

# Windham County Domestic Violence Investigative Report

Case # \_\_\_\_\_

## Victim Information

Last Name	First Name	MI	D.O.B.			
Street Address		City/Town	State Zip Code			
Home Phone	Work or Message Phone		<b>Complainant (if other than victim)</b>			
		<table style="width: 100%; border: none;"> <tr> <td style="width: 30%;">Last Name</td> <td style="width: 30%;">First Name</td> <td style="width: 40%;">MI</td> </tr> </table>		Last Name	First Name	MI
Last Name	First Name	MI				
Were there witnesses present during domestic violence? Yes <input type="radio"/> No <input type="radio"/>			Street Address			
Were statements taken? Yes <input type="radio"/> No <input type="radio"/> Recorded Written			<table style="width: 100%; border: none;"> <tr> <td style="width: 30%;">City/Town</td> <td style="width: 30%;">State</td> <td style="width: 40%;">Zip code</td> </tr> </table>	City/Town	State	Zip code
City/Town	State	Zip code				
Were there children present during the violence? Yes <input type="radio"/> No <input type="radio"/>			<table style="width: 100%; border: none;"> <tr> <td style="width: 30%;">Home Phone</td> <td style="width: 30%;">Work Phone</td> <td style="width: 40%;">D.O.B.</td> </tr> </table>	Home Phone	Work Phone	D.O.B.
Home Phone	Work Phone	D.O.B.				
Were statements taken? Yes <input type="radio"/> No <input type="radio"/> Recorded Written List Children's Names/Ages (Ensure all Witnesses are on Discovery Form)			What is the victim's demeanor? (Circle <b>ALL</b> that apply) Angry Crying Fearful Hysterical Calm Apologetic Afraid Irrational Nervous Threatening Intoxicated BAC% _____ Denial Uncooperative			
<b>Victim/Suspect Relationship</b>			<b>Strangulation Symptoms</b>			
Spouse <input type="radio"/> Former Spouse <input type="radio"/> Co-habitants <input type="radio"/> Former Co-habitants <input type="radio"/> Dating/Engaged <input type="radio"/> Family Member <input type="radio"/> Parent of child from relationship <input type="radio"/>			(Circle all that apply)			
Length of relationship _____ Yrs _____ Mos Date relationship ended (if applicable) _____			Neck Pain Sore Throat Scratch Marks Tiny Red Spots Red Linear Marks or Bruises Rope or Cord Burns Raspy or Hoarse Sounding Voice Difficulty Swallowing Ears Ringing Neck Swelling Light Headed Fainting or Unconscious Nausea or Vomiting Loss of Body Function Miscarriage Did the suspect say anything at the time of Strangling? _____ What? _____ _____ _____			
Has this type of incident happened in the past with this offender? Yes <input type="radio"/> No <input type="radio"/>			List any witnesses to past incidents (Phone#)			
When? _____			_____ _____ _____ _____ _____			
Did you get injured? _____						
Did you report it to police? Yes <input type="radio"/> No <input type="radio"/>						
What Department? _____						



## *Lethality & Risk Assessment*

- Gun present in the home or accessible to suspect.
  - Suspect has used or threatened to use a weapon.
  - Parties had a recent separation or threatened separation.
  - Suspect abuses alcohol.
  - Suspect uses illegal drugs or abuses legal drugs.
  - Increase in frequency or severity of violence.
  - Suspect has been convicted of assaulting you or any other family member?
  - Suspect is violent outside of the relationship.
  - Suspect has destroyed cherished personal items.
  - Suspect is jealous or tries to control partner's daily activities.
  - Suspect has accused the victim of cheating.
  - Suspect has said, "If I can't have you, no one can"
  - Suspect threatens to kill.
  - Suspect contemplated, threatened, or attempted suicide.
  - Has the suspect been following, calling, threatening?
  - Have you ever been treated by a doctor or hospitalized for injuries inflicted by the suspect?
  - Suspect has been arrested for assaulting you or any other family member.
  - Suspect is violent toward children.
  - Suspect has injured or killed pets.
  - Suspect has forced victim to have sex when victim didn't agree.
  - Suspect has directed violence toward pregnant partner.
  - Victim is currently pregnant.
  - Victim contemplated, threatened, or attempted suicide.
  - Suspect attempted to prevent victim from calling for help.
- (Describe) \_\_\_\_\_

### **Source of Referral**

- |    |  |                        |
|----|--|------------------------|
| 1. | 911 call from residence/scene                | Callers Name & Phone # |
| 2. | 911 call from other location                 |                        |
| 3. | Direct call to dispatch from residence/scene | _____                  |
| 4. | Direct call to dispatch from other location  |                        |

# Authorization for Release of Medical Information

Please complete this form thoroughly. Your medical records cannot be released unless the form is complete and is signed.

