PSYCHIATRIC ABUSE CASE SUMMARY INVESTIGATION FORM

Hello,

Thank you for contacting the Citizens Commission on Human Rights. Your response is very much appreciated. Without the interest and help of people like you, we would not have progressed as far as we have in the fight against human rights violations so prevalent in the psychiatric system.

Remember, the first step to correcting injustices and human rights abuse is to report them. Conditions can be changed as our organization has shown over and over again. All information will be kept in strict confidence.

If you have a psychiatric abuse or crime to report, please ensure that you fill in this form as fully as possible. If there are further details that you want to make known or that you feel need to be conveyed, other than what is covered here, please add additional data to this form. This gives our office the basic information on you or your family member or friend's case.

After printing this form, fill it out as completely as possible, and then mail it to:

CCHR St. Louis
P.O. Box 300256
St. Louis, MO 63130-9256

After this form has been reviewed, a representative from our office will contact you by phone or letter to acknowledge receipt of this information and inform you of the next steps to be taken on your case.

While CCHR does not provide medical or legal advice, it works closely with and supports medical doctors and medical practice. A key CCHR focus is psychiatry's fraudulent use of subjective "diagnoses" that lack any scientific or medical merit. Based on these false diagnoses, psychiatrists justify and prescribe life-damaging treatments, including mind-altering drugs, which mask a person's underlying difficulties and prevent his or her recovery.

Please fill out the following:

Your information:

Name: _____

Address: _____

City: _____

State/Province: _____

Zip/Postal Code: _____

Country: _____

Phone: _____

Email Address: _____

Birth Date: _____

Your Report:

Questions to be answered as fully as possible (Please give specific dates if possible)

WHEN DID THE ABUSE YOU WISH TO REPORT OCCUR?

_____

_____

_____

WHO WAS THE TREATING DOCTOR ON THE CASE? PLEASE WRITE IN FULL: NAME AND WHAT KIND OF A DOCTOR THEY ARE: I.E. PSYCHIATRIST, PSYCHOLOGIST, ETC.

_____

_____

_____

WHAT WAS THE LAST KNOWN ADDRESS AND PHONE NUMBER OF THE PRACTICE OF THIS PSYCHIATRIST, PSYCHOLOGIST, ETC.?

_____

_____

_____

WHAT ARE THE NAMES OF ANY OTHER STAFF OR DOCTORS THAT YOU FEELWERE INVOLVED IN THE ABUSE? [Please state what their position [job] was).

_____

_____

_____

WHAT IS THE NAME OF THE HOSPITAL/FACILITY THAT THIS OCCURRED IN? IF MORE THAN ONE, FACILITY, PLEASE INDICATE. INCLUDE THE ADDRESS AND PHONE NUMBER FOR EACH FACILITY IF KNOWN:

_____

_____

_____

IF THE INJURED PARTY IS/WAS INSURED (PRIVATE OR GOVERNMENT OR SOCIAL SECURITY MEDICAL COVERAGE), WHAT IS THE NAME OF THE INSURANCE COMPANY OR BENEFITS THAT PAID FOR YOUR TREATMENT AND/OR HOSPITALIZATION?

_____

_____

_____

WHAT WAS THE REASON YOU WERE PLACED UNDER THE CARE OF A PSYCHIATRIST IN THIS FACILITY ETC.? (Please differentiate what the psychiatrist diagnosed you as, or said you were suffering from, and what you feel was the problem [if any] at the time.)

_____

_____

_____

PLEASE ANSWER YES OR NO TO THE FOLLOWING. IF YES TO ANY OF THE QUESTIONS, PLEASE PROVIDE ANY DETAILS AS NEEDED.

DID YOU ADMIT YOURSELF VOLUNTARILY? (Circle one)

YES NO

WERE YOU ADMITTED INVOLUNTARILY (AGAINST YOUR WILL)?

YES NO

WERE THERE ANY COURT ORDERS INVOLVED IN YOUR SITUATION?

YES NO

IF YES, WHO REQUESTED THEM?

FOR WHAT REASON?

WERE YOU INFORMED OF YOUR RIGHTS AS A PATIENT BEFORE ADMISSION?

YES NO

IF NOT BEFORE ADMISSION, AT ANY TIME DURING YOUR ADMISSION?

YES NO

IF YES, WHO INFORMED YOU AND WHAT WERE YOU TOLD?

DID ANY OF THE FOLLOWING OCCUR TO YOU? (If yes, please give specifics.)

