SHOREHAVEN
BEHAVIORAL HEALTH, INC.

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Dialectical Behavior Therapy [DBT]
Referral Form

Instructions: This form can be completed by Shorehaven's Referral Department or by Referring Therapist inside or outside of Shorehaven.

Please complete any information that you know at the time of referral to a DBT team member.

Date of referral: SBH case #:

Client: Client date of birth:

Type of DBT group: ☐ Adult ☐ AODA ☐ Adolescent (15-18)

Person making referral: ☐ Self referred

Current Client of: ☐ Not a client

Current level of care: ☐ None ☐ IOP ☐ DayTx ☐ In-Home ☐ Outpatient

Other

If coming from IP or IOP, Facility/Anticipated D/C date:

Why do you think DBT is the appropriate care:

Reasons for referring to DBT group (behaviors, symptoms, problems, impairments):

Diagnoses if known:

Need/willingness to transition to new therapist for individual DBT work: ☐ Yes ☐ No

Client's awareness of DBT: Aware it's a skills group:: ☐ Yes ☐ No Current therapist DBT trained: ☐ Yes ☐ No

Past experience with DBT:

If not member of the DBT team, Therapist willing to attend DBT consultation group and do therapy in parallel with skills group: : ☐ Yes ☐ No

Any anticipated barriers to treatment:

Need help with setting up transportation to attend group: ☐ Yes ☐ No

Name any potential group interfering behaviors (e.g., attendance, behaviors, AODA problem, life circumstances):

For adolescents, parent/caregiver aware of parent group involvement: