INTIMATE PARTNER VIOLENCE AND SEXUAL VIOLENCE HEALTH CARE FORM

Introduce yourself and let the person know that you are here to help and support them.
Please say: *All the information asked is to provide you with the best care and it will not be shared with others unless you give consent.*

REGISTRATION

month | day | year | hour | min

Information in this section recorded by:
Name: _____ Professional position: _____ Health facility : _____
Regional Health Authority : _____ Informed Consent Given no ◯ yes ●

SURNAME	FIRST NAME	MIDDLE NAME	NICKNAME
STREET ADDRESS	VILLAGE	CITY	COUNTY
PHONE NUMBER (cellphone)	PHONE NUMBER (landline)	EMERGENCY CONTACT PERSON	PHONE NUMBER

ID TYPE ID card ◯ Driver's license ◯ T&T passport ◯ Other passport ◯ Other ◯ _____
Name of the country: _____ ID not shared ◯

Date of birth (month | day | year) **Age**

Country of birth T&T ◯ other ◯ _____

Nationality T&T ◯ other ◯ _____

Union status
Married and living with partner ◯
Common-law and living with partner ◯
Visiting partner ◯
No longer living with spouse ◯
No longer living with common-law partner ◯
Never had a spouse or common law partner ◯

Ethnicity
East Indian ◯ Chinese ◯
African ◯ Indigenous ◯
Mixed African-East Indian ◯ Syrian or Lebanese ◯
Mixed Other ◯ Portuguese ◯
Caucasian ◯ Other ◯

Religion
Anglican ◯ Pentecostal ◯ Islam ◯
Baptist – Spiritual Shouter ◯ Roman Catholic ◯ Presbyterian ◯
Baptist – other ◯ Seventh Day Adventist ◯ Rastafarian ◯
Moravian ◯ Brethren ◯ Other religion ◯
Jehovah's Witness ◯ Hinduism ◯ None ◯
Methodist ◯ Orisha ◯

Education
None ● Primary ◯ Secondary ◯ Tertiary ◯
Complete ◯ Incomplete ●

Referred by Self ◯ Relative ◯ Police ◯ Other Health Institution ◯ Social Services ◯ CSO ◯ Shelter ◯ Other ◯

Accompanied by: (name) _____ **Sex** F ◯ M ◯ **Relationship** _____

INITIAL HEALTH CARE

REGISTRATION month | day | year | hour | min

Information in this section recorded by:
Name: _____ Professional position: _____ Health facility : _____
Regional Health Authority : _____ Informed Consent Given no ◯ yes ●

GENERAL MEDICAL HISTORY

Gender ID Woman ◯ Man ◯ Non binary ◯

Sex Female ◯ Male ◯ Inter sex ●

	no	yes
NCD	◯	●
Disability	◯	●
Allergies	◯	●
Prescription drugs	◯	●
Surgeries	◯	●
Mental Health Problems	◯	●
Other	◯	●

Specify: _____

Contraceptive
IUD ◯ Implant ◯ Sterilization ◯ Injectable ◯ Pill ◯ None ◯

	no	yes
Condom	●	◯
Menstruating	●	◯
Pregnant	◯	●

1st day last menstrual period month | day | year

Gest. age | **Prev. pregnancies** | **Livebirths** | **Alive**

End previous pregnancy month | day | year — < 1 year ●

Vaccines

	no	yes	dk
Tetanus	◯	◯	◯
Hep B	◯	◯	◯
HPV	◯	◯	◯
COVID-19	◯	◯	◯

Tetanus: month | day | year

Test

	HIV	Other STI
–	◯	◯
+	●	●
dk	●	●
pending	●	●
not disclosed	●	●

Notes _____

Please ask: can you please tell me what happened? Take all the time you need and provide as much detail as you can.
All the information asked is to provide you with the best care and it will not be shared with others unless you give consent.

INCIDENT

Date of most recent incident month | day | year | hours | min — delay > 72 hs ●

1st reported
Now ◯
In other institution ◯ _____

Perpetrator (s) Number Male | Number Female

Who assaulted you?
Intimate partner ◯ Other known ◯
Family member ◯ Stranger ◯

Lives with perpetrator no ◯ yes ●

Where? At home ◯ Elsewhere ◯

Type of violence

	no	yes
Physical	◯	●
Sexual	◯	●
Psychoemotional	◯	◯

Disclosed by patient ◯
Asked ◯
Suspected ◯

Previous incident no ◯ yes ● dk ◯
Date of the incident month | day | year

	no	yes	dk
Same perpetrator	◯	●	◯
Protection order breached	◯	●	◯

Appearance of being under

	Drugs no	Drugs yes	Drugs dk	Alcohol no	Alcohol yes	Alcohol dk
Perpetrator	◯	●	◯	◯	●	◯
Survivor	◯	●	◯	◯	●	◯

Delay in receipt of care due to:

	no	yes
COVID 19 stay-at-home measures	◯	●
Partner restricted movement	◯	●
Weather	◯	●
Health problems	◯	●
Financial constraint	◯	●
Other	◯	●

