

MISSOULA COUNTYWIDE DOMESTIC VIOLENCE SUPPLEMENTAL FORM

Charges		Case#
Primary Officer		Cover Officer
<input type="checkbox"/> Intimate Partner (IPV conduct LAP) <input type="checkbox"/> In Custody <input type="checkbox"/> Misdemeanor <input type="checkbox"/> Follow up needed <input type="checkbox"/> Felony <input type="checkbox"/> Warrant Requested		
SUSPECT INFORMATION		
Name		DOB
Address		Phone/cell
Statement Obtained? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> ATTEMPTED		Military or Martial arts trained? <input type="checkbox"/> YES <input type="checkbox"/> NO
SUSPECT OBSERVATION		
<input type="checkbox"/> Angry <input type="checkbox"/> Apologetic <input type="checkbox"/> Afraid <input type="checkbox"/> Calm <input type="checkbox"/> Crying	<input type="checkbox"/> Fearful <input type="checkbox"/> Hysterical <input type="checkbox"/> Irrational <input type="checkbox"/> Nervous <input type="checkbox"/> Threatening	<input type="checkbox"/> Has Pain <input type="checkbox"/> Abrasion(s) <input type="checkbox"/> Bruise(s) <input type="checkbox"/> Concussion(s) <input type="checkbox"/> Fracture(s)
		<input type="checkbox"/> Laceration(s) <input type="checkbox"/> Swelling <input type="checkbox"/> Strangulation <input type="checkbox"/> Other:
		<input type="checkbox"/> Alleged Self Defense <input type="checkbox"/> Alleged Mutual Combat <input type="checkbox"/> Alcohol? PBT _____ <input type="checkbox"/> Drugs? Type(s):
VICTIM INFORMATION		
Name		DOB
Address		Phone/cell
Email		Work phone
Social media		Emergency contact:
Statement Obtained? <input type="checkbox"/> YES <input type="checkbox"/> NO		
VICTIM OBSERVATION		
<input type="checkbox"/> Angry <input type="checkbox"/> Apologetic <input type="checkbox"/> Afraid <input type="checkbox"/> Calm <input type="checkbox"/> Crying	<input type="checkbox"/> Fearful <input type="checkbox"/> Hysterical <input type="checkbox"/> Irrational <input type="checkbox"/> Nervous <input type="checkbox"/> Threatening	<input type="checkbox"/> Has Pain <input type="checkbox"/> Abrasion(s) <input type="checkbox"/> Bruise(s) <input type="checkbox"/> Concussion(s) <input type="checkbox"/> Fracture(s)
		<input type="checkbox"/> Laceration(s) <input type="checkbox"/> Swelling <input type="checkbox"/> Strangulation <input type="checkbox"/> Other:
		<input type="checkbox"/> Alleged Self Defense <input type="checkbox"/> Alleged Mutual Combat <input type="checkbox"/> Alcohol? PBT _____ <input type="checkbox"/> Drugs? Type(s): <input type="checkbox"/> Pregnant?
RELATIONSHIP BETWEEN VICTIM AND SUSPECT		
INTIMATE (Conduct LAP) <input type="checkbox"/> Dating <input type="checkbox"/> Separated <input type="checkbox"/> Engaged <input type="checkbox"/> Divorce Pending <input type="checkbox"/> Spouse <input type="checkbox"/> Divorced <input type="checkbox"/> Same sex <input type="checkbox"/> Formerly dating	NON-INTIMATE (NO LAP) <input type="checkbox"/> Cohabitants <input type="checkbox"/> Parent/child relationship <input type="checkbox"/> Emancipated minor <input type="checkbox"/> Other family relationship	Length of Relationship Years/Months _____ Children in common? <input type="checkbox"/> YES <input type="checkbox"/> NO If applicable, when did the relationship end? _____
DOMESTIC VIOLENCE HISTORY		
Prior Domestic Violence? YES <input type="checkbox"/> NO <input type="checkbox"/>		Does the victim have a protective order against the suspect? YES <input type="checkbox"/> NO <input type="checkbox"/>
Documented? YES <input type="checkbox"/> NO <input type="checkbox"/>		CJIN Entered? YES <input type="checkbox"/> NO <input type="checkbox"/> Issuing court
Prior Convictions? YES <input type="checkbox"/> NO <input type="checkbox"/> When: _____		
PREVIOUS HISTORY OF OFFENDER		
Protective orders against the suspect? YES <input type="checkbox"/> NO <input type="checkbox"/>		Is suspect on probation/parole? YES <input type="checkbox"/> NO
Who petitioned? Victim/Someone else?		Warrants? YES <input type="checkbox"/> NO <input type="checkbox"/>
POTENTIAL RELATED CRIMES & DANGEROUSNESS INDICATORS		
THREATS TO <input type="checkbox"/> Damage Property <input type="checkbox"/> Harm family members or loved ones <input type="checkbox"/> Take Children <input type="checkbox"/> Harm Animals		
HISTORY OF <input type="checkbox"/> Assaults <input type="checkbox"/> Abuse of Children <input type="checkbox"/> Emotional/Verbal Abuse in person, text, email, social media, voicemail <input type="checkbox"/> Financial Abuse	<input type="checkbox"/> Harassment <input type="checkbox"/> Harming Animals <input type="checkbox"/> Intimidation <input type="checkbox"/> Isolation <input type="checkbox"/> Parole/Probation Violation <input type="checkbox"/> Earlier Partner Abuse <input type="checkbox"/> Protective Order Violation	<input type="checkbox"/> Stalking <input type="checkbox"/> Strangulation (Please complete Strangulation Form) <input type="checkbox"/> Demanded or Forced Sex When? _____ How often? _____ Reported? If yes, to Whom? _____ Did victim go to First Step/ER?



