**MEDICAL ADVOCACY FORM**

**Date:** **Length of time (increments of .25, .50, etc):**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone #:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (for follow up)

 OK to leave a message? ❑ Yes ❑ No

**Visit Medical Facility:** **Treated for Injuries:** ❑ Yes ❑ No

❑ Yes ❑ No Date: **Seriousness of Injury:**

**Medical Facility:** ❑ Required hospital admission

❑ Clinic ❑ Emergency Room ❑ ER Transfer ❑ Not required ❑ Unknown

❑ Private Physician ❑ Unknown ❑ None **Photos Taken:**❑ Yes ❑ No

**Facility Name:** ❑ Unknown ❑ Not Reported

**Treated by SANE:** **Evidence Collection Kit Used:**

❑ Yes ❑ No ❑ Unknown ❑ Not Reported ❑ Yes ❑ No ❑ Unknown

**Police Called:** ❑ Yes ❑ No ❑ Unknown ❑ Not Reported ❑ Not Reported

**Age:** \_\_\_\_\_\_\_

**Gender Identity:** ❑ Female ❑ Transgender Female ❑ Gender Non-Conforming

 ❑ Male ❑ Transgender Male ❑ Unknown

**Race/Ethnicity:** ❑ American Indian/Alaska Native ❑ Asian

 ❑ Black/African American ❑ Hispanic/Latino/a/x

 ❑ Middle Eastern/North African ❑ Native Hawaiian/Pacific Islander

 ❑ White ❑ Unknown

**SUMMARY OF CONTACT:**

**STAFF/VOLUNTEER NAME:**

**48-HOUR FOLLOW UP**

**Date:** **Length of time (increments of .25, .50, etc):**

**SUMMARY OF CONTACT/REFFERALS:**

**STAFF/VOLUNTEER NAME:**