Department
Domestic Violence Investigation

Logo

revised 7/23/09

Complaint # _____

Source / Origin

- ☐ 911 Call from residence
- ☐ 911 Call from outside residence
- ☐ Non 911 call
- ☐ On view
- ☐ Other: _____

Relationship between Victim and Suspect

- ☐ Spouse
- ☐ Ex-Spouse
- ☐ Cohabitants
- ☐ Parent / Child
- ☐ Child in Common
- ☐ Dating
- ☐ Prior Dating
- ☐ Siblings
- ☐ Other: _____

NOTE: List all witnesses (children present) on IR form.

Victim Demeanor ☐V1 ☐V2

- ☐ Angry
- ☐ Crying
- ☐ Hysterical
- ☐ Afraid / Fearful
- ☐ Irrational
- ☐ Nervous
- ☐ Apologetic
- ☐ Calm
- ☐ Threatening
- ☐ Other:

Suspect Demeanor ☐S1 ☐S2

- ☐ Angry
- ☐ Crying
- ☐ Hysterical
- ☐ Afraid / Fearful
- ☐ Irrational
- ☐ Nervous
- ☐ Apologetic
- ☐ Calm
- ☐ Threatening
- ☐ Other:

Child Information

- ☐ Not Present
- ☐ Physically checked
- ☐ Angry
- ☐ Crying
- ☐ Hysterical
- ☐ Afraid/fearful
- ☐ Irrational
- ☐ Nervous
- ☐ Apologetic
- ☐ Calm
- ☐ Threatening
- ☐ Victim
- ☐ Sleeping
- ☐ Other: _____

Evidence Information

Evidence Collected: ☐ At scene ☐ Hospital ☐ Other: _____

Photographs: ☐ Digital ☐ Polaroid ☐ 35mm ☐ Video
☐ **Follow-up photos requested / recommended**

Statements: ☐ Victim ☐ Suspect ☐ Witness
☐ To be obtained: ☐ V ☐ S ☐ W

Referrals Made

As required by State Law - NDCC 12.1-34-02 and 50-25.1-03

- ☐ CVIC — Follow-up? ☐ Y ☐ N
- ☐ Personal Physician ☐ 960 Form
- ☐ NHS ☐ Private Atty.
- ☐ Other: _____

Note: Domestic Violence Victims are not to be "referred" to the States Attorney's Office.
Officer must complete affidavit or request for review.
Domestic crimes are not to be sent to the City Prosecutor.

Lethality Assessment

- ☐ History of Domestic Violence
- ☐ Suspect used a weapon
- ☐ Suspect has access to a weapon
- ☐ Suspect threatened to use a weapon
- ☐ Suspect violent towards others
- ☐ Suspect stalks / threatens victim
- ☐ Incident occurred during separation
- ☐ Protection Order / No Contact Order violated
- ☐ Suspect using alcohol / drugs at incident
- ☐ Suspect abuses alcohol / drugs
- ☐ Suspect threatened / attempted suicide
- ☐ Victim threatened / attempted suicide
- ☐ Violence towards pregnant partner
- ☐ Suspect stated "If I can't have you, no one will."
- ☐ Suspect has injured / killed pets
- ☐ Violent episodes more frequent
- ☐ Violence is getting more severe
- ☐ Suspect threatens to kill
- ☐ Forced Sexual Activity
- ☐ Victim responses are all "NO"
- ☐ Other _____

