injury Documentation (written only)		
Written and Photo documentation		
Forensic evidence collection		
Police involvement		
Diagnostic testing		
Prophylactic medication		
Community referrals		

CONSULTATION/REFERRAL REQUIRED

Name and Designation_____ Reason for consultation/referral_____

Outcome_____

DATE: _____ **Signature/Designation** _____

Patient Label/hospital number_____

5. PHYSICAL EVIDENCE COLLECTION:

PHOTOGRAPHS TAKEN

Have police taken photographs of injuries?		☐ Yes ☐ No	
If SA/DV Nurse is taking photographs, complete the following information:			
Digital Camera		Other	
Time Photographs Taken		Location (room)	

Image Description	Body Location

(If a Polaroid camera was used, indicate on each Polaroid picture,
the name of the patient, date, time, signature of photographer and sequence of each picture.)

Items Collected

1.	3.
2.	4.

Injury Diagrams Used (Circle diagrams used)

Body – Front	Head – Front/Back	Foot – Right
Body – Back	Head Profile – Right/Left	Female Genitalia
Body Profile – Left	Neck – Top of Head – Shoulders	Male Genitalia
Body Profile – Right	Hands – Right/Left	Teeth/mouth
Body Front – Male	Feet – Bottom	
Body Back – Male	Foot – Left	

RELEASE OF ABOVE EVIDENCE AND DOCUMENTATION
Release to:
Name of Police Officer:_____Signature:_____ Police Service:_____Division:____
Print
By:
Name of SA/DV Nurse:_____Signature:_____ Designation:_____
Print
Date:_____ Time: _____ Location:_____

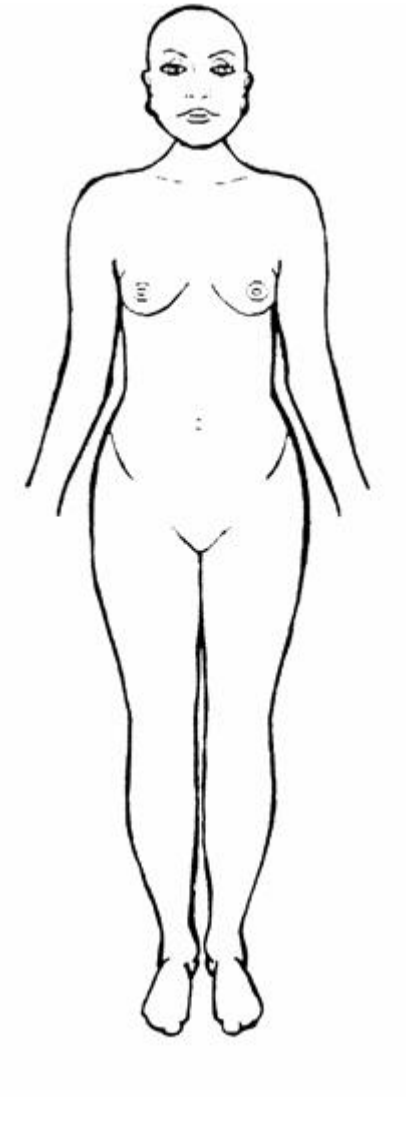
DATE: _____ **Signature/Designation** _____

Patient Label/hospital number_____

INJURY DIAGRAMS:

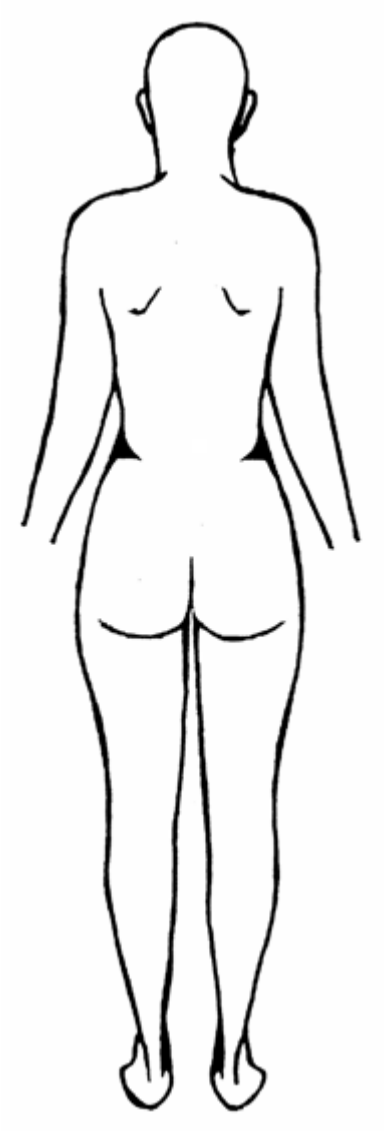
Mark all areas of tenderness and injuries on diagrams, indicating type of injury, size, shape and colour.

