CHATS

Ohio Domestic Violence Network ODVN | The Center on Partner-Inflicted Brain Injury

Medical Advocacy Form

Please fill out information as accurately as possible to share with a healthcare provider. A domestic violence advocate can assist you.

Name _____ **Age** _____

Main health concern:

_____

Most recent injury to the head/neck/face: **Approximate date** _____

- ☐ Hit or other injury/force to the head, neck, or face
- ☐ Choked, strangled, or anything else that made it hard to breathe
- ☐ Dazed, confused, or altered consciousness (lost consciousness, blacked or passed out, including overdose)

Changes, signs & symptoms after injury:

_____

History of injuries from violence (such as injuries to the head, neck, or face; strangulation; or lack of oxygen). **Include approximate dates and types of injuries.**

_____

Have you ever received medical care for head/neck/face injuries? ☐ Yes ☐ No

When and where _____

Have you ever been diagnosed with a concussion or brain injury? ☐ Yes ☐ No

Details

Current medical conditions, allergies, diagnosis and/or medications:

What are you goals for today's visit and your long-term health?

Referral to

Date/location of next appointment

Notes:

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