Portland DBT INSTITUTE

Referral For Clinical Services

Client Information **Date:**

First name: _____ Last name: _____

Parent name(s) if teen: _____

Date of birth: _____ Age: _____

Gender (Circle one): M / F / Trans / NB / Other: _____

Address: _____

City: _____State: _____ Zip: _____

Phone (Cell /Home/Work): _____ Extension: _____

Email: _____

Best time to call: _____

Is it OK for us to leave a phone message? (Circle one): YES / NO

Therapist gender preference? (Circle One): Male / Female

Appointment availability (Circle all that apply): Morning / Afternoon / Evening

Referral Source (*if self-referred, skip to next section*)

Relationship to client: _____

First name: _____ Last name: _____

Address: _____

City: _____State: _____ Zip: _____

Phone (Cell/Home/Work) _____ Extension: _____

Email: _____

Best time to call: _____ Ok to leave a message? (Circle one): YES / NO

Reasons or Concerns for Seeking Treatment

Eating disorder concerns? (Circle one): YES / NO

If yes (Circle one): Binging / Purging / Restricting

Other: _____

Self-harming behaviors? (Circle one): YES / NO

If yes (Circle one): Burning / Cutting / Picking

Other: _____

Alcohol or drug abuse? (Circle one): YES / NO

If yes, drug(s) of choice: _____

Hospitalizations in the past year for mental health reasons? (Circle one): YES / NO

If yes, most current date of hospitalization: _____

Access to a firearm? (Circle one): YES / NO

Suicidal thoughts? (Circle one): YES / NO

If yes, how frequently? _____

Suicide attempts in the past six months? (Circle one): YES / NO

If yes, date of most recent attempt: _____

History of abuse/trauma? (Circle one): YES / NO

If yes, circle applicable response(s): Physical / Emotional / Verbal / Sexual / Childhood

Other reasons or concerns for seeking treatment: _____

_____

_____

_____

_____

Client Insurance Information

Primary Insurance Company: _____

Member ID number: _____ Group ID number: _____

Provider or customer service phone number: _____

We appreciate you contacting us for services. Once your referral is received and reviewed, a member of our Intake Team will reach out to you (typically within 5-10 business days). You may submit your referral via secure fax at (503) 231-8153, or via mail at 5200 SW Macadam Ave, Suite 580, Portland OR, 97239. For follow-up questions, please contact our referral line at (503) 290-3291.