PHYSICAL ABUSE?

YES NO

DRUGGED WITHOUT PERMISSION?

YES NO

IF YES, WHAT DRUGS WERE YOU GIVEN? (Include dosages & how often they were given)

_____

_____

_____

OVER DRUGGED?

YES NO

ANY SIDE EFFECTS FROM THE DRUGS THAT WERE INTOLERABLE?

YES NO

IF YES, WHAT WERE THESE SIDE EFFECTS?

_____

_____

_____

PERMANENT OR PERSISTING EFFECTS OF THE DRUGS?

YES NO

IF YES, WHAT WERE THESE EFFECTS AND ARE YOU STILL AFFECTED BY THEM?

_____

_____

_____

NOT INFORMED ABOUT DRUG SIDE-EFFECTS?

YES NO

IF YOU WERE INFORMED, PLEASE SPECIFY WHAT YOU WERE TOLD.

_____

_____

_____

SEXUAL ABUSE, MISCONDUCT OR RAPE?

YES NO

If this did occur, it may be difficult to report the details, but please write what you can and who was involved in this abuse.

_____

_____

_____

WAS THIS SEXUAL ABUSE CALLED THERAPY?

YES NO

IF YES, BY WHOM?

_____

_____

_____

USE OF RESTRAINTS?

YES NO

PLACED IN ISOLATION?

YES NO

IF PLACED IN RESTRAINTS AND/OR ISOLATION WERE YOU CHECKED ON REGULARLY?

YES NO

IF SO, HOW OFTEN?

_____

_____

_____

WERE YOU EVER THREATENED WITH PHYSICAL HARM?

YES NO

IF YES, WHO BY?

_____

_____

_____

WAS THERE ANY REASON WHY THE THREAT WAS MADE?

_____

_____

_____

WERE YOU THREATENED WITH COMMITTAL OR PUNISHMENT IF YOU REFUSED TO ACCEPT THE PSYCHIATRIC TREATMENT GIVEN TO YOU?

YES NO

IF YES, WHO BY AND WHAT HAPPENED?

_____

_____

_____

WERE YOU COERCED INTO HOSPITALIZATION OR TREATMENT?

YES NO

IF YES, WHO BY AND HOW?

WERE YOU GIVEN ELECTROSHOCK? (Also known as Electric Shock Treatment, Electroconvulsive Therapy, Shock Treatment and ECT.)

YES NO

IF YES, WHAT WERE YOU TOLD ABOUT THE ELECTROSHOCK TREATMENT PRIOR TO ITS ADMINISTRATION?

DID YOU SIGN ANY FORM GIVING CONSENT TO THE ELECTROSHOCK?

YES NO

IF YES, WHAT DID THE FORM SAY?

WAS YOUR INSURANCE COMPLETELY USED UP?

YES NO

HOW MUCH WAS USED?

DO YOU HAVE COPIES OF THE INSURANCE BILLINGS AND MEDICAL RECORDS?

YES NO

WERE THERE ANY CHARGES FOR SERVICES YOU DIDN'T RECEIVE?

YES NO

ANY DOUBLE BILLING ON YOUR INSURANCE?

YES NO

ANY OUTRAGEOUS CHARGES ON YOUR INSURANCE BILLS?

YES NO

DID YOU WITNESS ANY OF THE ABOVE DONE TO OTHERS?

YES NO

IF YES, AND YOU HAVE THE INFORMATION, PLEASE STATE NAMES, WHAT WAS DONE AND WHO COMMITTED THE ABUSE:

_____

_____

_____

WHAT WAS THE REASON GIVEN FOR DISCHARGING YOU?

_____

_____

_____

HAVE YOU CONTACTED AN ATTORNEY?

YES NO

WHAT WAS HIS OR HER RESPONSE TO THE CASE? (This does not affect our interest in the case.)

_____

HAVE YOU FILED ANY COMPLAINTS ON THIS/THESE ABUSE(S)?

YES NO

IF YES, WITH WHAT ORGANIZATION OR OFFICIAL?

WHEN WAS THE COMPLAINT FILED?

