

STATE OF MICHIGAN
STANDARD DOMESTIC RELATIONSHIP INCIDENT REPORT (Complies with MCL 764.15c)

TIME / DATE OF INCIDENT	DISPATCH TIME	ARRIVAL TIME	TIME CLEARED	CALL RECEIVED <input type="checkbox"/> 911 SINGLE CALL <input type="checkbox"/> 911 MULTIPLE CALLS <input type="checkbox"/> OTHER
NAME OF PERSON WHO CALLED THE POLICE				
ADDRESS OF PERSON WHO CALLED THE POLICE				
INCIDENT LOCATION: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> Vehicle <input type="checkbox"/> Store <input type="checkbox"/> Hotel <input type="checkbox"/> Bar/Club <input type="checkbox"/> Other _____				
ADDRESS		CITY	COUNTY NO.	TOWNSHIP NO.

VICTIM Victim's Identifying or Contact Information May be Exempt from Disclosure Under the Freedom of Information Act and Crime Victim's Rights Act.

LAST NAME		FIRST NAME		MIDDLE NAME
RACE	SEX	DATE OF BIRTH	HEIGHT	WEIGHT
ADDRESS		CITY		ZIP CODE
TELEPHONE: (Home) () () ()		(Work) () () ()		(Cellular) () () ()
CONTACT PERSON IF DIFFERENT FROM ABOVE				TELEPHONE () () ()
ADDRESS		CITY		ZIP CODE

SUSPECT ARRESTED YES NO LOCATION LODGED CHARGE

LAST NAME		FIRST NAME		MIDDLE NAME
RACE	SEX	DATE OF BIRTH	HEIGHT	WEIGHT
OPERATOR'S LICENSE NUMBER		SOCIAL SECURITY NUMBER		
ADDRESS		CITY		ZIP CODE
TELEPHONE: (Home) () () ()		(Work) () () ()		(Cellular) () () ()


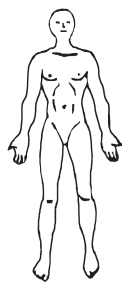
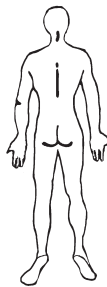
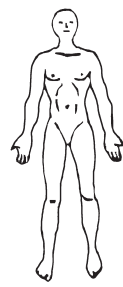
VICTIM RELATIONSHIP WITH OFFENDER IS (Check One)

Length Of Relationship _____ Years _____ Months

Spouse Former Spouse Has Had Child In Common Dating Relationship Former Dating Relationship
 Resident of the Same Household as Partner or Intimate Partner
 Former Resident of the Same Household as Partner or Intimate Partner

IF VICTIM IS RESIDENT OR FORMER RESIDENT BUT **NOT** AS A PARTNER OR INTIMATE PARTNER (Check One):
 Parent Child Sibling Grandparent Grandchild Roommate Other _____

VICTIM INJURIES DESCRIBE HOW INJURIES OCCURRED IN NARRATIVE **SUSPECT INJURIES** DESCRIBE HOW INJURIES OCCURRED IN NARRATIVE

<p>BACK</p>  <p><input type="checkbox"/> BROKEN/LOSS OF TEETH <input type="checkbox"/> GUNSHOT WOUND <input type="checkbox"/> LOSS OF CONSCIOUSNESS</p>	<p>FRONT</p>  <p><input type="checkbox"/> BROKEN/LOSS OF TEETH <input type="checkbox"/> GUNSHOT WOUND <input type="checkbox"/> LOSS OF CONSCIOUSNESS</p>	<p><input type="checkbox"/> FATAL <input type="checkbox"/> COMPLAINT OF PAIN <input type="checkbox"/> COMPLAINT OF STRANGULATION <input type="checkbox"/> NECK PAIN <input type="checkbox"/> INVOLUNTARY URINATION OR DEFECATION <input type="checkbox"/> SORE THROAT <input type="checkbox"/> RASPY VOICE <input type="checkbox"/> DIFFICULTY SWALLOWING <input type="checkbox"/> SCRATCH MARKS <input type="checkbox"/> ROPE OR CORD BURN <input type="checkbox"/> RED LINEAR MARKS OR BRUISING <input type="checkbox"/> NECK SWELLING <input type="checkbox"/> BRUISING <input type="checkbox"/> FRACTURE <input type="checkbox"/> ABRASIONS <input type="checkbox"/> CONCUSSION <input type="checkbox"/> BURNS <input type="checkbox"/> CUTS <input type="checkbox"/> LACERATIONS <input type="checkbox"/> NONE <input type="checkbox"/> OTHER _____</p>	<p>BACK</p>  <p><input type="checkbox"/> BROKEN/LOSS OF TEETH <input type="checkbox"/> GUNSHOT WOUND <input type="checkbox"/> LOSS OF CONSCIOUSNESS</p>	<p>FRONT</p>  <p><input type="checkbox"/> BROKEN/LOSS OF TEETH <input type="checkbox"/> GUNSHOT WOUND <input type="checkbox"/> LOSS OF CONSCIOUSNESS</p>	<p><input type="checkbox"/> FATAL <input type="checkbox"/> COMPLAINT OF PAIN <input type="checkbox"/> COMPLAINT OF STRANGULATION <input type="checkbox"/> NECK PAIN <input type="checkbox"/> INVOLUNTARY URINATION OR DEFECATION <input type="checkbox"/> SORE THROAT <input type="checkbox"/> RASPY VOICE <input type="checkbox"/> DIFFICULTY SWALLOWING <input type="checkbox"/> SCRATCH MARKS <input type="checkbox"/> ROPE OR CORD BURN <input type="checkbox"/> RED LINEAR MARKS OR BRUISING <input type="checkbox"/> NECK SWELLING <input type="checkbox"/> BRUISING <input type="checkbox"/> FRACTURE <input type="checkbox"/> ABRASIONS <input type="checkbox"/> CONCUSSION <input type="checkbox"/> BURNS <input type="checkbox"/> CUTS <input type="checkbox"/> LACERATIONS <input type="checkbox"/> NONE <input type="checkbox"/> OTHER _____</p>
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OFFICERS	COMPLAINT NUMBER
	INCIDENT NUMBER
	FILE CLASS
TIME OF REPORT	AGENCY
DATE OF REPORT	ORI

