

Attachment 4

Domestic Violence Report/Supplemental

**developed by
Contra Costa County
Advisory Council Against Domestic Violence,
Police/Victims Committee**

Domestic Violence Reports can include, but are not limited to, the following Penal Code violations, if they meet the definition of Domestic Violence as defined in 13700 PC: 136.1, 148, 166.4, 187, 264, 203, 207, 236/237, 240, 242, 243(b), 243(d), 243(e), 245(a)(1), 262, 273.5, 273.6, 415, 417, 418, 422, 591, 597, 602.5, 646.9, 647(f), 653m, 12020(a), 12025(a), 12031.

DATE TIME REPORTED	LAW ENFORCEMENT AGENCY	CASE NUMBER
SECTION	CRIME	CLASSIFICATION
LOCATION OF OCCURRENCE		TIME OF OCCURRENCE
SUSPECTS NAME (L, F, M)	DOB	RACE / SEX
ADDRESS	PHONE	D.L. #
VICTIM'S NAME (L, F, M)	DOB	RACE/SEX
ADDRESS	PHONE	ALTERNATIVE PHONE (VICTIM CONTACT)

COMPLETE ABOVE SECTION ONLY IF INFORMATION IS NOT ATTACHED ON AGENCY REPORT FORM

RESPONDED TO A CALL OF _____ AT (LOC)
 FOUND THE VICTIM AT (LOC) _____

MARK ALL THAT APPLY		MARK ALL THAT APPLY			WITNESSES PRESENT DURING DOMESTIC VIOLENCE?	
<input type="checkbox"/> S	<input type="checkbox"/> Demeanor	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/>	<input type="checkbox"/> Apologetic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	STATEMENT(S) TAKEN?	
<input type="checkbox"/>	<input type="checkbox"/> Afraid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/>	<input type="checkbox"/> Angry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SPONTANEOUS STATEMENT(S) TAKEN?	
<input type="checkbox"/>	<input type="checkbox"/> Calm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/>	<input type="checkbox"/> Tearful/Crying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CHILDREN PRESENT DURING DOMESTIC VIOLENCE?	
<input type="checkbox"/>	<input type="checkbox"/> Hysterical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/>	<input type="checkbox"/> Emotional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	STATEMENT(S) TAKEN?	
<input type="checkbox"/>	<input type="checkbox"/> Nervous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<input type="checkbox"/>	<input type="checkbox"/> Upset	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NAMES OF ALL WITNESSES / CHILDREN PRESENT ' AGES / DOB	
<input type="checkbox"/>	<input type="checkbox"/> Threatening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1	_____
<input type="checkbox"/>	<input type="checkbox"/> Other-Explain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2	_____
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3	_____

RELATIONSHIP BETWEEN VICTIM AND SUSPECT

MARK ALL THAT APPLY

SPOUSE FORMER SPOUSE

COHABITANTS FORMER COHABITANTS

PARENTS OF COMMON CHILD EMANCIPATED MINOR

DATING / ENGAGED FORMER DATING

SAME SEX

LENGTH OF RELATIONSHIP: _____ YEAR(S) _____ MONTH(S)
 _____ WEEK(S) _____ DAY(S)

PHOTOGRAPHS

FROM: CRIME SCENE HOSPITAL
 OTHER _____

PHOTOS: YES HOW MANY? _____ NO

TYPE: 35MM POLAROID

DESCRIBE ALL PHOTOGRAPHS:

PHOTOS OF VICTIM'S INJURIES? YES NO

PHOTOS OF SUSPECT'S INJURIES? YES NO

PHOTOS OF CRIME SCENE? YES NO

PHOTOS OF CHILDREN? YES NO

PRIOR DOMESTIC VIOLENCE HISTORY

VICTIM DESCRIBED PRIOR HISTORY OF VIOLENCE? YES NO

HAVE POLICE BEEN CALLED BEFORE? YES NO

NUMBER OF PRIOR INCIDENTS: _____ REPORTED _____ NOT REPORTED

SUSPECT'S / VICTIM'S CLOTHING COLLECTED? YES NO
 (PARTICULARLY IF TORN, BLOODY, ETC.)

SCENE DIAGRAM? YES NO

HOW WERE POLICE SUMMONED? TELEPHONE ONVIEW
 OTHER: _____

WHO SUMMONED POLICE? VICTIM OTHER: _____

RESTRAINING ORDERS YES NO

STATUS: CURRENT TYPE: EMERGENCY
 EXPIRED TEMPORARY
 NOT VERIFIED PERMANENT (3+ YRS.)
 ACKNOWLEDGED BY SUSPECT

WEAPON(S) USED DURING INCIDENT (Including unspent, lost, etc.)