In addition, are you interested in the following:

1. Having CCHR further investigate your/this case.

YES NO

2. Having complaints filed on your/another's (with their permission) behalf with the proper authorities.

YES NO

3. Doing media interviews on your case to alert the public to these issues.

YES NO

4. Assisting in obtaining legislation in your state on issues that address the type of abuses in your or another's case.

YES NO

5. Writing letters to congressmen on these abuses.

YES NO

6. Starting or getting involved in a support group for people who have suffered similar abuses.

YES NO

Thank you again for filling out this interview form. Someone from our office will be getting back to you to assist with the next steps to take on your case once this information has been reviewed and it has been determined what we can best do to help expose and correct what has been done to you.

Please mail the completed form to:

CCHR St. Louis
P.O. Box 300256
St. Louis, MO 63130-9256

CITIZENS COMMISSION ON HUMAN RIGHTS®

Established in 1969 by the Church of Scientology to investigate and expose psychiatric violations of human rights

Step Two-A
GENERAL RELEASE FORM

I, _____, of
(Name)

_____
(Address)

do hereby authorize the Citizens Commission on Human Rights (CCHR), or its duly appointed representative, to conduct an investigation into my case as a medical / psychiatric patient and/or recipient of treatment. This investigation may include, but is not limited to, the acquisition of medical records or psychiatric records, including, but not limited to, ward charts, evaluations and other information, inspection of the facility(s) in which I was treated and/or a resident, photographs of my person, recording of my voice and full benefit of my personal knowledge of my case.

_____ _____
Date *Signature*

_____ _____
Date *Witness Signature*

_____ _____
Date *CCHR Representative*

Subscribed and sworn to before me this_____day of_____, 20_____.

_____
Notary Public in and for the
State of:_____
County of:_____
Residing at:_____

_____
My commission expires:_____

I hereby acknowledge receipt of a copy of the fully executed authorization above.

_____ _____
Date *Signed*

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Step Two-B
MEDICAL RECORDS RELEASE FORM

Doctor and/or hospital:_____

Regarding patient:_____

Of: (address at time of treatment)_____

Date(s) of treatment:_____

You are hereby authorized to allow the Citizens Commission on Human Rights (CCHR)—its representatives, agents or employees—to examine, copy or photostat all medical and/or psychiatric (mental health) records pertaining to examinations, treatments, or consultations of the above patient. This includes, but is not limited to, admissions and discharge reports, medical and psychiatric (mental health) history, laboratory findings, x-rays and reports, diagnostic and prognostic records, treatment and medication records, billing records, ward charts, ward and nurse's notes, dietary information and all medical reports.

Once obtained by CCHR, these records may then be copied and/or disclosed by CCHR as authorized by law.

This authorization is made with my knowledge and consent. The patient has a right to have a copy of this authorization.

_____ _____

Date *Signed (Patient)*

_____ _____

Date *Signed (Parent/Guardian if needed)*

Witnessed or notarized

_____ _____

Date *Signed*

_____ _____

Date *Signed*

Subscribed and sworn to before me this_____day of_____, 20_____.

_____

Notary Public in and for the
State of:_____

County of:_____

Residing at:_____

_____

My commission expires:_____

I hereby acknowledge receipt of a copy of the fully executed authorization above.

_____ _____

Date *Signed*

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Step Two-C
RELEASE FORM

I, _____, of
(Name)

_____
(Address)

do hereby authorize the Citizens Commission on Human Rights (CCHR) to utilize my name and the information that I have provided to CCHR—its representatives, agents or employees—regarding my knowledge of psychiatric abuses in the name of mental treatment and any other factual information or documentation provided by myself or other persons, in presentations to government agencies and information packets or news releases for the media, in order to establish the existence of the particular abusive situations within the psychiatric profession which my case represents and to seek reforms of these situations. This would apply to any information that I have not specifically requested in writing to be held confidential.

This information or documentation (referred to above) would include but not be limited to: recorded interviews, photographs, letters, and copies or photostats of medical and/or psychiatric records pertaining to examinations, treatments, or consultations including, but not limited to, admissions and discharge reports, medical and psychiatric history, laboratory findings, x-rays, medication records, billing records, ward charts, ward and nurse's notes, dietary information, and all medical reports.

I recognize that CCHR is a social reform organization whose purpose is to investigate and expose psychiatric violations of human rights.

_____ _____
Date *Signature*

_____ _____
Date *Witness*

_____ _____
Date *Witness*

Subscribed and sworn to before me this_____day of_____, 20_____.

_____
Notary Public in and for the
State of:_____
County of:_____
Residing at:_____

_____
My commission expires:_____

I hereby acknowledge receipt of a copy of the fully executed authorization above.

_____ _____
Date *Signed*