Body Front



☐ No injuries observed

Body Back



☐ No injuries observed

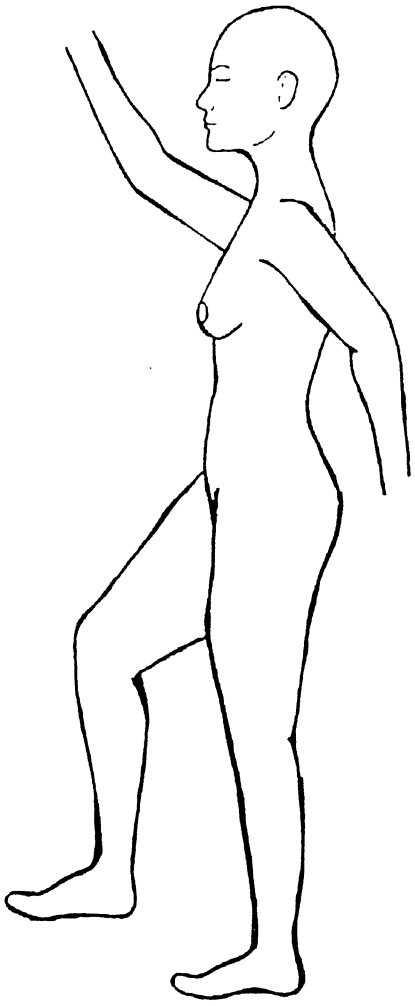
DATE: _____ **Signature/Designation**_____

Patient Label/hospital number_____

INJURY DIAGRAMS:

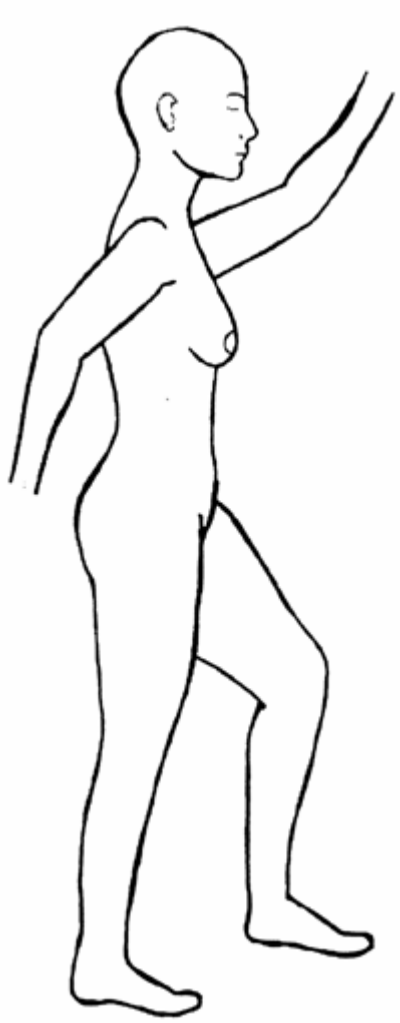
Mark all areas of tenderness and injuries on diagrams, indicating type of injury, size, shape and colour.

