FORENSIC MEDICAL EXAMINATION
DOMESTIC VIOLENCE & INTIMATE PARTNER VIOLENCE

LAW ENFORCEMENT INVOLVEMENT: ☐ Reported (Report #): _____ ☐ Not Indicated

CONFIDENTIAL DOCUMENT

A. GENERAL INFORMATION (print)

1.	Name of Patient:					
2.	Address:			City:	State:	Zip:
3.	Age:	DOB:	Gender:	Ethnicity:	Date of Service:	
4.	Cell Phone:		Landline:	Email:		
5.	OK to leave message on:	☐ Cell Phone	☐ Landline	☐ Email		

B. AGENCY INFORMATION

1.	**Notification of Advocacy Center:**	☐ Yes	☐ Patient Declined	NOTES:
	Name of Agency (if applicable):			
2.	**Notification of Adult Protective Services:**	☐ Yes	☐ Not Applicable	
	Referral Number (if applicable):			
3.	**Notification of Child Protective Services:**	☐ Yes	☐ Not Applicable	
	Referral Number (if applicable):			
4.	**Interpreter Used:**	☐ Yes	☐ Not Applicable	
	Representative Name:			

C. JURISDICTION

1. Responding Officer (if applicable): _____ Agency: _____

2. Responding Detective (if applicable): _____ Agency: _____

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D. PATIENT HISTORY

1.	Name of person providing history?			
2.	Pertinent medical history:			
3.	Last tetanus immunization:			
4.	Medications:			
5.	Additional information related to patient history:			
6.	Any pre-existing physical injuries?	☐ Yes	☐ No	
7.	If yes, describe:			
8.	Self-reported injuries:			
9.	Pain following assault 0-10:			
10.	Pregnancy test completed	☐ Yes	☐ No	
11.	Currently pregnant	☐ Yes	☐ No	☐ Unknown
12.	Abuse increased since pregnant	☐ Yes	☐ No	
13.	Partner threatened you while pregnant	☐ Yes	☐ No	
14.	Current/previous pregnancy complications:			
15.	Additional pregnancy related patient history information:			

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E. CHILD/DEPENDENT ADULT INVOLVMENT

1.

	Child/Dependent Name	Gender	DOB/ Age	Biologically	Guardianship
a.					
b.					
c.					
d.					
e.					
f.					

2.	Have children/dependent adult been injured?	☐ Yes	☐ No
3.	Were children/dependent adult present during abuse?	☐ Yes	☐ No
4.	Are children/dependent adult in home at risk for abuse?	☐ Yes	☐ No

5. If yes to any, describe:

F. HISTORY OF ABUSE BY PARTNER

1.	How long has physical violence been going on?	☐ Yes	☐ No	Notes:
2.	Has the physical violence increased in ***frequency*** over the last year?	☐ Yes	☐ No	
3.	Has the violence increased in ***severity*** over the last year?	☐ Yes	☐ No	
4.	Have you witnessed them physically assaulting others?	☐ Yes	☐ No	
5.	Have they made threats to or harmed any of your animals/pets?	☐ Yes	☐ No	
6.	Have physical assaults occurred at your workplace or in public?	☐ Yes	☐ No	
7.	Have they utilized a deadly weapon against you in the past?	☐ Yes	☐ No	
8.	Have they threatened to kill you?	☐ Yes	☐ No	
9.	Have they ever threatened or tried to commit suicide?	☐ Yes	☐ No	
10.	Have they ever forced you to have sex when you did not wish to do so?	☐ Yes	☐ No	
11.	Have they knowingly and intentionally photographed, filmed, or recorded an image or video of your intimate area without your consent?	☐ Yes	☐ No	
12.	Have they harassed you with the intent to injure, terrify, threaten, or intimidate you?	☐ Yes	☐ No	
13.	Have they harassed your family member or a household member of yours with the intent to injure, terrify, threaten, or intimidate you?	☐ Yes	☐ No	
14.	Have they intentionally followed, detained, or restrained you?	☐ Yes	☐ No	
15.	Do you have an order of protection from abuse against them?	☐ Yes	☐ No	
16.	Have they ever violated an order of protection you had against them?	☐ Yes	☐ No	
17.	Have any assaults in the past resulted in medical treatment?	☐ Yes	☐ No	
18.	Do you have any lasting effects from prior assaults?	☐ Yes	☐ No	

19. Additional information regarding history of abuse:

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G. METHODS OF ABUSE BY PARTNER

1.	Threat of harm	☐ Yes	☐ No	☐ Unknown
2.	Grasping / holding / grabbing / restraint	☐ Yes	☐ No	☐ Unknown
3.	Body as restraint	☐ Yes	☐ No	☐ Unknown
4.	Use of ligature (where used)	☐ Yes	☐ No	☐ Unknown
5.	Presence of weapon (what kind)	☐ Yes	☐ No	☐ Unknown
6.	Weapon inflicted injuries	☐ Yes	☐ No	☐ Unknown
7.	Physical Blows	☐ Yes	☐ No	☐ Unknown
8.	Hands	☐ Yes	☐ No	☐ Unknown
9.	Feet	☐ Yes	☐ No	☐ Unknown
10.	Strangulation	☐ Yes	☐ No	☐ Unknown
11.	Burns	☐ Yes	☐ No	☐ Unknown
12.	Use of images / media	☐ Taken/Viewed	☐ No	☐ Unknown
13.	Control of phone or device	☐ Yes	☐ No	☐ Unknown
14.	Injury to Partner	☐ Yes	☐ No	☐ Unknown
15.	Additional Information:			

H. ASSAILANT INFORMATION

1.	Assailant Name:		Assailant DOB:	
2.	Assailant Gender:		Assailant Age:	
3.	Current whereabouts:	☐ Unknown ☐ Custody	☐ Known:	
4.	Relationship to patient	☐ Spouse:	☐ Current	☐ Former
		☐ Dating:	☐ Current	☐ Former
		☐ Cohabitant/Domestic Partner:	☐ Current	☐ Former
		☐ Partner: Child Together:	☐ Yes	☐ No
		☐ Other:		
5.	Does the assailant own a gun:		☐ Yes ☐ No	☐ Unknown
6.	Any additional details about assailant:			

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I. EVENTS OF ASSAULT

1.	Date of Assault:		Time of Assault:	
2.	Location of Assault:			
3.	Description of Assault:			

4. Additional pages included: ☐ YES ☐ NO

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J. REVIEW OF SYSTEMS

	System	Findings/Reports by Patient			
1.	**Eyes**	☐ Blurred Vision ☐ Double Vision ☐ Itching ☐ Pain	☐ Redness ☐ Photophobia ☐ Discharge ☐ Subconjunctival Hemorrhage	☐ NONE	
2.	**Ears, Nose, Throat**	**EARS** ☐ Pain ☐ Bleeding ☐ Drainage ☐ Ringing ☐ Hearing Loss ☐ NONE	**NOSE** ☐ Pain ☐ Bleeding ☐ Discharge ☐ NONE	**THROAT** ☐ Pain ☐ Hoarse ☐ Dysphagia ☐ NONE	**MOUTH** ☐ Pain ☐ Bleeding ☐ Missing Teeth ☐ NONE
3.	**Respiratory**	☐ Cough ☐ Wheezing ☐ Hemoptysis	☐ Shortness of Breath ☐ Pain with Breathing	☐ NONE	
4.	**Cardiovascular**	☐ Chest Pain ☐ Dizzy Spells ☐ Edema ☐ Diaphoresis	☐ Palpitations ☐ Syncope ☐ Orthopnea ☐ Left Arm Pain	☐ NONE	
5.	**Gastrointestinal**	☐ Nausea ☐ Rectal Pain	☐ Vomiting ☐ Incontinence	☐ NONE	
6.	**Genitourinary**	☐ Dysuria ☐ Pelvic Pain ☐ Discharge	☐ Hematuria ☐ Incontinence ☐ Abnormal Bleeding	☐ NONE	
7.	**Neurological**	☐ Headache ☐ Seizure ☐ Weakness	☐ Dizziness ☐ Fainting ☐ Numbness	☐ NONE	
8.	**Musculoskeletal**	☐ Neck (Pain or Swelling) ☐ Pelvis Pain ☐ Lower Extremity Pain ☐ Back Pain	☐ Chest Wall Pain ☐ Shoulder Pain ☐ Upper Extremity Pain ☐ Rib Pain	☐ NONE	
9.	**Pain**	Pain Level: /10 Description:	☐ Denies Acute/Chronic Pain		
10.	**Behavioral**	☐ Fidgeting ☐ Withdrawn ☐ Quiet ☐ Tense ☐ Trembling ☐ Lack of eye contact	☐ Restless ☐ Loud ☐ Sobbing ☐ Tearful ☐ Yelling ☐ Calm/Cooperative		
11.	**Strangulation Screening**	Did your partner apply any pressure on your throat or neck?	☐ Yes ☐ No ☐ Unsure		
		Did your partner cover your mouth and nose by any means?	☐ Yes ☐ No ☐ Unsure		
		Did you experience any change in location or positioning without any memory of it?	☐ Yes ☐ No ☐ Unsure		
		If yes or unsure to any, complete strangulation assessment addendum.			

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K. FORENSIC EXAMINATION, PHOTOGRAPHY, AND BODY DIAGRAM

Legend: Types of Findings						
A-Abrasions	DE-Debris	B-Bruise	IN-Induration	BL-Blood	OI-Other Injury	T-Tears
BI-Bite	DF-Deformity	R-Redness	IW-Incised Wound	MS-Moist Secretion	PE-Petechiae	S-Swelling
BU-Burn	DS-Dry Secretion	FB-Foreign Body	LA-Laceration	OF-Other Foreign Materials	SI-Suction Injury	TE-Tenderness

			Photograph		
Body Locator #	Type	Description			Number
			☐Yes	☐No	
			☐Yes	☐No	
			☐Yes	☐No	
			☐Yes	☐No	
			☐Yes	☐No	
			☐Yes	☐No	
			☐Yes	☐No	
			☐Yes	☐No	
			☐Yes	☐No	
			☐Yes	☐No	
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			☐Yes	☐No	
			☐Yes	☐No	
			☐Yes	☐No	
			☐Yes	☐No	
			☐Yes	☐No	
			☐Yes	☐No	

Additional photo log included:	☐Yes ☐No	Total # of pictures taken:	

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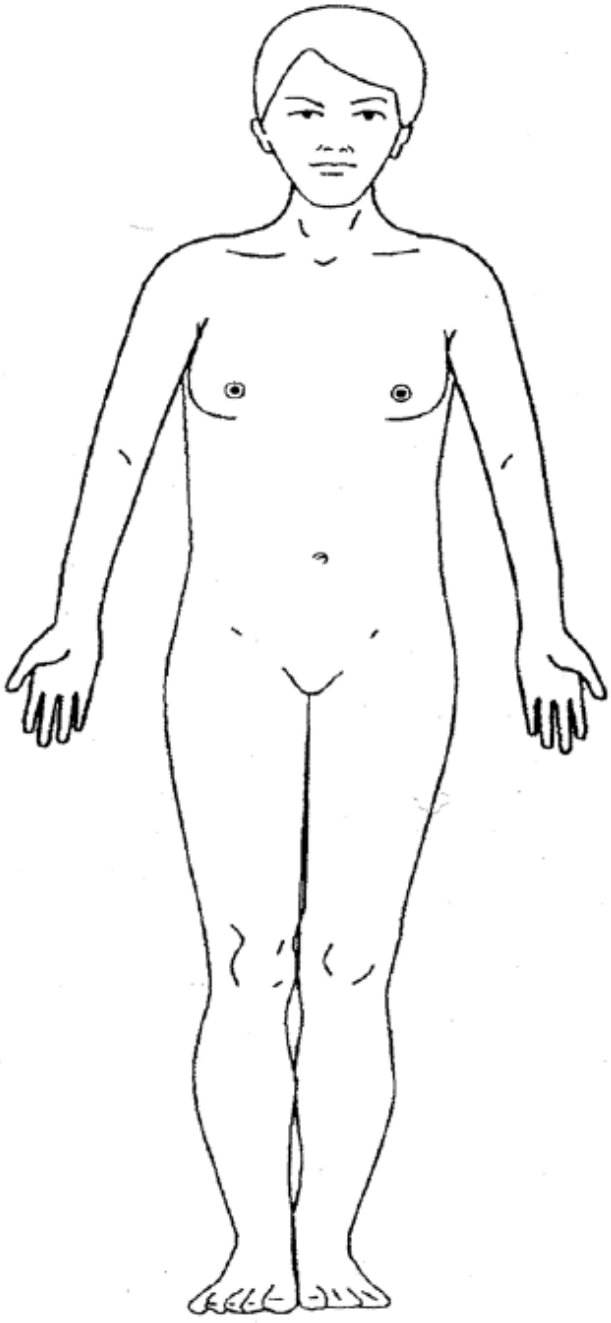

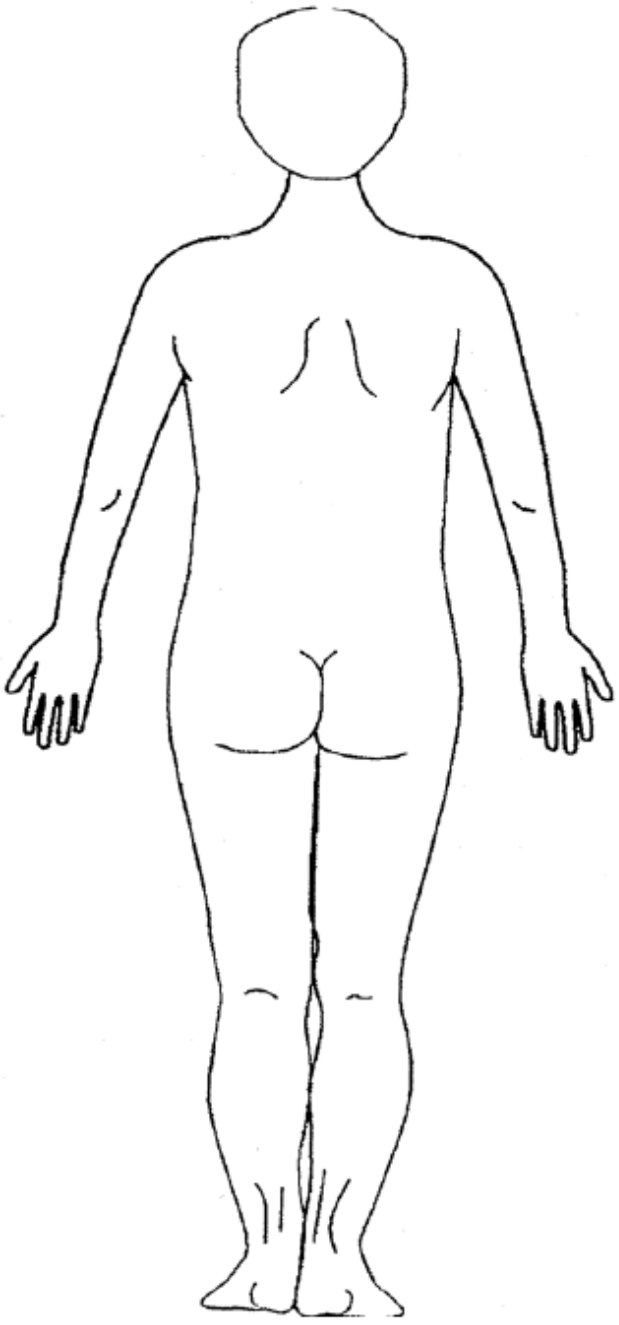

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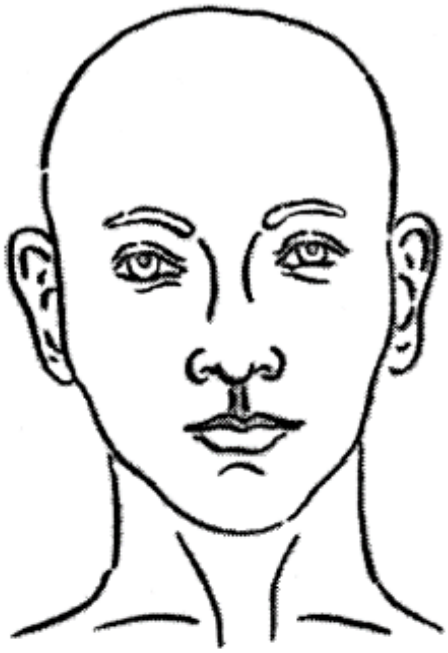