Description of incident _____

CLINICAL EXAM

Information in this section recorded by: Name: _____
Professional position: _____ Health facility : _____
Informed Consent Given no ◯ yes ● Regional Health Authority : _____

Witnessed by :
Name: _____ Professional position: _____
Sex F ◯ M ◯ month | day | year | hour | min

DESCRIPTION OF VIOLENT EVENT

PHYSICAL no ◯ yes ●

Type

	no	yes	dk
Beating	◯	●	◯
Biting	◯	●	◯
Pulling hair	◯	●	◯
Strangling	◯	●	◯
Cutting	◯	●	◯
Burning	◯	●	◯
Other	◯	●	◯

Injury Severe ● Mild ● None ◯

Mode

	no	yes
Force	◯	●
Knife	◯	●
Use of restraints	◯	●
Firearm	◯	●
Other object	◯	●

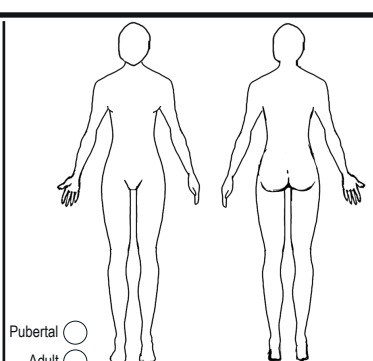
Weight (kg) | **Height (cm)** 1 | | |

Blood pressure (systolic) | **Blood pressure** (diastolic)

Pulse rate | **Resp. rate**

Temperature °C , |

	Done	Not done
Bimanual exam	◯	●
Vagino rectal	◯	●



SEXUAL ASSAULT Rape no ◯ yes ●

Penetration	Vaginal	Anal	Oral
Penis	◯	◯	◯
W/ejaculation	◯	◯	◯
Finger	◯	◯	◯
Other	◯	◯	◯
Dk	◯	◯	◯

Post assault

	no	yes
Vomited	◯	●
Urinated	◯	●
Defecated	◯	●
Brushed teeth	◯	●
Ate / Drank	◯	●
Rinsed mouth	◯	●
Changed clothes	◯	●
Washed/ Bathed	◯	●
Used tampon/ pad	◯	●

Date of last consensual sexual intercourse month | day | year

With who? Same person (s) ◯ Other person (s) ◯

Genital injuries

	no	yes
Vulva / scrotum	◯	●
Cervix	◯	●
Vagina / penis	◯	●
Introitus / hymen	◯	●
Anus	◯	●

Mark injuries in the drawing and describe _____

● This color means **WATCH** (does not necessarily indicate risk or inadequate practices)

EMOTIONAL STATE

Appearance (no / yes)
- Disarray (clothing, hair, etc.)
- Intoxicated
- Distracted-restless

Mood (no / yes)
- Calm
- Very sad
- Angry
- Anxious

Speech (no / yes)
- Clear
- With difficulty
- Slow
- Crying
- Fast
- Silent

Suicidal attempt no yes
- Self harming thoughts (no / yes)
- Action taken
- Flash backs of the incident
- Repeated bad thoughts

LAB TEST

Test	Options	Date	Result received	Name laboratory
Pregnancy	– / + / dk	month / day / year	month / day / year	
Genital swab	no / yes	month / day / year	month / day / year	
Anal swab	no / yes	month / day / year	month / day / year	
Blood group	no / yes		month / day / year	
Rh	– / + / not done		month / day / year	
HIV / STI	– / + / dk		month / day / year	

LEGAL EVIDENCE COLLECTED

Evidence	no / yes	Date collected	Date sent	Laboratory	Current location of evidence
Pubic hair		month / day / year	month / day / year		
Head hair		month / day / year	month / day / year		
Nails		month / day / year	month / day / year		
Clothing		month / day / year	month / day / year		
Saliva		month / day / year	month / day / year		
Semen		month / day / year	month / day / year		

IMMEDIATE CARE

1st line support no yes

(no / yes)
- STI PEP
- HIV PEP → > 72 hs.
- Emerg. contraception → > 120 hs.
- Wounds
- Tetanus vac
- Hep B vac
- Other

FURTHER HEALTH CARE NEEDS

Further (no / yes)
- STI
- HIV
- Contraception
- Wounds
- Hep B vac
- Surgery
- Mental health
- Other

SAFETY ASSESSMENT

(no / yes)
- Safe place to go
- Safety plan developed

POLICE REPORT

- Done
- Decided not to report
- Undecided

Date month / day / year

Detail:

DEPENDENTS *(One line for each)*

Total number

Name	Age	Resides w/perpetrator (no / yes)	At risk (no / yes)	Sex (F / M)
Name:				
Name:				
Name:				
Name:				
Name:				
Name:				

REFERRAL TO (no / yes)	CONTACT DETAILS → NAME OF PROFESSIONAL / POSITION / AGENCY	CONSENT TO SHARE INFORMATION (no / yes)
Social services		
Financial support		
Medical social worker		
Mental health care		
Police		
Housing / shelter		
Support group		

Next visit agreed no yes

month / day / year

NOTES:

This color means **WATCH** (does not necessarily indicate risk or inadequate practices)