



**HAWKE'S BAY**  
District Health Board  
Whakawāteatia

## INTIMATE PARTNER VIOLENCE (IPV) ASSESSMENT AND INTERVENTION DOCUMENTATION

Fill in only if patient label is unavailable

Name:..... DoB:.....

NHI:..... Phone:.....

Address:.....

### INSTRUCTION FOR COMPLETING THE FORM

Risk Assessment Declined  Please state reason: .....

IPV Routine Enquiry:  IPV+ (Positive)

Full name & relationship of alleged abuser(s): .....

Are there any current/previous orders on the alleged abuser?  Yes  No

If yes please identify:

Trespass notice  Protection order  Bail conditions  Police Safety Order  Recent family violence charges

### ASSESS PERSONS HEALTH AND RISK

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

1. Is your partner here now?  Yes  No  Declined

2. Are you afraid to go/stay home?  Yes  No  Declined

(For each of the questions 3, 4, 5 and 6 a 'Yes' answer requires further investigation)

3. Has the physical violence increased in frequency or severity over the past year?  Yes  No  Declined

4. Has your partner ever choked you (one or more times)?  Yes  No  Declined

A 'Yes' answer requires intervention as per the Clinical Guideline: Assessment & Management of Strangulation

5. Have you ever been knocked out by your partner?  Yes  No  Declined

6. Has your partner ever used a weapon against you, or threatened you with a weapon?  Yes  No  Declined

7. Do you believe your partner is capable of killing you?  Yes  No  Declined

8. Is your partner constantly jealous of you?  Yes  No  Declined

If yes - has the jealousy resulted in violence?  Yes  No  Declined

9. Have you recently left your partner, or are you considering leaving?  Yes  No  Declined

10. Has your partner ever threatened to commit suicide?  Yes  No  Declined

11. Have you ever considered hurting yourself/suicide?  Yes  No  Declined

12. Is alcohol or substance misuse a problem for you or your partner?  Yes  No  Declined

### ASSESS HEALTH AND RISK DURING PREGNANCY

Is the Person Pregnant?  Yes  No EDD: ..... LMC: .....

13. Have you ever been beaten by your partner while pregnant?  Yes  No  Declined

### ASSESS RISK TO CHILDREN

14. Have the children seen or heard the violence?  Yes  No  Declined

15. Has anyone physically abused the children?  Yes  No  Declined

If yes – who? (Full name & relationship to the child) .....

Also if yes please consider if a Report of Concern (ROC) needs to be completed

Names & DOB of child(ren) living at home: .....

### ACCESS TO SUPPORT AND SERVICES

What support (if any) is available to you? .....

What services have you used in the past or are involved with currently? .....

### REFERRALS (Document referrals/reports made)

No referral or report made  Police – with consent  Police – without consent  Social Work

Report of Concern completed and sent  Mental Health Service (name service for your DHB)  CYF

Cultural Support services (name service/s for your DHB)  Childrens team (only include if your DHB has one)

Sexual Health Service/ Sexual Assault Assessment and Treatment Service

Specialist Family Violence agencies (individual to each DHB)

Provision of Family Violence Community Agency Card/referral information  Other (please specify)