YES TYPE: _____ NO

WEAPON(S) IMPOUNDED? YES NO

FIREARM(S) IMPOUNDED FOR SAFETY? YES NO

ISSUING COURT: _____

ORDER OR DOCKET NO.: _____

COPY ATTACHED WITH PROOF OF SERVICE? YES NO

ISSUED? YES ISSUING JUDGE _____
 NO

EVIDENCE OF SUBSTANCE OR CHEMICAL USE

SUSPECT YES TYPE: _____ NO

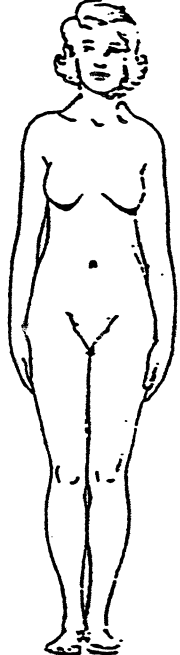
VICTIM YES TYPE: _____ NO

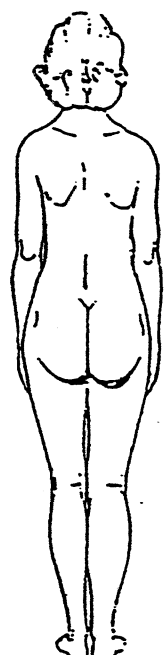
SYNOPSIS

DATE / TIME WRITTEN _____ REVIEWED BY _____ ROUTING _____

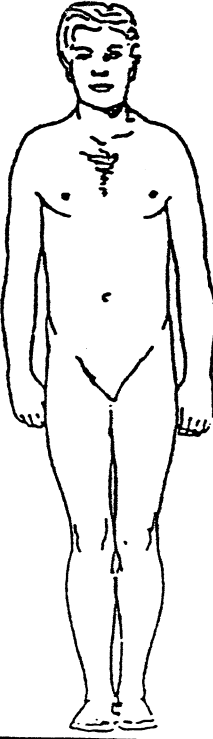
MEDICAL REQUEST	PARAMEDICS / EMTS / ID / HOSPITAL INFORMATION	VICTIM ASSISTANCE
<input type="checkbox"/> NONE <input type="checkbox"/> WILL SEEK OWN DOCTOR DOCTORS NAME: _____ CITY / PHONE: _____ <input type="checkbox"/> FIRST AID <input type="checkbox"/> PARAMEDICS <input type="checkbox"/> HOSPITAL <input type="checkbox"/> REFUSED MEDICAL AID	PARAMEDIC UNIT NAME / NUMBER: _____ E.M.T. NAME(S), I.D. (S): _____ FIRST AID RENDERED BY OTHER(S)? (NAMES): _____ _____ HOSPITAL NAME: _____ CITY: _____ ATTENDING PHYSICIAN(S) / NURSE(S) (NAMES): _____	<input type="checkbox"/> GIVEN D.V. PAMPHLET <input type="checkbox"/> GIVEN VICTIM OF VIOLENT CRIME CARD <input type="checkbox"/> GIVEN CASE NUMBER <input type="checkbox"/> GIVEN BWA PHONE NUMBER <input type="checkbox"/> BWA EMERGENCY RESPONSE TEAM CALLED <input type="checkbox"/> GIVEN D.V. UNIT PHONE NUMBER <input type="checkbox"/> CONFIDENTIALITY PROVISION EXPLAINED (293 P REQUESTED? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> OTHER SERVICES _____

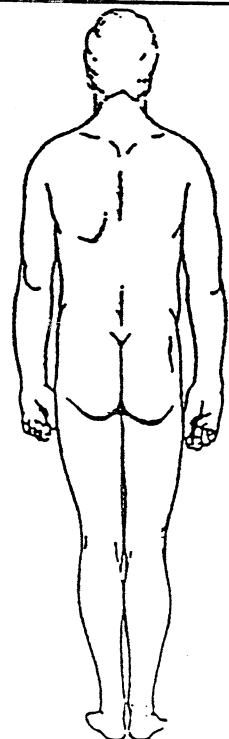
CASE DISPOSITION	PROBATION / PAROLE INFORMATION
VICTIM EXPRESSED WILLINGNES TO COOPERATE? <input type="checkbox"/> YES <input type="checkbox"/> NO CASE REFERRED TO INVESTIGATIONS / DETECTIVES? <input type="checkbox"/> YES <input type="checkbox"/> NO CASE REFERRED TO DA'S OFFICE? <input type="checkbox"/> YES <input type="checkbox"/> NO OTHER: _____	<input type="checkbox"/> SUSPECT <input type="checkbox"/> VICTIM DATE OF PAROLE / PROBATION: _____ COUNTY: _____ CONVICTED OF: _____

<input type="checkbox"/> VICTIM <input type="checkbox"/> SUSPECT HEIGHT _____ WEIGHT _____	
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PLEASE DRAW ON DIAGRAM(S) THE LOCATION OF ANY INJURIES.

<input type="checkbox"/> VICTIM <input type="checkbox"/> SUSPECT HEIGHT _____ WEIGHT _____	
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TO ALL HEALTH CARE PROVIDERS:
 Having been advised of my right to refuse, I hereby consent to the release to law enforcement and the District Attorney's Office, of information in my medical records pertaining to injuries sustained on _____ (fill in date of incident being investigated).

Signature _____ Date _____ Witness / _____