Medical Treatment

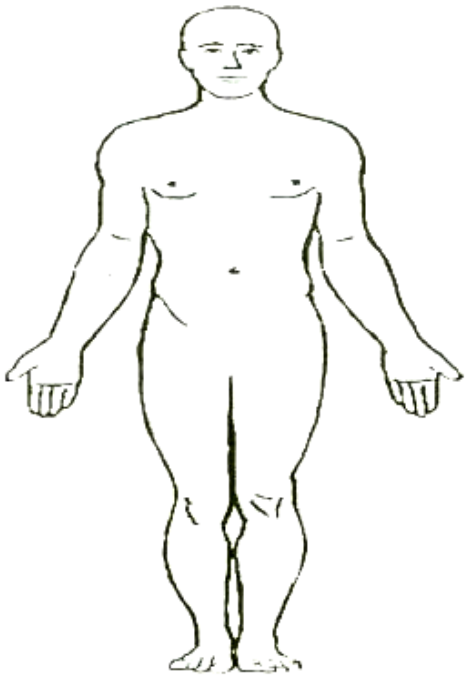
- ☐ First Aid
- ☐ Paramedics on scene
- ☐ At Hospital
- ☐ Refused
- ☐ Self treated
- ☐ None
- ☐ Other: _____

Strangulation Symptoms (This section for strangulation injuries **only**)

- ☐ Neck pain
- ☐ Scratch marks
- ☐ Tiny red spots
- ☐ Difficulty swallowing
- ☐ Loss of body functions
- ☐ Ears ringing
- ☐ Neck swelling
- ☐ Red linear marks / Bruising
- ☐ Rope or cord burns / Marks
- ☐ Raspy voice
- ☐ Nausea / Vomiting
- ☐ Fainting / Unconsciousness
- ☐ Light headed
- ☐ Miscarriage
- ☐ Personality changes
- ☐ Other: _____

Body Diagram

(Draw a line from injury description to appropriate area on diagram)



☐**V1** ☐**V2** ☐**S1** ☐**S2**

Laceration

Scrape

Swelling

Bruise

Reddened area

Bleeding

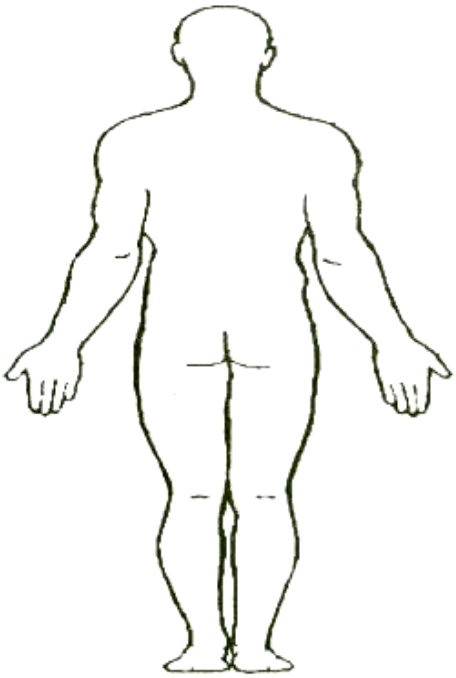
Puncture

Firearm wound

Bite mark

Pain

Other:



Medical Release

(Please have the victim date and sign this portion if medical records are needed to further investigation.)

Patient name _____

Street Address _____ City _____ State, Zip _____

Birth Date _____ Soc. Sec. No. _____ Home Phone _____

I authorize _____(Insert Medical Facility Name) to release all information they have pertaining to me, including, but not limited to Mental Health Records_____**(initial)** HIV or Aids Records_____ **(initial)** and Chemical Dependency Records_____**(initial)** over the past three years or **limited to the date(s) of** _____ to the Grand Forks Police Department. Please **do / do not (circle)** include Xray films. The purpose of this is for investigation of a legal matter, and can be in **oral form / written form / both (circle).** The release is effective 12 months from this date. A photocopy is as valid as the original. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g., probation, parole, etc.) and that in any event this consent expires automatically as described above. I understand that information disclosed under this authorization may be disclosed again by the person or organization to which it is sent. I also understand the Chemical Dependency client / patient's records are protected by Federal Law (42CFR Part 2) and cannot be disclosed without this written consent unless otherwise provided by federal regulation. I understand that information disclosed under this authorization may be disclosed again by the person or organization to which it is sent (ie States Attorney). The privacy of this information may not be protected under the federal privacy regulations.

Signature of Patient or Guardian: Date: Witness: