Insurance Information: _____

DBT REFERRAL FORM

(All elements of this form must be completed before we can consider this patient for the skills training group!)
Fax: (919) 962-9729. Attn: Catherine Forneris, Ph.D., ABPP.

Date: _____
Referring provider(s): _____ Contact Info: Phone/E-mail: _____

Patient's name: _____

MR#: _____ Age: _____

Current mailing address: _____

Telephone number(s): H: _____ C: _____ W: _____

Patient's current diagnosis (es): 1) _____
2) _____
3) _____
4) _____

Current Psychiatric Medications: 1) _____
2) _____
3) _____
4) _____

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

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

How long has this patient been in therapy? _____

How often does this patient see the therapist? _____

Does this patient 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 _____)

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

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