Body Profile Left



☐ No injuries observed

Body Profile Right



☐ No injuries observed

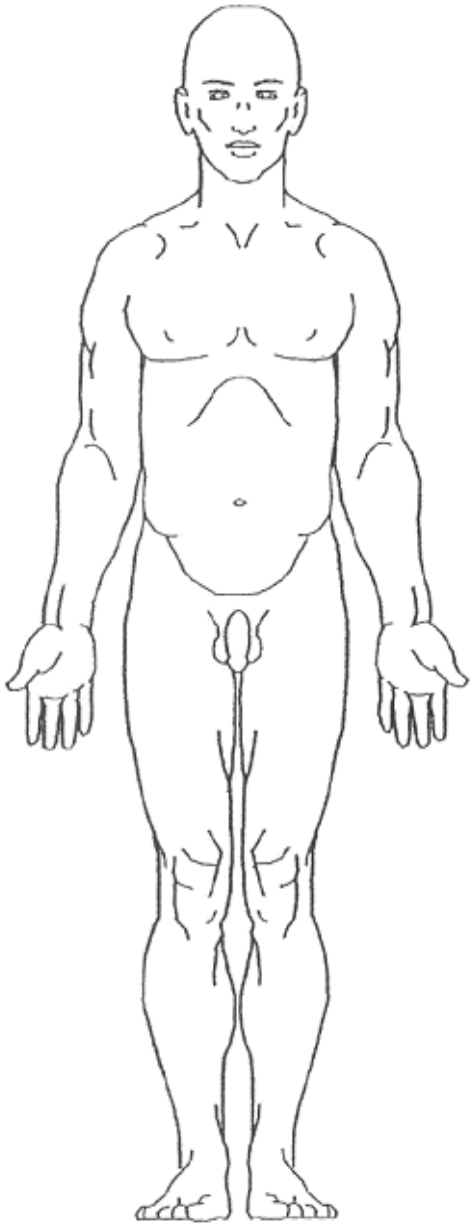
DATE: _____ **Signature/Designation**_____

Patient Label/hospital number_____

INJURY DIAGRAMS:

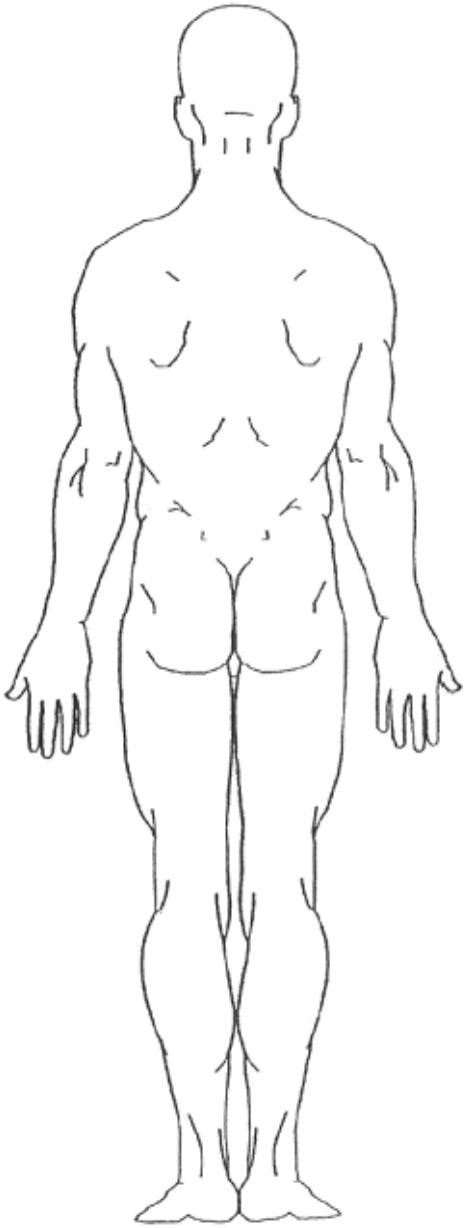
Mark all areas of tenderness and injuries on diagrams, indicating type of injury, size, shape and colour.

Body Front – Male



☐ No injuries observed

Body Back - Male



☐ No injuries observed

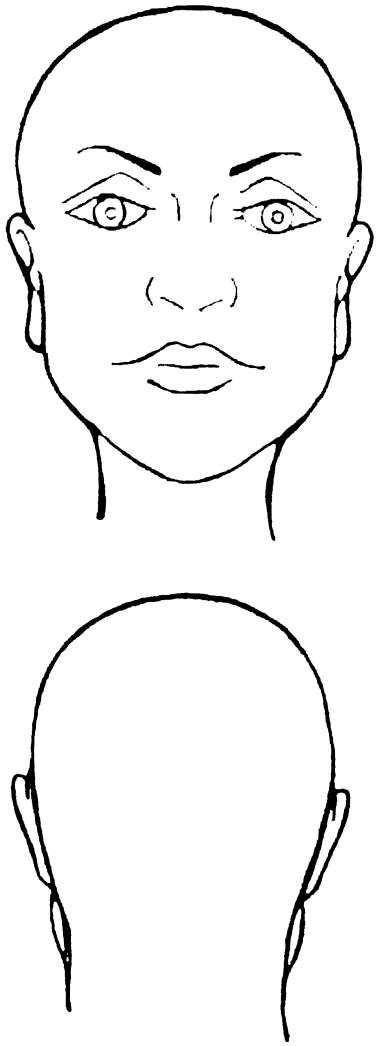
DATE: _____ **Signature/Designation**_____

Patient Label/hospital number_____

INJURY DIAGRAMS:

Mark all areas of tenderness and injuries on diagrams, indicating type of injury, size, shape and colour.

