CCHR UK, PO Box 188, East Grinstead, RH19 4RB

Psychiatric Abuse Report Form

Please print this report form, fill it in and return it to the address above. This is your chance to tell the story about what happened to you or your friend/family member in the psychiatric system.

Any information you give on this form will be treated in the strictest confidence.

Introduction

Are you the abused person? yes ☐ no☐

Your email

Details of the abused person

First name

Last name

Address

Town

Postcode

Telephone

Age

Gender male ☐ female☐

Your Details (if reporting about someone else)

Your name

Your telephone

Your relationship to the abused person

Details of the abuse

Type of Abuse That Occurred (Check as many as apply)

Received ECT (electroshock) ☐
Psychiatric Drugs ☐
Patient Died ☐
Misdiagnosed ☐
Child Protective Services ☐
Involuntarily Committed ☐
Restrained ☐
Child Drugging ☐
Physical Abuse ☐

Court Ordered to Receive Psychiatric Treatment ☐
Sexual Assault ☐
Elderly Abuse ☐
No Medical Exam ☐
Seclusion ☐
No Informed Consent ☐
Denied Patients Rights ☐
Coercion ☐
Other ☐

Summary of abuse that occurred

Approximate date the abuse occurred

Approximately how many times?

Doctors & Location

#1: Facility where the abuse took place
#1: What county is the facility in?
#1: Doctor type:
Psychiatrist ☐
Psychologist ☐
GP ☐
Psychiatric Nurse ☐
Paediatrician ☐
Neurologist ☐
#1: Name of doctor(s)/psychiatrist(s) involved

#2: Facility where the abuse took place

#2: What county is the facility in?

#2: Doctor type:

Psychiatrist ☐

Psychologist ☐

GP ☐

Psychiatric Nurse ☐

Paediatrician ☐

Neurologist ☐

#2: Name of doctor(s)/psychiatrist(s) involved

Any other information you would like to give?

What would you like to achieve as a result of reporting this abuse?

YOUR INFORMATION IS KEPT STRICTLY CONFIDENTIAL AND WILL ONLY BE USED WITH YOUR PERMISSION.

☐ I HEREBY AUTHORISE THE CITIZENS COMMISSION ON HUMAN RIGHTS (CCHR) TO CONDUCT AN INVESTIGATION INTO THIS CASE OR:

☐ I DO NOT WISH ANY ACTION TO BE TAKEN. THE DETAILS OF MY TREATMENT ARE BEING SENT AS INFORMATION ONLY.

SIGNED: _____