DV STRANGULATION REPORT

PATIENT INFORMATION / MEDICAL

Patient Information

Name			Date	Time
HMC #	DOB	Address	Apt. #	
Gender	Preferred Pronouns	City	State	Zip
Phone Number	Okay to Leave Msg? ☐ Yes ☐ No	Email		
Accompanied by		Relationship		
Preferred Contact	Okay to Leave Msg? ☐ Yes ☐ No	Relationship		
Police Report Made ☐ Yes ☐ No ☐ Unk Police Dept Case Number		Primary Language Name of Interpreter:	Interpreter Used ☐ Yes ☐ No	

Current Concern

Medical History

Medical/Surgical History, Hospitalizations, Chronic Illness ☐ No Medical Hx

PCP: Clinic:

Current Contraception ☐ N/A ☐ OC's: Missed Pills? _____ ☐ IUD: x___yrs ☐ Condoms ☐ Contraceptive Implant ☐ Other:_____ LMP: ☐ No Menarche	Currently Pregnant ☐ Yes ☐ No If Yes, # of Weeks_____ Receiving Prenatal Care ☐ Yes ☐ No ☐ Unk Is Assailant Aware of Pregnancy ☐ Yes ☐ No ☐ Unk G_____ P_____

Medications

List ☐ No Medications

Currently Taking: ☐ Yes ☐ No ☐ Unk

Examiner Name (Print)	Signature	Date

PLACE PATIENT LABEL HERE

ASSAULT HISTORY / RISK ASSESSMENT

Assault History

Date/Time of Current Assault	Hours Since Assault	Location of Assault ☐ Own Home ☐ Other Home ☐ Other_____	
Pt Relationship to Assailant	Length of Relationship	# of Past DV Assaults	Date of last DV Assault

IPV History

☐ Verbal Abuse ☐ Threats ☐ Stalking ☐ Physical Assault ☐ Strangulation ☐ Use of Weapon ☐ Financial Abuse
☐ Other_____ # of Reported DV Assaults _____ # of Unreported DV Assaults _____

Substance Use at Time of Assault

By Patient ☐ Yes ☐ No ☐ Unk Type Amt Time	By Assailant ☐ Yes ☐ No ☐ Unk Type Amt Time

Use of Force (Current Assault)

☐ Restrained ☐ Hit ☐ Kicked ☐ Thrown ☐ Bitten ☐ Strangled ☐ Blow to Head ☐ Blow to Abdomen
☐ Other Force (Describe)_____

Use of Threats / Harassment (Current Assault)

Unwanted Contact ☐ Yes ☐ No
☐ In Person ☐ by Another Person ☐ by Text/Phone ☐ on Social Media ☐ by Email ☐ Other_____
☐ Threat to Harm ☐ Threat to Kill ☐ Threat w/Weapon ☐ Other Threat/Harassment_____
Under Surveillance ☐ Yes ☐ No ☐ Unk Pt Fearful of Safety ☐ Yes ☐ No ☐ Unk

Minor Children

Child(ren) within Sight/Sound of this Assault ☐ Yes ☐ No ☐ Unk
Child(ren) Assaulted/Injured During this Assault ☐ Yes ☐ No ☐ Unk
Photos Taken of Children ☐ Yes ☐ No ☐ Unk Photos Taken by:_____

CPS Referral Made ☐ Yes ☐ No ☐ Unk	Prior CPS Involvement ☐ Yes ☐ No ☐ Unk		Children are in the Custody of (Name/Relationship)
Name of Child	**Gender**	**DOB**	**Currently Resides**

Examiner Name (Print) **Signature** **Date**

PLACE PATIENT LABEL HERE

PATIENT NARRATIVE

Present During Exam
Patient Demeanor
Patient Narrative
Examiner Name (Print) Signature Date

PLACE PATIENT LABEL HERE

ASSESSMENT / PLAN

Assessment	Plan	Evidence Collected
1. _____ (History, Report of DV/Strangulation) 2. _____ (Acute Physical Findings) 3. _____ (Other Findings/Medical Conditions) 4. _____ (Other Findings/Medical Conditions)	☐ Medical-Surgical Eval ☐ Urine Beta HCG Results _____ ☐ Imaging Done (Circle): CT / CTA / X-Ray / MRI ☐ Other_____ ☐ Suicide Assessment Done	☐ Clothing ☐ Photos ☐ Fingertip Swabs ☐ Skin Swabs Site(s):_____ ☐ Reference Blood ☐ Control Swabs ☐ Other_____ ☐ No Evidence Collected

Strangulation Assessment	
☐ Strangulation Assessment Done ☐ Strangulation Discharge Instructions Reviewed w/Pt	☐ Pt Evaluated for Strangulation by ED MD Prior to FNE Arrival ☐ Pt Referred to ED MD for Strangulation Evaluation