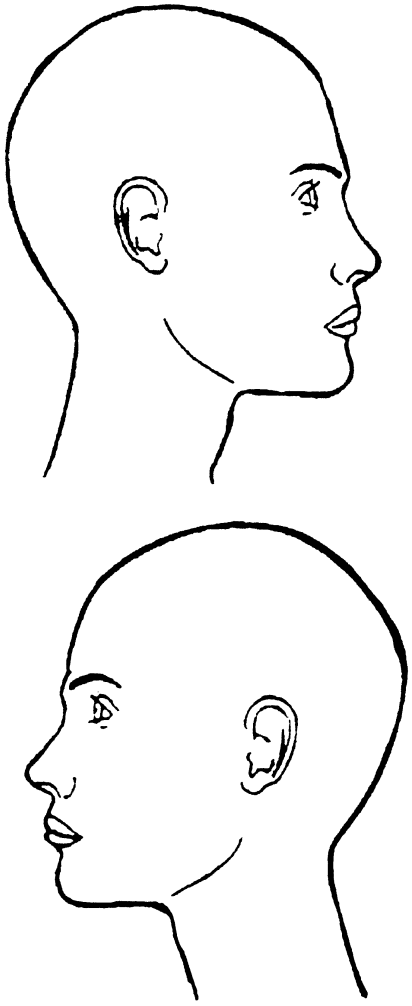
Head – Front/Back



☐ No injuries observed

Head Profile -Right

Right



Left

☐ No injuries observed

DATE: _____ **Signature/Designation**_____

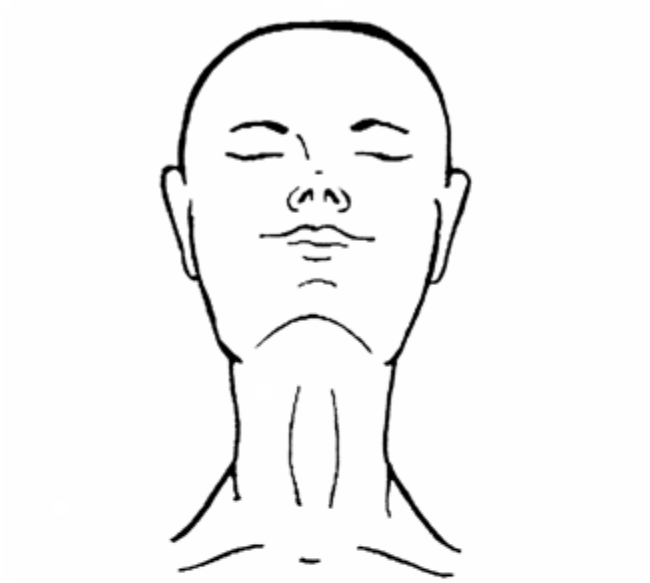
Patient Label/hospital number_____

INJURY DIAGRAMS:

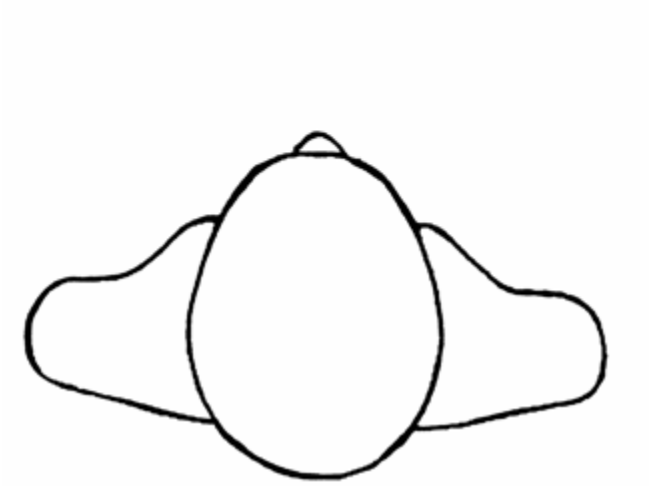
Mark all areas of tenderness and injuries on diagrams, indicating type of injury, size, shape and colour.