## Please Print

### Information about You

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

I hereby authorize \_\_\_\_\_ to release

(Health Care Provider)

records of my treatment dated \_\_\_\_\_, to the office of the Windham County

State's Attorney and \_\_\_\_\_.

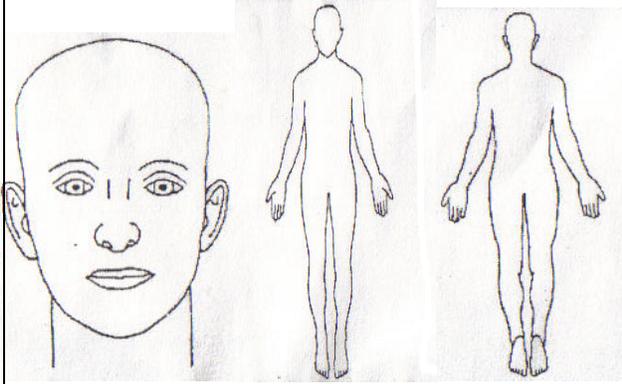
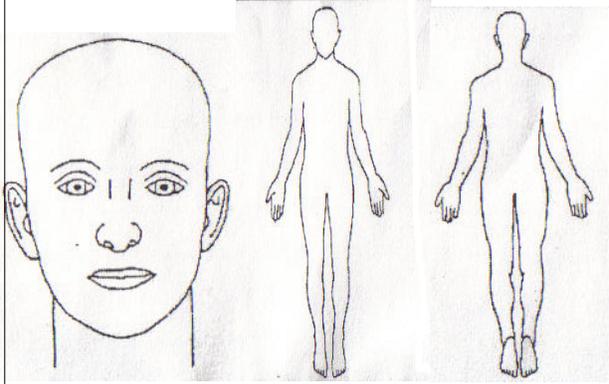
(Investigating Agency)

This authorization is valid for 90 days and may be revoked at any time in writing prior to the expiration date.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Witness's Signature

# Suspect Information

Last Name	First Name	MI	D.O.B.
Street Address	City/Town	State	Zip Code
Home Phone	Work Phone	Place of employment- _____	
What is the Suspect's demeanor? (Circle <b>ALL</b> that apply) Angry Crying Fearful Hysterical Calm Apologetic Afraid Irrational Nervous Threatening Intoxicated BAC% _____ Denial Uncooperative		Length of employment- _____ Is Suspect on Probation? Yes <input type="checkbox"/> No <input type="checkbox"/> Name of Probation Officer- _____	
Victim's Injuries Complains of Pain? What, Where? _____ How were injuries documented? Video 35mm Digital Other _____		Suspect's Injuries Complains of Pain? What, Where? _____ How were injuries documented? Video 35mm Digital Other _____	
Bruises <input type="checkbox"/> Lacerations <input type="checkbox"/> Abrasions <input type="checkbox"/> Fractures <input type="checkbox"/> Minor Cuts <input type="checkbox"/> Concussion <input type="checkbox"/> Other <input type="checkbox"/> Internal Injuries <input type="checkbox"/>		Bruises <input type="checkbox"/> Lacerations <input type="checkbox"/> Abrasions <input type="checkbox"/> Fractures <input type="checkbox"/> Minor Cuts <input type="checkbox"/> Concussion <input type="checkbox"/> Other <input type="checkbox"/> Internal Injuries <input type="checkbox"/>	
Ht: _____ Wt: _____		Ht: _____ Wt: _____	
			
<b><u>Medical Treatment (circle/fill-in)</u></b> None Will Seek own Doctor _____ Paramedics Hospital _____ Refused Treatment Transported to hospital by _____ EMS Run #		<b><u>Medical Treatment (circle/fill-in)</u></b> None Will Seek own Doctor _____ Paramedics Hospital _____ Refused Treatment Transported to hospital by _____ EMS Run #	







