PSYCHIATRIC ABUSE REPORT FORM

Protect Yourself Against Misdiagnosis and Abuse

INFORMATION:

Anyone diagnosed with a psychiatric (mental) disorder and/or their parent or guardian has the right to informed consent and to know that unlike medical conditions, psychiatrists do not have blood or other biological tests to ascertain the presence or absence of a mental illness. It is also important to know that according to a leading medical manual, "Mental health professionals working within a mental health system have a professional and a legal obligation to recognize the presence of *physical* disease in their patients" to rule these out causing "a patient's mental disorder."

Frequently psychiatrists do not conduct thorough physical exams to rule out medical conditions, thereby misdiagnosing the patient. This can result in inappropriate and dangerous treatment, added to the fact that the real underlying medical condition is left untreated. It is also extremely costly to your insurance company.

Further, if a psychiatrist says that your mental condition is caused by a chemical imbalance in the brain or is a neurobiological disorder, you have the right to ask for the lab or other test to prove that diagnosis.

This Psychiatric Abuse Report Form is a guide only for information you may wish to provide. Please give as much detail as you wish.

YOUR NAME_____

ADDRESS_____

_____

PHONE _____(MOBILE)_____(HOME/WORK)

EMAIL_____

IS THIS STATEMENT ABOUT YOURSELF? _____

OR ANOTHER? _____

IF ANOTHER, PLEASE PROVIDE NAME AND CONTACT INFORMATION

_____

_____

NAME OF DOCTOR/PSYCHIATRIST SEEN:_____

ADDRESS/CONTACT INFORMATION OF DOCTOR/PSYCHIATRIST:

_____

_____

NAME OF HOSPITAL, IF ANY_____

ADDRESS/CONTACT INFORMATION OF HOSPITAL:

_____

_____

DATE (S) SEEN:_____

REASON FOR VISIT:

_____

SYMPTOMS CONVEYED TO DOCTOR/PSYCHIATRIST_____

_____

_____

_____

HOW LONG WAS THE CONSULTATION?_____

_____

WHAT WAS THE DIAGNOSIS? (Provide as many specifics as given you.)

_____

_____

WHAT TESTS DID THE DOCTOR CONDUCT? For example:

Lab Test _____ Blood Test _____X-Ray_____

Brain Scan (PET scan, MRI, Cat Scan)_____

WERE YOU TOLD THAT A CHEMICAL IMBALANCE WAS IN SOME WAY CAUSING YOUR MENTAL CONDITION? IF SO, WHAT WAS SAID, AND DID YOU ASK THE DOCTOR/PSYCHIATRIST FOR A TEST TO SUBSTANTIATE THIS? IF SO, WHAT DID HE SAY?

_____

_____

WHAT TREATMENT WAS PRESCRIBED? (If one or more psychiatric drugs, name the drug, the dose and the reason this was recommended.)

_____

_____

WHAT INFORMATION WERE YOU GIVEN ABOUT POTENTIAL SIDE EFFECTS OF THE TREATMENT PRESCRIBED?

_____

_____

DID YOU SIGN ANY CONSENT FORM REGARDING THE TREATMENT ADMINISTERED YOU?

_____

_____

DID YOU EXPERIENCE ANY ADVERSE REACTON (SIDE EFFECT) FROM THE TREATMENT? (Provide details.)

_____

_____

WERE YOU HOSPITALIZED A) VOLUNTARILY___ OR
B) INVOLUNTARILY ___?

IF HOSPITALIZED, WHAT WAS THE NAME AND ADDRESS OF THE FACILITY?

_____

_____

HOW LONG WERE YOU HOSPITALIZED? _____

DESCRIBE HOW YOU WERE TREATED IN THE HOSPITAL.

_____

_____

WAS THERE ANY LONG-TERM PHYSICAL OR MENTAL DAMAGE CAUSED AS A RESULT OF THE TREATMENT? (Provide details.)

_____

_____

DID YOU LATER ESTABLISH THAT THERE WAS A MEDICAL CONDITION THAT WASN'T DETERMINED AND DIAGNOSED BEFORE YOU WERE GIVEN THE PSYCHIATRIC DIAGNOSIS? If so, please provide

specifics and if that condition was diagnosed by another physician, and what tests were conducted to correctly diagnose the physical condition?

_____

_____

WAS YOUR INSURANCE COMPANY BILLED FOR THE TREATMENT FOR THE EARLIER MISDIAGNOSIS? (Please give specifics, including insurance company and amount billed.)

_____

_____

IS THERE ANYTHING ELSE YOU WOULD LIKE TO TELL US ABOUT THE ABUSE EXPERIENCED?

_____

_____

SIGNED_____ DATE_____

PLEASE SEND THIS TO THE NASHVILLE CHAPTER OF CITIZENS COMMISSION ON HUMAN RIGHTS:

CCHR Nashville
PO Box 41795
Nashville, TN 37204