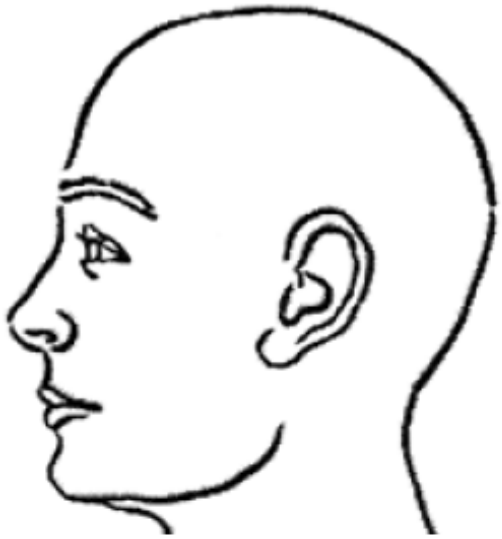

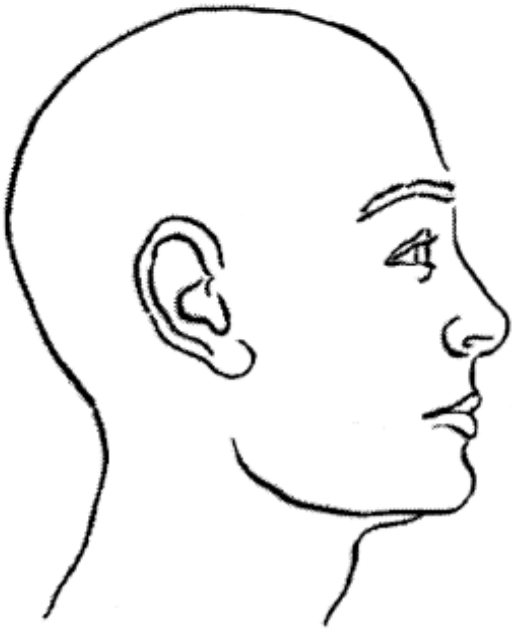

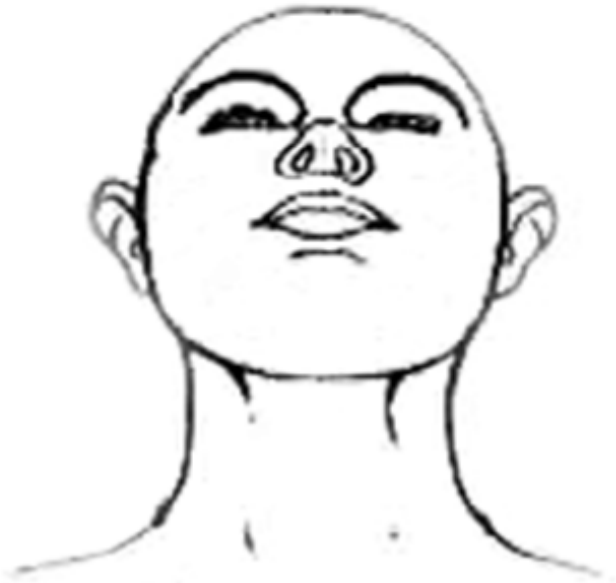

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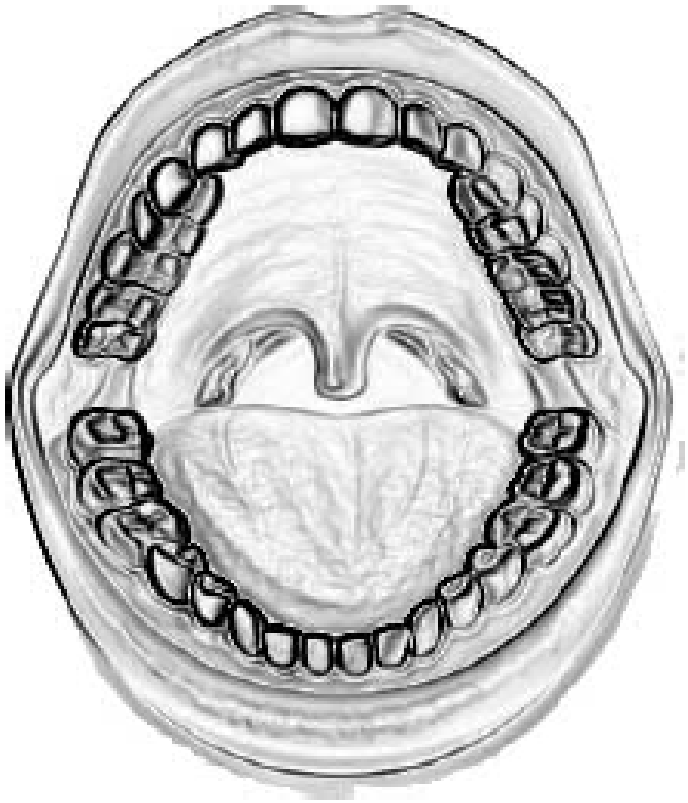

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L. REVIEW OF FINDINGS

1.	System and physical assessment findings reviewed with physician/advanced practice professional?	☐ YES Provider Name:
2.	Diagnostics performed (Radiography, blood work, etc.)	

M. DISCHARGE/SAFETY PLAN

1.	Patient has support person?	☐ Yes ☐ No Referral to:
2.	Patient has a safe place to go?	☐ Yes ☐ No Referral to:
3.	Patient discharging:	☐ Alone ☐ With Friend ☐ With Family
4.	Mode of transportation:	☐ Private Vehicle ☐ With Advocacy ☐ Public Transportation ☐ Patient Admitted ☐ Law Enforcement
5.	Resources provided:	☐ Advocacy ☐ Shelter Resources ☐ Crime Victim Reparations (CVR) Program ☐ Follow Up Care ☐ Forensic Examiner Program Contact Information ☐ Other:
6.	Other discharge and safety details:	

N. FORENSIC EXAMINER DOCUMENTATION COMPLETION

1. Forensic Examiner Name (Print) _____ Date: _____

2. Forensic Examiner Name (Sign): _____ Time: _____

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