Neck – Top of Head – Shoulders

Right **Left**



Left **Right**



☐ No injuries observed

DATE: _____ **Signature/Designation**_____

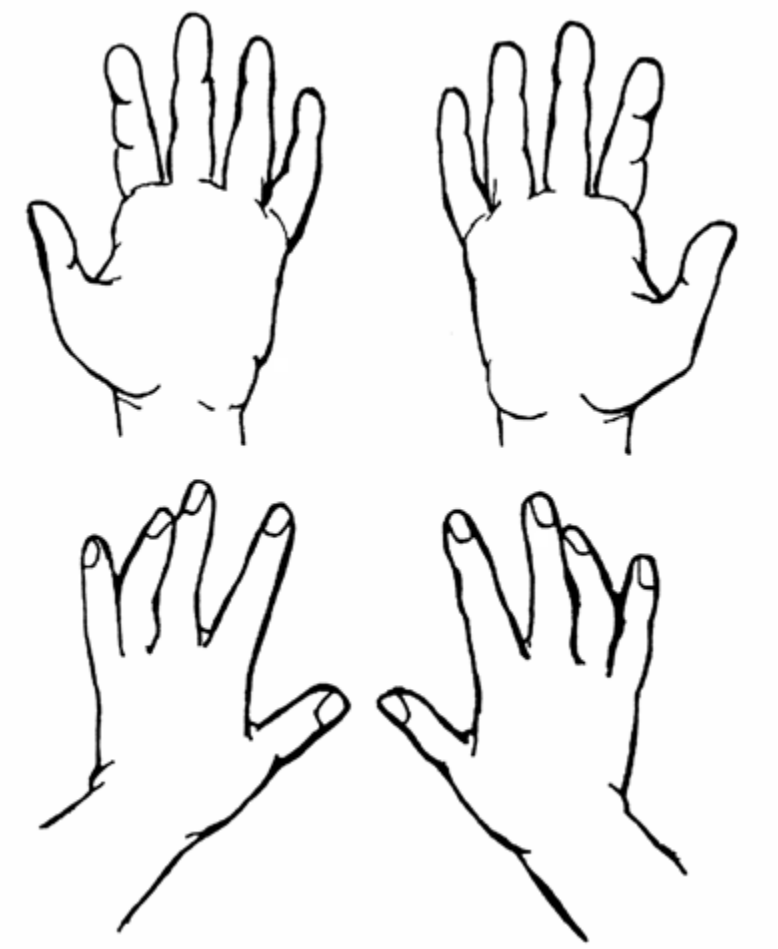
Patient Label/hospital number_____

INJURY DIAGRAMS:

Mark all areas of tenderness and injuries on diagrams, indicating type of injury, size, shape and colour.

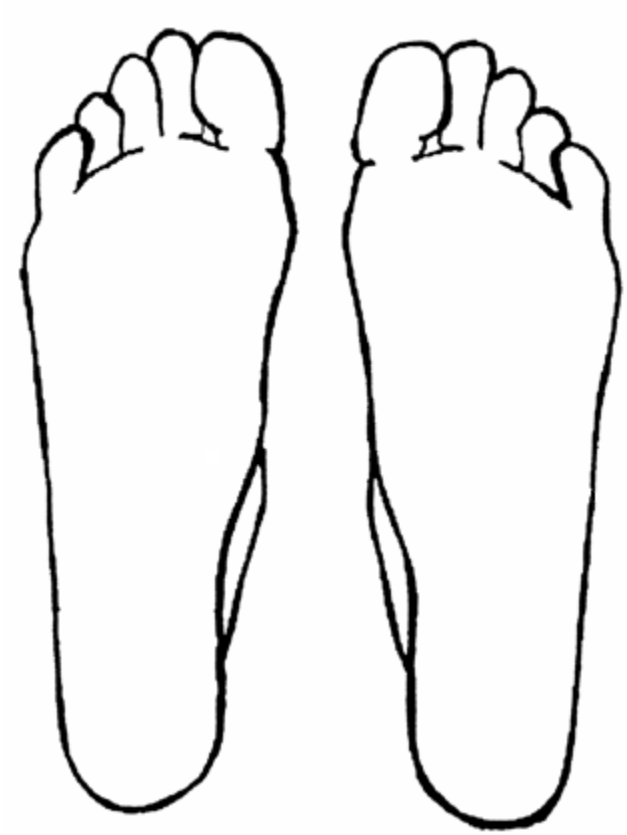
Hands

Left **Right**



☐ No injuries observed

Feet – Bottom



☐ No injuries observed

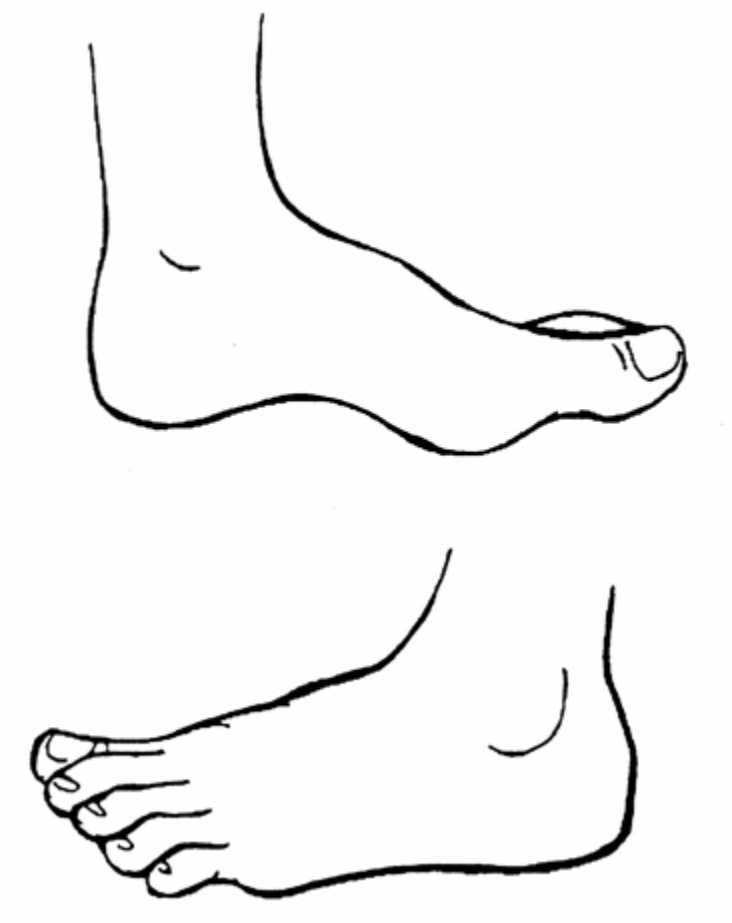
DATE: _____ **Signature/Designation** _____

Patient Label/hospital number_____

INJURY DIAGRAMS:

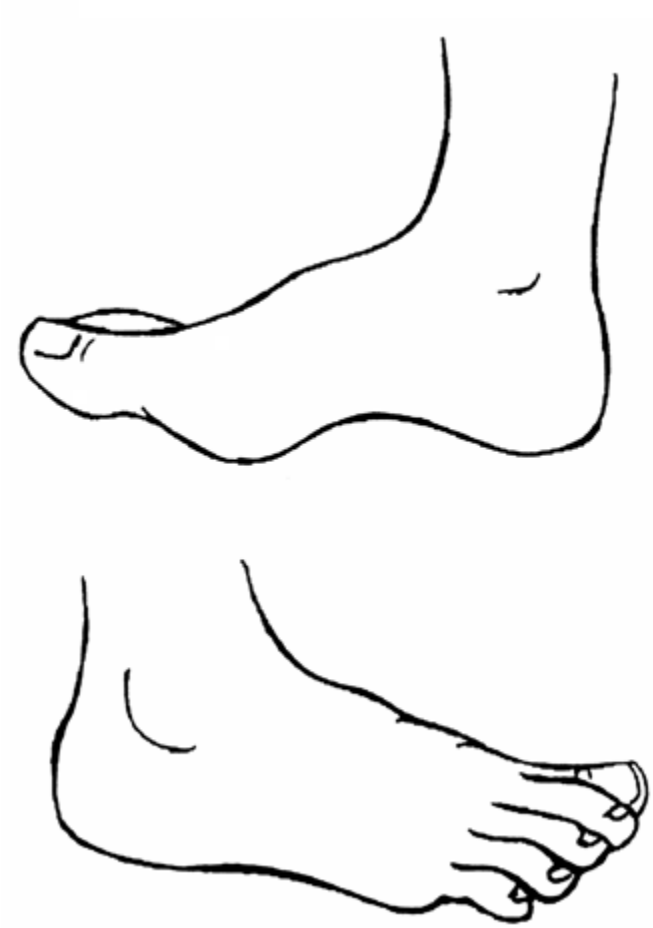
Mark all areas of tenderness and injuries on diagrams, indicating type of injury, size, shape and colour.

