ANTARMAN

Centre for Psychosocial Wellbeing

DBT REFERRAL FORM

(All elements of this form must be completed before we can consider this patient for the skills training group!)

Referred By _____ Date _____

Client Name _____ Age _____ Gender: Male/Female/Other

Address _____

Current Diagnosis (es), if applicable: _____

_____

Name & Contact Number of Consulting Psychiatrist/ Psychologist:

_____

Is the client currently on any psychiatric medications : Yes _____ No: _____

Is the client medication compliant? Yes ☐No ☐

Does this client have an individual psychotherapist: Yes _____ No: _____

If "yes", name and contact number of therapist:

_____

How long has this client been in therapy?

_____

How often does this client see the therapist? _____

Does the client have attendance issues? Yes ☐No ☐

Does this client have any of the following history or behavior(s):

1. Self-harm: Current _____ Past ____ (How long ago _____)
2. Suicide attempts: Current _____ Past _____ (How long ago _____)
3. Substance abuse: Current ____ Past _____(How long ago _____)
4. Eating disorder: Current _____ Past _____(How long ago _____)
5. Other impulsive behaviors: Current ____ Past _____ (How long ago _____) Pls specify

_____

Have you discussed DBT with the client and/or his/her parent(s)? Yes _____ No: _____

Is the client familiar with DBT: Yes _____ No: _____

Why do you think this person would be a good fit for DBT? _____

_____