Clinical Domestic Abuse Disclosure Record

For use by GPs, practice nurses, and clinical staff when a patient discloses domestic abuse

This is a confidential clinical safeguarding record. Store in accordance with local safeguarding procedures and the capabilities of the clinical record system in use. Access must be restricted in line with GDPR and NHS Caldicott principles. It may be requested by police, courts, or other statutory bodies.

How to Use This Record

Complete this record as soon as possible after a patient discloses domestic abuse, while the details are fresh.

Record facts only. Do not include personal opinions, assumptions, or clinical judgements in this log.

Store this record securely, with access restricted. It must not be visible to other household members or to anyone accompanying the patient.

Retain in accordance with the NHS Records Management Code of Practice and local retention schedules. Where safeguarding concerns remain active, records may require extended retention in line with organisational policy.

Never disclose the existence of this record to the perpetrator if they are also a registered patient at the practice.

Note: If the patient is also a child or if a child may be at risk, follow your practice's child safeguarding procedures alongside this record.

Part 1: Record Details

Date of disclosure:	
Time of disclosure:	
Appointment type:	
Name of clinician completing this record:	
Role / designation:	
Date this record was completed:	

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Part 2: Patient Details

Record only what is necessary for safeguarding purposes. Avoid duplicating data already held in the clinical record.

Patient name:	
Date of birth:	
NHS number:	
Address:	
Preferred contact method:	
Is a safety word or code in place?	
Emergency contact (if given by patient):	

If the patient shares a GP registration with the perpetrator, consider whether additional access controls, safeguarding alerts, or consultation with the Practice Safeguarding Lead are required.

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Part 3: Nature of the Disclosure

Record what was disclosed in the patient's own words where possible. Do not interpret or paraphrase in a way that introduces assumptions.

Type(s) of abuse disclosed:

☐ Physical	☐ Sexual
☐ Emotional / Psychological	☐ Economic / Financial
☐ Controlling / Coercive	☐ Tech-facilitated / Digital
☐ Image-based / Deepfake	☐ Stalking / Harassment
☐ Honour-based	☐ Forced Marriage
☐ Reputation-based	☐ Other: _____

Summary of what the patient disclosed:	
Duration of abuse (if known):	
Is the perpetrator known to the practice?	
Relationship to patient:	
Is this the first disclosure to any agency?	
Has the patient disclosed to police previously?	
If so, reference / details:	

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Part 4: Immediate Risk Assessment

This is a prompt to identify whether immediate action is required. It does not replace a formal DASH risk assessment or the use of validated clinical safeguarding tools.

If you answered Yes to any of questions 1 to 5, you may have a legal duty or professional obligation to act. Do not promise absolute confidentiality. Explain clearly to the patient what you need to do and why, and confirm that your support will continue.

Immediate safety	
Is the patient in immediate danger right now?	☐ Yes ☐ No
Has the patient disclosed a risk to their life (threats to kill, strangulation, weapons)?	☐ Yes ☐ No
Has violence escalated in the last twelve months?	☐ Yes ☐ No
Children and dependants	
Are there children living in the household who may be at risk?	☐ Yes ☐ No
Has the patient disclosed forced marriage or FGM concerning themselves or a dependant?	☐ Yes ☐ No
Mental health and vulnerability	
Has the patient indicated suicidal thoughts or intent?	☐ Yes ☐ No
Does the patient have additional vulnerabilities (disability, substance use, immigration status, language barrier)?	☐ Yes ☐ No
Perpetrator proximity	
Is the perpetrator also registered at this practice?	☐ Yes ☐ No
Has the perpetrator attended the surgery or contacted the practice about this patient?	☐ Yes ☐ No
Has the patient been followed, monitored, or tracked (including digitally)?	☐ Yes ☐ No
Clinical risk indicators	
Is there evidence or disclosure of non-fatal strangulation or attempted strangulation?	☐ Yes ☐ No
Is the patient currently pregnant or within twelve months postpartum?	☐ Yes ☐ No
Escalation	
Was escalation required?	☐ Yes ☐ No

If escalation was required, who was informed and when?	
DASH assessment completed or referral made to an appropriately trained professional? (Y / N / Referred)	
Referral made to MARAC? (Y / N / Pending)	

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Part 5: Support Offered and Agreed

Tick all that apply. Record the patient's response and any agreed actions.

Support offered	Yes	No	N/A
IDVA / specialist domestic abuse service referral offered	☐	☐	☐
Safety planning discussion completed (see Part 6)	☐	☐	☐
DASH assessment offered or referral made to an appropriately trained professional	☐	☐	☐
MARAC referral discussed with patient	☐	☐	☐
Safe Accommodation information provided	☐	☐	☐
National Domestic Abuse Helpline number given (0808 2000 247)	☐	☐	☐
Local refuge / specialist services signposted	☐	☐	☐
Clare's Law (Right to Ask) explained, where appropriate	☐	☐	☐
Legal advice helpline details provided	☐	☐	☐
Follow-up appointment booked at patient's request	☐	☐	☐
Tech safety advice provided (tracking, spyware, shared accounts)	☐	☐	☐
Financial abuse support information provided	☐	☐	☐
Children's safeguarding referral made	☐	☐	☐
Mental health / crisis referral made	☐	☐	☐
Interpreter or language support arranged	☐	☐	☐

External services signposted (specify):	
Any other support agreed:	

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Part 6: Safety Planning Summary

Complete this section with the patient where it is safe to do so. Keep this section brief; full safety planning guidance is available from your designated safeguarding lead or local IDVA service.

Does the perpetrator know where the patient works or attends appointments?	
Has the patient been followed or approached near the surgery?	
Has the perpetrator's behaviour escalated recently?	
Key safety adjustments agreed:	
Patient's emergency contact for today:	
Is a code word or safety signal in place with the practice?	
Date safety plan to be reviewed:	

Part 7: Follow-Up and Review

Date of next planned contact or appointment:	
Who will lead the follow-up:	
Actions outstanding:	

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Part 8: Subsequent Entries

Use this section to record any follow-up conversations, changes to the safety plan, new disclosures, or referral updates. Each entry must be dated and signed.

Date	Notes (factual summary only)	Recorded by

Part 9: Record Closure

Complete this section when the active support period has ended or when the patient has permanently left the practice.

Date record closed:	
Reason for closure:	
Name of person closing the record:	
Retention period applied (in line with NHS Records Management Code of Practice and local schedule):	
Scheduled destruction date:	

Any ongoing safeguarding concerns requiring extended retention?	☐ Yes ☐ No

If yes, retention extended to:	
Authorised by:	

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