Foot – Left



☐ No injuries observed

Foot – Right



☐ No injuries observed

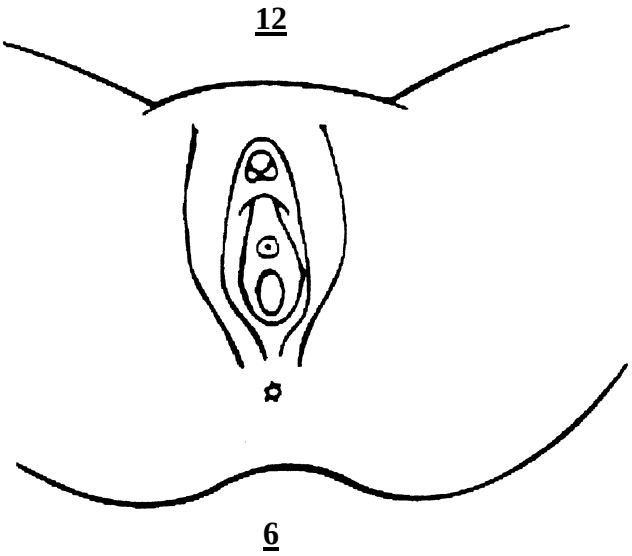
DATE: _____ **Signature/Designation**_____

Patient Label/hospital number_____

INJURY DIAGRAMS

Mark all areas of tenderness and injuries on diagrams, indicating type of injury, size, shape and colour.

Female Genitalia



GENITAL EXAM (include all signs of trauma)

Prepuce / Clitoris	
Periurethral	
Labia Majora	
Labia Minora	
Hymen	
Vagina	
Cervix	
Fossa Navicularis	
Posterior Fourchette	
Perineum	
Anus / Rectum	

Please check if utilized: ☐ Polilight ☐ Colposcopy ☐ No injuries observed

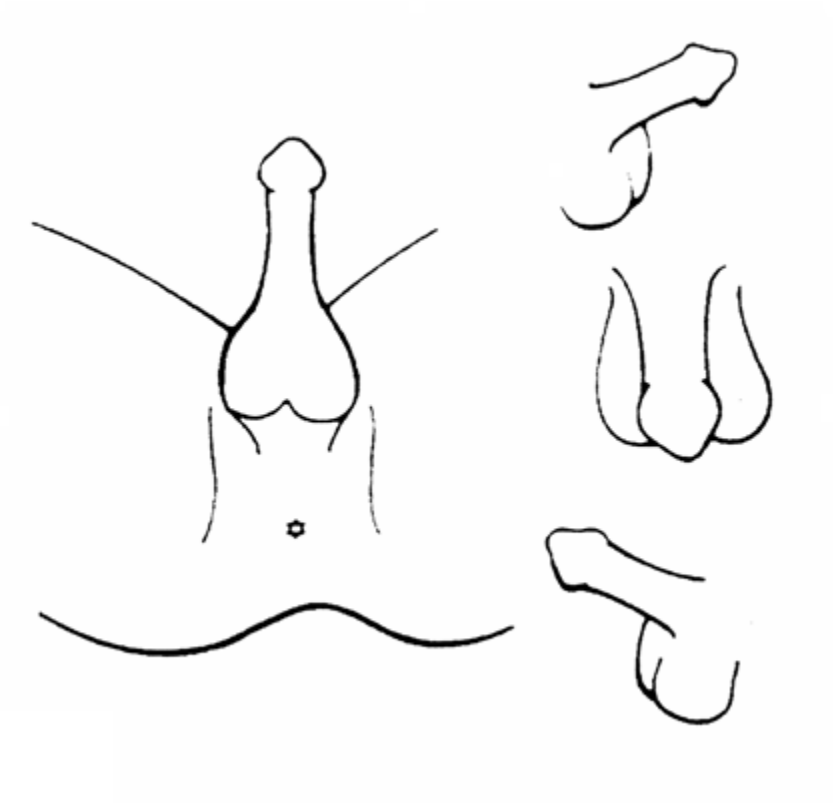
DATE: _____ **Signature/Designation**_____

Patient Label/hospital number_____

INJURY DIAGRAMS

Mark all areas of tenderness and injuries on diagrams, indicating type of injury, size, shape and colour.

