REFERRAL FOR INDIVIDUAL AND GROUP DBT SERVICES WITH GPDBT

Please fill out referral form prior to contacting us to guide our conversation regarding your interest in DBT services. We review all referrals during our consultation team meetings to determine placement in our DBT program.

Client Information Date: _____

First Name (legal): _____ Last Name: _____
Preferred Name (if different): _____ Date of Birth: _____ Age: _____
Parent name(s) if under 18 years: _____
Interpreter required? (Mark one): ___YES ___NO If yes, language needed: _____
Ethnicity (Mark one or write in): ___ Hispanic ___Non-Hispanic ___Other: _____
Race (Mark all that apply or write in): ___Black or African-American ___American Indian or Alaska Native ___Native Hawaiian or Other Pacific Islander ___White ___Middle Eastern or North African ___Asian ___Some other race or origin:_____

Religion or spirituality: _____

Gender Identity (Mark all that apply or write in): ___Female ___Male ___Non-binary/3rd gender ___Two Spirit ___Other: _____ ___Prefer not to say

Gender currently listed on insurance policy: ___Female ___Male [Note: Required for us to bill insurance]
Pronouns: ___She, her, hers ___He, him, his ___They, them, theirs ___Other: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Type (Mark one): __Cell __Home __Work

Secondary phone: _____ Type (Mark one): __Cell __Home __Work

OK for us to leave voicemails? (Mark one): ___YES ___NO Best time to call?: _____

Email address: _____

(Note: Email will be used to update wait list status, follow-up if we are unable to reach you by phone, or provide scheduling information.) This service is optional but helps us contact you faster and give you more information about our wait list and available services.

Therapist gender preference? (Mark one): ___Male ___Female ___Other gender identity:_____
Appointment availability (Mark all that apply): ___Morning ___Afternoon ___Evening (i.e. 4pm or later)
Are there accommodations needed due to a disability? If so, please specify: _____
_____

*Please note that we are not always able to accommodate therapist preferences

Referral Source (if client is self-referred, you may skip to next section)

Relationship to client: _____ First and Last name: _____
Agency name: _____ Address (street, city, state, zip):_____

Phone number _____

Have you signed release___ Yes ___ NO Do we have your permission to contact them ___YES ___NO

Reasons or Concerns for Seeking Treatment:

Eating disorder concerns? (Mark one): ___YES ___NO If yes, (Mark all that apply): ___Binging ___Purging ___Restricting ___Over-exercise ___Other (please list) _____

Self-harming behaviors? (Mark one): ___YES ___NO If yes (Mark all that apply): ___Burning ___Cutting ___Picking ___Other (please list): _____

Alcohol or drug abuse? (Mark one): ___YES ___NO If yes, which substances(s):
_____

Hospitalizations in the past year for mental health reasons? (Mark one): ___YES ___NO

If yes, most current date of hospitalization: _____

Please describe dates and previous hospitalizations: _____

_____

Access to a firearm? (Mark one): ___YES ___NO

Suicidal thoughts?: ___YES ___NO If yes, how frequently: _____

Suicide attempts in the past six (6) months? (Mark one): ___YES ___NO

If yes, date of most recent attempt: _____

Any current legal involvement? (e.g. mandated therapy, restraining order, etc.): ___YES ___NO

History of assault/violence towards others? (Mark one): ___YES ___NO

Homicidal thoughts? (Mark one): ___YES ___NO

History of trauma/traumatic experiences? (Mark one): ___YES ___NO

Other reasons or concerns for seeking treatment: _____
_____
_____

Client Insurance Information

Insurance Company: _____

Member ID number: _____ Group ID number: _____
Provider or customer service phone number: _____

Are you willing to see a provider who does not take insurance and either pay out-of-pocket and use out-of-network insurance benefits for individual therapy?_____

Thank you for contacting Greater Portland DBT and for your referral! We look forward to hopefully working with you soon!