UW Health

Psychiatry

UW Psychiatry Clinic
Adolescent Dialectical Behavior Therapy (DBT)
Referral Form

Patient Information

Patient's Name: _____ Date of Birth: _____/_____/_____
Parent/Guardian Name(s) _____
Does patient have health insurance? ___Yes ___No Name of insurance: _____
☐ Have you discussed DBT with your patient?
☐ Have you informed them that a parent is required to attend all sessions?
☐ Have you informed them that our group meets for 6-week periods weekly on Thursdays from 4:00-6:00PM?

Referring Provider: _____
Address: _____
Email: _____ Phone: _____ FAX: _____

Patient's Diagnoses and Symptoms

Diagnoses:

Borderline Personality Trait Assessment
(Please check applicable traits)

☐ Frantic efforts to avoid real or imagined abandonment
☐ A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
☐ Identity disturbance: markedly and persistently unstable self-image or sense of self
☐ Impulsivity that is potentially self-damaging
____ spending ____ sex ____ alcohol abuse or dependence
____ reckless driving ____ binge eating ____ illicit drug abuse or dependence
☐ Does patient currently abuse alcohol or other drugs?
☐ Does patient have a history of alcohol or drug abuse?
If so, when did they last abuse? _____
☐ Is patient currently being treated for alcohol or other drug abuse?
☐ Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
____ history of suicide attempts ____ history of cutting
____ chronic suicidal ideation ____ other (specify: _____)
☐ Affective instability due to a marked reactivity of mood
____ anger ____ depression ____ anxiety
☐ Chronic feelings of emptiness
☐ Inappropriate, intense anger or difficulty controlling anger
☐ Transient, stress-related paranoid ideation or severe dissociative symptoms
☐ History of or current Abuse:
____ physical ____ sexual ____ emotional ____ neglect
Does the patient or their family have an active ChIPs case?
☐ Academic Problems
____ truancy ____ suspensions ____ expulsions
☐ Does the patient currently have any involvement in the juvenile justice system?
If so, please describe.

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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

Megan Kasdorf
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Received from therapist: ____/____/_____
To: ☐ Michael Thalasinos ☐ Megan Kasdorf
Appropriate for intake? ___ Yes ___ No-why not?
_____
If no, patient called? ___ Yes ___ No therapist called? ___ Yes ___ No
If yes, scheduled intake ____/____/_____ with
_____