THIS FORM SHOULD BE COMPLETED FOR ANY ALLEGED CRIME OR ALLEGED PPO VIOLATION WHERE THE VICTIM AND OFFENDER HAVE A DOMESTIC RELATIONSHIP

VICTIM MEDICAL TREATMENT	SUSPECT MEDICAL TREATMENT
<input type="checkbox"/> NONE <input type="checkbox"/> WILL SEEK OWN <input type="checkbox"/> FIRST AID RENDERED <input type="checkbox"/> EMT <input type="checkbox"/> HOSPITAL <input type="checkbox"/> CLINIC <input type="checkbox"/> REFUSED	<input type="checkbox"/> NONE <input type="checkbox"/> WILL SEEK OWN <input type="checkbox"/> FIRST AID RENDERED <input type="checkbox"/> EMT <input type="checkbox"/> HOSPITAL <input type="checkbox"/> CLINIC <input type="checkbox"/> REFUSED
TRANSPORTED BY: (Name) _____	TRANSPORTED BY: (Name) _____
HOSPITAL _____	HOSPITAL _____
NAMES OF TREATING PHYSICIAN/NURSE _____	NAMES OF TREATING PHYSICIAN/NURSE _____
TELEPHONE OR PAGER NUMBER _____	TELEPHONE OR PAGER NUMBER _____
ADMITTED: <input type="checkbox"/> YES <input type="checkbox"/> NO	ADMITTED: <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> PATIENT SIGNED RELEASE FOR MEDICAL RECORDS	<input type="checkbox"/> PATIENT SIGNED RELEASE FOR MEDICAL RECORDS

ALCOHOL / CONTROLLED SUBSTANCE USE AT TIME OF INCIDENT	
VICTIM	SUSPECT
<input type="checkbox"/> Alcohol <input type="checkbox"/> Controlled Substance (Detail What and How Used in Narrative)	<input type="checkbox"/> Alcohol <input type="checkbox"/> Controlled Substance (Detail What and How Used in Narrative)

WEAPONS	DESCRIBE WEAPON USE IN NARRATIVE	WEAPON RECOVERED
		■ YES ■ NO
<input type="checkbox"/> PERSONAL (Hands, Fists, Feet) <input type="checkbox"/> BLUNT OBJECT <input type="checkbox"/> CUTTING INSTRUMENT <input type="checkbox"/> FIREARM-TYPE UNKNOWN <input type="checkbox"/> POISON <input type="checkbox"/> EXPLOSIVE		<input type="checkbox"/> HANDGUN <input type="checkbox"/> LONG GUN <input type="checkbox"/> OTHER _____

EVIDENCE	
<input type="checkbox"/> PICTURES <input type="checkbox"/> Digital <input type="checkbox"/> Polaroid <input type="checkbox"/> 35mm <input type="checkbox"/> PICTURES OF <input type="checkbox"/> Scene <input type="checkbox"/> Children <input type="checkbox"/> Injuries <input type="checkbox"/> Victim <input type="checkbox"/> Suspect <input type="checkbox"/> Follow-up Pictures to be Taken (Date _____)	<input type="checkbox"/> PHYSICAL EVIDENCE GATHERED (Describe in Narrative) <input type="checkbox"/> PROPERTY DAMAGE (Describe in Narrative) <input type="checkbox"/> CRIME LAB CALLED <input type="checkbox"/> TELEPHONE DISCONNECTED/DAMAGED <input type="checkbox"/> 911 TAPE OTHER EVIDENCE <input type="checkbox"/> Letters <input type="checkbox"/> Answering Machine <input type="checkbox"/> Caller ID <input type="checkbox"/> Phone Records <input type="checkbox"/> Video Tapes <input type="checkbox"/> Audio Tapes <input type="checkbox"/> Other