Exam Details	
☐ Medications (list) ☐ No Medications Given ☐ See EMR	☐ Drug Allergies (list) ☐ NKDA
Time Spent w/Pt and Family (Minutes)	Location of Exam ☐ ED ☐ Inpatient ☐ HATC ☐ Other _____
Case Discussed with (Name of MD):	

Exam Performed by (FNE, MD, other):	Signature	Date/Time
Evidence Packaged by:	Signature	Date/Time

Discharge Plan	
Discharged To: ☐ Home ☐ Other Phone (if different from above):	Pt Education and Community Resource Materials Given: ☐ Yes ☐ No

Follow Up Appointments	
HATC Appointment Date/Time	Other:

Examiner Name (Print)	Signature	Discharge Time/Date

PLACE PATIENT LABEL HERE

Strangulation History

Number of Times Pressure was Applied to Neck

☐ Once ☐ Multiple (#) ☐ Unk

Estimated Time Pressure was applied ____ seconds/____minutes ☐ Unk

Circle Pt's Estimated Level of Pressure

1 (Light) 2 3 (Firm) 4 5 (Crushing)

Method of Strangulation ☐ R Hand ☐ L Hand ☐ Both Hands ☐ Arms ☐ Chokehold ☐ Other Body Part

☐ Ligature ☐ Clothing ☐ Jewelry ☐ Other: _____

Details	**Describe**
Mouth/Nose Covered	☐ Yes ☐ No ☐ Unk
Pressure on Chest/Abdomen	☐ Yes ☐ No ☐ Unk
Lifted Off Ground by Neck	☐ Yes ☐ No ☐ Unk
Shaken During the Assault	☐ Yes ☐ No ☐ Unk
Anything Enter Mouth	☐ Yes ☐ No ☐ Unk
Head Hit with/into any Object	☐ Yes ☐ No ☐ Unk
Did Assailant Make Oral Contact with or Spit on Body	☐ Yes ☐ No ☐ Unk
Did Pt Scratch/Hit/Injure Assailant During Assault	☐ Yes ☐ No ☐ Unk
Weapon Used During Assault	☐ Yes ☐ No ☐ Unk
Did Assailant Say Anything During Assault	☐ Yes ☐ No ☐ Unk
What Did Pt Believe Would Happen	☐ Yes ☐ No ☐ Unk
How Did Strangulation Stop	☐ Yes ☐ No ☐ Unk

Additional Comments

Examiner Name (Print)	**Signature**	**Date**

PLACE PATIENT LABEL HERE

Strangulation Symptoms		
Symptoms	**When Present**	**Details**
Headache	☐ None ☐ During ☐ After ☐ Now	
Dizzy/Lightheaded	☐ None ☐ During ☐ After ☐ Now	
Loss of Consciousness	☐ None ☐ During ☐ After ☐ Now	
Memory Loss	☐ None ☐ During ☐ After ☐ Now	
Confusion/Agitation	☐ None ☐ During ☐ After ☐ Now	
Weakness/Numbness	☐ None ☐ During ☐ After ☐ Now	
Vision Changes	☐ None ☐ During ☐ After ☐ Now	
Blood in Ears/Nose/Mouth	☐ None ☐ During ☐ After ☐ Now	
Ringing in Ears	☐ None ☐ During ☐ After ☐ Now	
Neck Pain	☐ None ☐ During ☐ After ☐ Now	
Sore Throat	☐ None ☐ During ☐ After ☐ Now	
Difficulty Swallowing	☐ None ☐ During ☐ After ☐ Now	
Pain with Swallowing	☐ None ☐ During ☐ After ☐ Now	
Drool/Excess Saliva	☐ None ☐ During ☐ After ☐ Now	
Tongue Swelling	☐ None ☐ During ☐ After ☐ Now	
Voice Changes/Hoarseness	☐ None ☐ During ☐ After ☐ Now	
Hyperventilation	☐ None ☐ During ☐ After ☐ Now	
Difficulty Breathing	☐ None ☐ During ☐ After ☐ Now	
Coughing	☐ None ☐ During ☐ After ☐ Now	
Coughing up Blood	☐ None ☐ During ☐ After ☐ Now	
Nausea/Vomiting	☐ None ☐ During ☐ After ☐ Now	
Loss of Bladder Control	☐ None ☐ During ☐ After ☐ Now	
Loss of Bowel Control	☐ None ☐ During ☐ After ☐ Now	
Vaginal Bleeding (if pregnant)	☐ None ☐ During ☐ After ☐ Now	
Pelvic Cramping (if pregnant)	☐ None ☐ During ☐ After ☐ Now	
Other Body Pain (describe)	☐ None ☐ During ☐ After ☐ Now	
Examiner Name (Print)	**Signature**	**Date**

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