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CHILD WITNESSES			
Were there children present during the violence? YES <input type="checkbox"/> NO <input type="checkbox"/>		Statements taken from Children YES <input type="checkbox"/> NO <input type="checkbox"/>	
Location of the children during the incident?		Was DCFS notified? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Are the children who were at the incident listed on the face page? YES <input type="checkbox"/> NO <input type="checkbox"/>			
WEAPONS			
Was a weapon used during this incident? YES <input type="checkbox"/> NO <input type="checkbox"/>		Firearms(s) impounded as EVIDENCE <input type="checkbox"/> / FOR SAFETY <input type="checkbox"/>	
If YES, describe		Weapon other than firearm(s) impounded as EVIDENCE <input type="checkbox"/> / FOR SAFETY <input type="checkbox"/>	
MEDICAL TREATMENT			
EMS / Fire department personnel at scene? <input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> Transported to hospital	
<input type="checkbox"/> Treated by paramedics <input type="checkbox"/> First aid given at scene		<input type="checkbox"/> No medical treatment provided	
Name of EMS with victim at scene:		<input type="checkbox"/> Medical aid offered but refused	
		<input type="checkbox"/> Will seek own doctor	
OFFICER CHECKLIST			
<input type="checkbox"/> Consider contacting duty detective. <input type="checkbox"/> Photograph BOTH parties to document injuries and/or lack of injuries where the parties claim injury or physical contact occurred. <input type="checkbox"/> Photograph the scene and location of physical evidence. Document where all evidence items were found. <input type="checkbox"/> If weapon used, photograph and collect the weapon. <input type="checkbox"/> If strangulation was done using an object, photograph and collect the object. <input type="checkbox"/> If defecation or urination in clothing, photograph and collect the clothing as evidence. <input type="checkbox"/> If victim vomited, photograph the vomit. <input type="checkbox"/> Obtain name and contact information of witnesses, including outcry witnesses. <input type="checkbox"/> Obtain a medical release. <input type="checkbox"/> Obtain evidence from hospital if available, or follow-up to retrieve. <input type="checkbox"/> Officer caution?			
LETHALITY ASSESSMENT			
<i>A YES response to one or more of Questions 1-3 automatically triggers the protocol referral to the YWCA crisis line</i>			
1. Have they ever used a weapon against you or threatened you with a weapon?		YES	NO
If yes; type of weapon:			Declined to Answer
2. Have they threatened to kill you or your children?		YES	NO
3. Do you think they might try to kill you?		YES	NO
			Declined to Answer
<i>A YES response to four or more of Questions 4-11 also triggers the protocol referral to the YWCA crisis line</i>			
4. Do they have a gun, or can they get one easily?		YES	NO
5. Have they ever tried to "choke" or strangle you? How many times?		YES	NO
6. Are they violently or constantly jealous or do they control most of your daily activities?		YES	NO
7. Have you left them or separated after living together or being married?		YES	NO
8. Are they unemployed?		YES	NO
9. Have they ever tried to kill themselves?		YES	NO
10. Do you have children they know are not theirs?		YES	NO
11. Do they follow or spy on you or leave threatening messages?		YES	NO
			Declined to Answer
<i>Officers may activate the protocol referral, because of the victim's response to the question below, or whenever the officer believes the victim is in a potentially lethal situation.</i>			
12. Is there anything else that worries you about your safety?			
CHECK ONE <input type="checkbox"/> The victim declined to take the Lethality Assessment <input type="checkbox"/> Victim did not screen in <input type="checkbox"/> Victim screened in AT HIGHER RISK based on assessment <input type="checkbox"/> Victim screened in AT HIGHER RISK based on the belief of the officer		PROTOCOLS FOLLOWED After discussing the high-risk assessment, did the victim speak with the YWCA Advocate? <input type="checkbox"/> YES <input type="checkbox"/> NO YWCA Crisis Line call made? <input type="checkbox"/> YES <input type="checkbox"/> NO (800) 483-7858 or (406) 542-1944	