Male Genitalia



GENITAL EXAM (include all signs of trauma)

Penis	
Scrotum	
Anus / Rectum	

☐ No injuries observed

DATE: _____ **Signature/Designation**_____

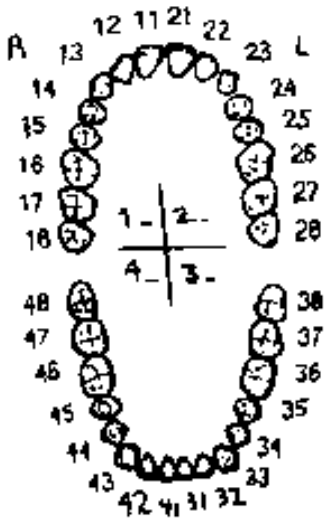
Patient Label/hospital number_____

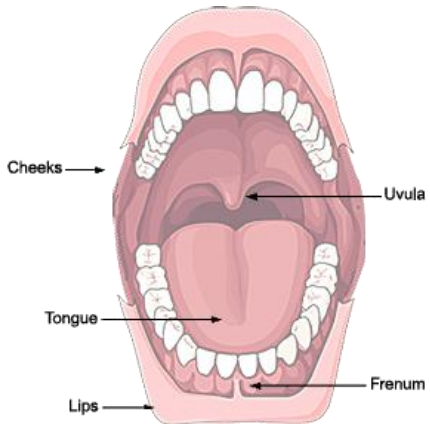
INJURY DIAGRAMS

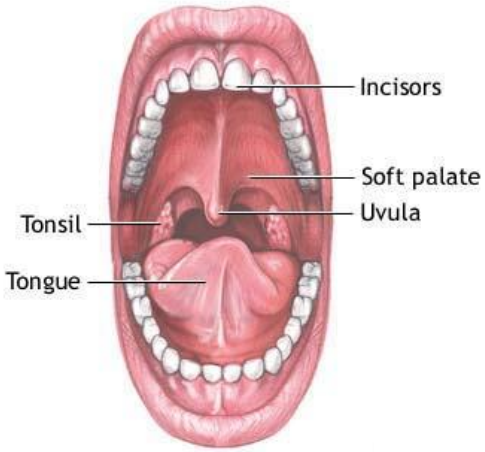
Mark all areas of tenderness and injuries on diagrams, indicating type of injury, size, shape and colour.

Teeth Identification System

Permanent Teeth







☐ No injuries observed

DATE: _____ **Signature/Designation**_____

Patient Label/hospital number_____

SAFETY PLANNING

1. Safety planning for patient, and children if any _____
2. Procedures to follow in case of an emergency (e.g. calling 911) _____
3. Safe place to go in case of an emergency _____
4. Items required in case of an emergency (clothing, keys, documents) _____
5. Informal social support network (family, friends, co-workers) _____
6. Formal support network (police, shelters, counsellors) _____
7. Dealing with stalking and threats _____
8. Suicidal ideation _____
9. Physical and emotional self-care _____
10. Safety plan for pets, if any and of concern _____
11. Other (please specify): _____

REFERRAL

Information provided to the patient on available services:

Shelter _____ Other _____

Legal assistance_____

ADDITIONAL NOTES

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

DATE: _____ **Signature/Designation**_____

Patient Label/hospital number_____

DISCHARGE PLAN

Medical Follow-up:

Prophylactic medications given:_____

☐ Family Physician: _____ Diagnostic tests done:_____

☐ Other: _____

Follow-up by the SA/DVCC: Client wishes Follow-up services ☐ Yes ☐ No

Telephone Follow-up:

Client prefers to call:

☐ Yes ☐ No ☐ Business card given Phone number:_____

SA/DV Nurse to call ☐ Yes ☐ No

State code name if required: _____ Preferred time/date: _____

In Person Follow-up appointment:_____

Counselling Services:

☐ Explained ☐ Declined Referral form completed: ☐ Yes ☐ No

Written Information / Education:

☐ Strangulation aftercare ☐ Sexual assault information ☐ Head injury aftercare

☐ Community resources, 24-hour support lines ☐Other:_____

Discharge:

Discharged at: _____ by: _____ to: _____

(time) (nurse) (place)

Accompanied by: ☐ family/friend ☐ self ☐ police ☐ agency worker ☐ other _____

Transportation: ☐ own ☐ family/friend ☐ police ☐ taxi ☐ other _____

ADDITIONAL NOTES

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

DATE: _____ **Signature/Designation**_____