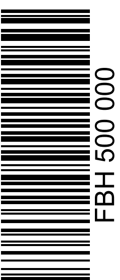
FBH 500 000

FAMILY VIOLENCE ASSESSMENT FORM (FVAF) (Reporting Clinician)

SURNAME: .... UR NO: ....
GIVEN NAMES: ....
D.O.B: .... SEX: ....
ADMISSION DATE: ....
CONSULTANT: .... WARD/CLINIC: ....
USE LABEL IF AVAILABLE

Identify

FV alert completed ☐ IPM ☐ BOS ☐ Other ....

Communication Interpreter required ☐ Yes ☐ No Preferred language spoken ....
Preferred interpreter: ☐ Male ☐ Female ☐ Locally known interpreter ☐ External unknown interpreter

Identified types of FV ☐ Physical ☐ Sexual ☐ Psychological ☐ Stalking ☐ Economic/Financial
☐ Coercive/threatening behaviour ☐ Historical ☐ Child abuse and neglect Other................................

Alleged perpetrator relationship to client ☐ Partner/spouse ☐ Ex-partner ☐ Other ....

Situation

Client report of situation

Clinician's assessment of situation

Children/other in the family
☐ Children exposed to FV (Child Protection must be informed if no protective carer)
☐ Direct harm to children (Child Protection must be informed) Location/residence of children ....
☐ Vulnerable other: elderly, disabled dependent (consider risks and response)

Legal Status ☐ Current Intervention Order/IVO ☐ Unknown ☐ N/A
Date and time of incident Date ………… Time………. ☐ Unknown ☐ N/A

Background

History of FV
☐ Previous known history ☐ Patient reports history ☐ No known history

Clients Living Arrangements
☐ Residing with perpetrator ☐ Residing separate to perpetrator
☐ Transient ☐ Homeless ☐ Other:...

Assessment

Identified Risks ☐ Disclosed FV ☐ Suspected FV

Patient ☐ Pregnant/New birth ☐ Mental Health ☐ Substance Abuse ☐ Other............................
....

Perpetrator (e.g. use of weapons, threats to kill etc)...
....

Relationship ☐ Recent separated ☐ Planning to separate ☐ Other ....

Safety ☐ Patient feels safe to go home ☐ Patient feels unsafe to go home
Clinician assessed urgency for action ☐ Immediate ☐ Short term (< 48hrs)
Safety threat to treating team identified (inform NUM/management and develop appropriate safety plan/response to threats) ☐ Yes ☐ No

Recommendations

Referrals
☐ Consent obtained ☐ Client declined ☐ Mandatory report
Internal ☐ Social Work ☐ Psych Triage ☐ Aboriginal Health Liaison Officer ☐ **If pregnant, Maternity Support**
☐ Other ....
External ☐ CNV ☐ CASA ☐ Police ☐ Legal ☐ Child Protection ☐ Child FIRST
☐ Other community agency .... ☐ **Information** (brochures/numbers) provided
Consent obtained to provide details to external service ☐ Yes ☐ No ☐ N/A

Safety Plan ☐ Legal intervention IVO / Protective Order ☐ Police ☐ CNV support
☐ Family/friend support ☐ Other ....

Client discharged to
☐ Home ☐ Friends/family
☐ Refuge ☐ Unknown

☐ Client wishes considered in discharge planning

Key Contacts
CNV worker ....
Police..
Child Protection..
Other..

Form Completed by (print Name)	**Designation**	**Signature**	**Date**

BOS: Birth Outcomes System
iPM: Inpatient Patient Management
CASA: Centre Against Sexual Assault
IVO: Intervention order
CNV: Centre for non- violence
FV: Family violence

June 2015

FAMILY VIOLENCE ASSESSMENT FORM (FVAF)

MR230

FAMILY VIOLENCE ASSESSMENT FORM (FVAF) (Service)

SURNAME: .... UR NO: ....

GIVEN NAMES: ....

D.O.B: .... SEX: ....

ADMISSION DATE: ....

CONSULTANT: .... WARD/CLINIC: ....

USE LABEL IF AVAILABLE

The following sections of the form are for the use of the services/clinicians referred to: Social Work/ Maternity Support/ AHLO/CASA

Identified concerns

Further identified risks

Safety plan

Additional Referrals Made

Internal ☐ Social Work ☐ AHLO ☐ Psych Triage ☐ Other ....
☐ **If pregnant, Maternity Support informed**

External ☐ CNV ☐ CASA ☐ Police informed ☐ Legal ☐ Child Protection ☐ Child FIRST
☐ Other community agency

Secondary Consultation Sought

Name: ______________________________ Designation/Service___________________________

Completing Clinician (print Name)	Designation/Service	Signature	Date

Upon completion, this form must be filed within the Medico Legal Tab of the patient record