

Your  
Hospital's  
Logo  
Here

Maternal Infant Health Unit  
**DOMESTIC  
VIOLENCE  
CHECKLIST**

PATIENT IDENTIFICATION

**DIRECTIONS: All items must be completed within two (2) hours of assessment. Initial items when completed. This form is a permanent part of the patient record.**

\_\_\_\_\_ Call patient information to change patient's name.

\_\_\_\_\_ Place patient in a room away from the unit entrance and close to the nursing station.

\_\_\_\_\_ Interview the patient for pertinent information and place in front of the chart.

- \*\* Description of past abuse
- \*\* Brief description of the abuser
- \*\* Identifying marks
- \*\* Nicknames or aliases
- \*\* Weapons used or carried at present or in the past
- \*\* Date of last involvement with the abuser
- \*\* Type of abuse (physical, mental, and/or sexual)
- \*\* Court order filed with police
- \*\* Names and descriptions of persons cleared to visit

\_\_\_\_\_ Alert safety and security of patient's situation and abuser's description

\_\_\_\_\_ Call Social Services Department for consult

\_\_\_\_\_ Notify the switchboard and place block on all incoming calls

\_\_\_\_\_ Notify Nurse Manager (or Supervisor in her absence) and nursing staff of entire situation.

**ALERT:**

- [1] Keep all doors to the MIH Unit and patient's room closed and secure at all times.
- [2] Secure the entrance to the Nursery and keep baby in view at all times.
- [3] Screen all visitors and limit patient visitors to 2-3. List their names and description on front of chart.
- [4] Utilize unit and hospital Domestic Violence Resource persons and/or call Social Services for further questions and/or guidance.

\_\_\_\_\_  
Initials

\_\_\_\_\_  
RN Signature / Title:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Initials

\_\_\_\_\_  
RN Signature / Title:

\_\_\_\_\_  
Date

**PART OF THE MEDICAL RECORD**