

Therapy Information

How often do you see your patient for therapy? ___ Weekly ___ Twice a Month
___ Other (please specify): _____

DBT is based on practical skills training group with classes requiring homework and parent/guardian participation. Parents/Guardians who are unable to benefit from participation due to substance dependence, legal involvement, or severe mental illness including active mania or psychosis are asked to seek their own treatment prior to group participation. Is/Are there a parent(s)/guardian(s) who would be able to participate in group? ___ Yes ___ No

If yes, please list their names: _____

Does your patient have any learning problems? ___ Yes ___ No

If yes, please describe: _____

Does your patient have an IEP or 504 plan? ___ Yes ___ No

Has your patient ever been diagnosed with an autism spectrum disorder (including Asperger's Disorder)? ___ Yes ___ No

Reasons(s) for Referring Patient to DBT

DBT focuses on 4 sets of skills. Which skills do you believe your patient needs help with?

- Interpersonal Conflict Issues
Difficulties establishing and maintaining balance in relationships (giving too much or too little).
Difficulties asking for what s/he wants. Difficulty saying "no."
- Emotional Regulation Issues
Labile emotions. Intense painful emotions. Feeling overwhelmed or controlled by emotions.
- Distress Tolerance Issues
Substance abuse. High risk sexual behaviors. Extreme financial difficulties. Criminal behaviors. Dysfunctional behaviors that interfere with work/school.
- Core Mindfulness Issues
Trouble focusing attention. Trouble staying in the present. Trouble being overly sensitive or misunderstanding others. Judging herself/himself.

Please see next page to provide additional information and please sign and date referral -thanks!

Additional information on referral:

Referring Provider's signature

Date

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Received from therapist: ____/____/____

To: Michael Thalasinios Megan Kasdorf

Appropriate for intake? ___ Yes ___ No-why not?

If no, patient called? ___ Yes ___ No therapist called? ___ Yes ___ No

If yes, scheduled intake ____/____/____ with
