

NHI .....	WARD .....
SURNAME .....	
FIRST NAME .....	
GENDER .....	DOB .....
AGE .....	
(or affix patient label)	

## Intimate Partner Violence (IPV) Family Violence (FV) Assessment and Intervention

<b>FV routine enquiry</b>	<input type="checkbox"/> FV+ (positive)
<b>Risk assessment</b>	<input type="checkbox"/> Declined Please state reason:
	Full name and relationship of alleged abuser(s):
	Are there any current/previous orders on the alleged abuser? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> If yes, please identify: <input type="checkbox"/> Trespass Notice <input type="checkbox"/> Protection Order <input type="checkbox"/> Bail conditions <input type="checkbox"/> Police Safety Order <input type="checkbox"/> Recent family violence charges
<b>Assess person's health and risk</b>	<p><b>A 'yes' answer to any of the health and risk questions requires further description in the history section and intervention as per the Intimate Partner Violence Intervention flowchart</b></p> <p>1. Is the person here now? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked</span></p> <p>2. Are you afraid to go/stay home? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked</span></p> <p><b>For each of the questions 3, 4, 5 and 6 a 'yes' answer requires further investigation</b></p> <p>3. Has the physical violence increased in frequency or severity over the past year? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked</span></p> <p>4. Has the person ever choked you? (one or more times) <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked</span></p> <p><b>A 'yes' answer to question 4, requires intervention as per the Clinical Guideline: Assessment and Management of Strangulation</b></p> <p>5. Have you ever been knocked out? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked</span></p> <p>6. Have they ever used a weapon against you, or threatened you with a weapon? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked</span></p> <p>7. Do you believe they are capable of killing you? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked</span></p> <p>8. Are they constantly jealous of you? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked</span></p> <p style="padding-left: 20px;">If yes, has the jealousy resulted in violence? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked</span></p> <p>9. Have you recently left the person, or are you considering leaving? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked</span></p> <p>10. Have they ever threatened to commit suicide? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked</span></p> <p>11. Have you ever considered hurting yourself/suicide? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked</span></p> <p>12. Is alcohol or substance misuse a problem for you or this person? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked</span></p>
<b>Assess health and risk during pregnancy</b>	<p>13. Are you pregnant? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> EDD: ..... Midwife: .....</p> <p>14. Have you ever been beaten while pregnant? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked</span></p>
<b>Assess risk to children</b>	<p>15. Have the children seen or heard the violence? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked</span></p> <p>16. Has anyone physically abused the children? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined <input type="checkbox"/> Not asked</span> If yes, who? (full name and relationship to the child) .....</p> <p>Names and DOB of child(ren) living at home:</p>
<b>Access to support services</b>	<p>What support (if any) is available to you?</p> <p>What services have you used in the past or are involved with currently?</p>

**COPY OF THE CLINICAL NOTES MUST BE ATTACHED TO THE ePROSAFE REFERRAL**

SURNAME ..... NHI .....  
 FIRST NAME ..... DOB .....  
 ADDRESS .....  
 ..... POSTCODE .....  
 (or affix patient label)

## IPV FV Assessment and Intervention

**Referrals now**

- No referral or report made
- Police/ISR – with consent  Police – without consent
- Ministry for Children, Oranga Tamariki/CYF  Report of Concern completed and sent
- Cultural Support Services, Pukenga Atawhai or Maori Community Service
- Continuing engagement with Specialist Mental Health Service
- Sexual Health Service/Sexual Assault Assessment and Treatment Service
- Children’s team
- Specialist Family Violence Agencies (Refuge, Stopping Violence Service, etc.)
- Given written information regarding services (yellow card or blue card, etc.)
- Other (*please specify*) phone call, face-to-face or referral declined:

Document history on separate sheet, including:

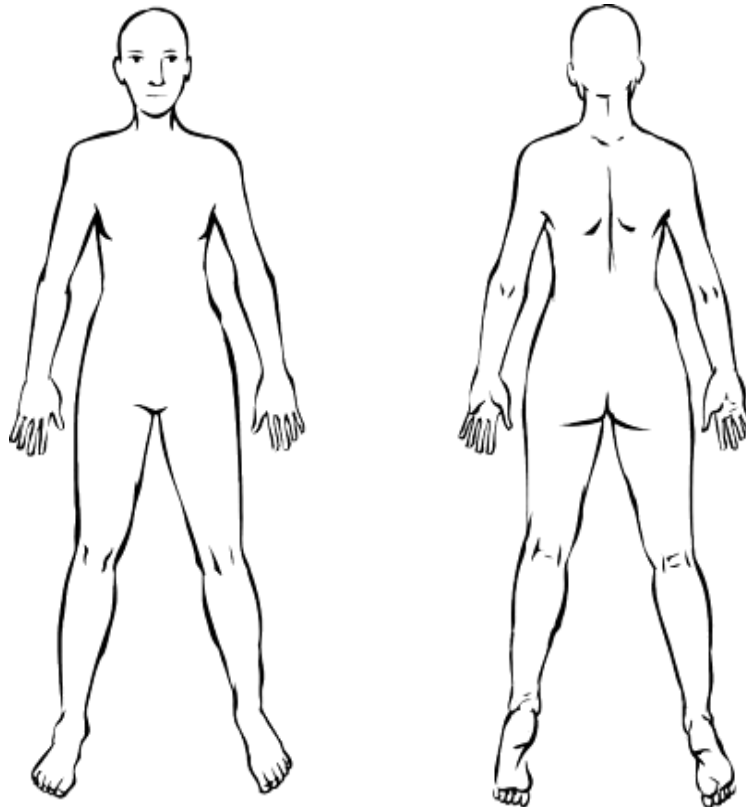
- Verbatim quotes
- Observations – patients demeanour
- Description of injuries
- Mechanism of injury, eg. punched with a closed fist
- Weapon used, eg. knife, gun, baseball bat

SAFETY PLAN for adults and children on separate sheet also (see intranet page of guidelines)

Record on SAP core documents, tick FV question and record underneath

**Body map**

*Measure, describe (incl. type, colour, texture, size) and mark location of each apparent injury (incl. bruising, scratches, abrasions, lacerations, areas of pain and tenderness)*



- Police/clinical photography offered:  Yes  No  Accepted  Declined
- Photographs taken:  Yes  No

