



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

REFERRAL FORM

CLIENT INFORMATION

First name:	
Surname:	
Date of Birth:	____/____/____
Preferred pronoun(s):	
Do you identify as:	<input type="checkbox"/> Aboriginal <input type="checkbox"/> Torres Strait Islander <input type="checkbox"/> Both <input type="checkbox"/> Neither
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	<input type="checkbox"/> Yes <input type="checkbox"/> No

Does the client experience chronic suicidal ideation or suicidal behaviours	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the client engage in self-harm	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the client engage in risky impulsive behaviour	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the client engage in restricted eating, binge eating, or behaviours to reduce weight (e.g. purging, laxative use or excessive exercise)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the client experiencing acute psychotic symptoms	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the client have a primary substance use disorder	<input type="checkbox"/> Yes <input type="checkbox"/> 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	

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.