WITNESSES				
LAST NAME		FIRST NAME		MIDDLE NAME
RACE	SEX	DATE OF BIRTH		
ADDRESS		CITY	ZIP CODE	
TELEPHONE: (Home) ()		(Work) ()	(Cellular) ()	
RELATIONSHIP TO VICTIM	RELATIONSHIP TO SUSPECT		STATEMENT TAKEN BY	

LAST NAME		FIRST NAME		MIDDLE NAME
RACE	SEX	DATE OF BIRTH		
ADDRESS		CITY	ZIP CODE	
TELEPHONE: (Home) ()		(Work) ()	(Cellular) ()	
RELATIONSHIP TO VICTIM	RELATIONSHIP TO SUSPECT		STATEMENT TAKEN BY	

WITNESSES (Continued)					
LAST NAME		FIRST NAME		MIDDLE NAME	
RACE	SEX	DATE OF BIRTH			
ADDRESS			CITY	ZIP CODE	
TELEPHONE: (Home) ()		(Work) ()		(Cellular) ()	
RELATIONSHIP TO VICTIM		RELATIONSHIP TO SUSPECT		STATEMENT TAKEN BY	

LAST NAME		FIRST NAME		MIDDLE NAME	
RACE	SEX	DATE OF BIRTH			
ADDRESS			CITY	ZIP CODE	
TELEPHONE: (Home) ()		(Work) ()		(Cellular) ()	
RELATIONSHIP TO VICTIM		RELATIONSHIP TO SUSPECT		STATEMENT TAKEN BY	

RISK FACTORS / LETHALITY ASSESSMENT		
DURING INVESTIGATION, ATTEMPT TO IDENTIFY THE FOLLOWING PAST OR PRESENT RISK FACTORS. (Check all that apply and give a detailed explanation in the Narrative)		
<input type="checkbox"/> Gun Present or Accessible to Suspect <input type="checkbox"/> Suspect Has Used or Threatened to Use a Weapon <input type="checkbox"/> Recent Separation or Threatened Separation <input type="checkbox"/> Suspect Abuses Alcohol or Other Drugs <input type="checkbox"/> Suspect Accuses Victim of Cheating	<input type="checkbox"/> Increased Frequency / Severity of Violence <input type="checkbox"/> Suspect is Violent Outside the Relationship <input type="checkbox"/> Suspect Destroyed Cherished Personal Items <input type="checkbox"/> Suspect Attempts to Control Partner's Daily Activities <input type="checkbox"/> Victim is Currently Pregnant	<input type="checkbox"/> Suspect Threatened to Kill: _____ <input type="checkbox"/> Suspect Threatened Suicide <input type="checkbox"/> Suspect Violent Toward Children <input type="checkbox"/> Suspect Has Injured or Killed Pets <input type="checkbox"/> Suspect has Forced Sex on Victim

PRIOR DOMESTIC VIOLENCE HISTORY BY SUSPECT <input type="checkbox"/> YES <input type="checkbox"/> NO	
<i>PROVIDE DETAIL IN NARRATIVE</i>	
PREVIOUSLY KNOWN TO WITNESSES <input type="checkbox"/> YES <input type="checkbox"/> NO	
If YES, Where and When Reported (Include Out of State) _____	

PERSONAL PROTECTION ORDER IN EFFECT	
<input type="checkbox"/> YES <input type="checkbox"/> NO (Court _____)	
FOREIGN PROTECTION ORDER IN EFFECT	
<input type="checkbox"/> YES <input type="checkbox"/> NO (Court _____)	
PROTECTIVE CONDITION OF RELEASE OR PROBATION ORDER IN EFFECT	
<input type="checkbox"/> YES <input type="checkbox"/> NO (Court _____)	
FOREIGN PROTECTIVE CONDITION OF RELEASE OR PROBATION ORDER IN EFFECT	
<input type="checkbox"/> YES <input type="checkbox"/> NO (Court _____)	

VICTIM ASSISTANCE
<input type="checkbox"/> CRIME VICTIM RIGHTS INFORMATION PROVIDED
<input type="checkbox"/> DOMESTIC VIOLENCE VICTIM RIGHTS AND SERVICE INFORMATION PROVIDED

INTERPRETER SERVICES PROVIDED
VICTIM <input type="checkbox"/> YES <input type="checkbox"/> NO LANGUAGE _____
SUSPECT <input type="checkbox"/> YES <input type="checkbox"/> NO LANGUAGE _____
*LIST INTERPRETERS IN WITNESS BOX

