

**DOMESTIC VIOLENCE SCREEN FOR FIELD PRACTITIONERS**

**Check here if patient did not answer any of the questions.**

Why?  Refused  Unconscious  Impaired  Agitated  Other (list reason)

**A "Yes " response to any of Questions #1-3 automatically triggers the FAP referral.**

1. Has he/she ever used a weapon against you or threatened you with a weapon?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	No answer
2. Has he/she threatened to kill you or your children?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	No answer
3. Do you think he/she might try to kill you?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	No answer

**Negative responses to Questions #1-3, but positive responses to at least four of questions #4-11, trigger the FAP referral**

4. Does he/she have a gun or can he /she get one easily?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	No answer
5. Has he/she ever tried to strangle/choke you?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	No answer
6. Is he she violently or constantly jealous or does he/she control most of your daily activities?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	No answer
7. Have you left him/her or separated after living together or being married?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	No answer
8. Is he/she unemployed?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	No answer
9. Has he/she ever tried to kill himself/ herself?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	No answer
10. Do you have a child that he/she knows is not his/hers?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	No answer
11. Does he/she follow or spy on you or leave threatening messages?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	No answer

Is there anything else that worries you about your safety? (if "yes") What worries you?

Check one:  Patient screened in as High Danger, according to the protocol (yes to any question 1-3)  
 Patient screened in as high Danger, based on the belief of the hospital staff member.  
 Patient did not screen in as High Danger.

Did the hospital staff member contact FAP/DAVA?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Did the patient speak with the FAP provider?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No