Dialectical Behaviour Therapy Program

ST VINCENT'S HOSPITAL SYDNEY

Referral Form

MRN		SURNAME	
OTHER NAMES			
DOB	SEX	AMO	WARD/CLINIC

(Please enter information or affix Patient Information Label)

Email this referral form and recent psychiatric summary letter to svh.dbt@svha.org.au

CLIENT INFORMATION	
First name:	
Surname:	
Date of Birth:	_____/_____/_____
Preferred pronoun(s):	
Address:	
Phone:	
Email:	

REFERRER INFORMATION		
Date:	_____/_____/_____	
Name:		
Agency:		
Address:		
Phone:		
Email:		
Provider number:		
Does the client have a current individual therapist?		
If yes:	*Name:*	
	Agency:	
	Phone:	
	Email:	
If no:	Is the client willing and able to engage with an individual therapist for the duration of the program	☐ Yes ☐ No

Does the client experience chronic suicidal ideation or suicidal behaviours	☐ Yes ☐ No
Does the client engage in self-harm	☐ Yes ☐ No
Does the client engage in risky impulsive behaviour	☐ Yes ☐ No
Does the client engage in restricted eating, binge eating, or behaviours to reduce weight *(e.g. purging, laxative use or excessive exercise)*	☐ Yes ☐ No
Is the client experiencing acute psychotic symptoms	☐ Yes ☐ No
Does the client have a primary substance use disorder	☐ Yes ☐ No
Approximately how many PECC or inpatient psychiatric admissions has the client had in the last 6 months	
Approximately how many Acute Care service episodes has the client had in the last 6 months	
Approximately how many visits to the Emergency Department for mental health issues has the client had in the last 6 months	☐ Yes ☐ No

Are there any potential barriers to the client engaging in the DBT program? *e.g. poor attendance, attending sessions late, aggression, substance use, client motivation, group environment.*

REFERRAL FORM