



# DOMESTIC VIOLENCE SCREENING TOOL

Name: \_\_\_\_\_

Is your partner excited about the baby?	
How is your family reacting to the pregnancy?	
How are you and your partner getting along?	
What happens when you and your partner fight or disagree?	
Is he helping you complete tasks that you are unable to do?	
How are things at home?	
Is anything preventing you from coming to your prenatal appointments?	
Has your partner ever prevented you from leaving the house, seeing friends, getting a job, education, etc.?	
Since your pregnancy began, have you been hit, kicked, slapped, or otherwise physically hurt by someone?	
Within the last year, has anyone forced you to engage in sexual activities that made you feel uncomfortable?	

Domestic Violence Identified: \_\_\_ Yes \_\_\_ No

Referral Process Implemented: \_\_\_ Yes \_\_\_ No Reason: \_\_\_\_\_

Safety Plan Completed: \_\_\_ Yes \_\_\_ No Reason: \_\_\_\_\_

Patient Declined Services/Crisis Number Provided: \_\_\_\_\_

CCName: \_\_\_\_\_ Date: \_\_\_\_\_