Portland DBT INSTITUTE

Referral For Clinical Services

Client Information **Date:**

First Name (legal): _____ Last Name: _____

Preferred Name (if different): _____ Date of Birth: _____ Age: _____

Parent name(s) if under 18 years: _____

Interpreter required? (*Mark one*): ___YES ___NO If yes, language needed: _____

Ethnicity (*Mark one or write in*): ___ Hispanic ___Non-Hispanic ___Other: _____

Race (*Mark all that apply or write in*): ___Black or African-American ___American Indian or Alaska Native ___Native Hawaiian or Other Pacific Islander ___White ___Middle Eastern or North African ___Asian ___Some other race or origin (*please list*):_____

Religion or spirituality: _____

Gender Identity (*Mark all that apply or write in*): ___Female ___Male ___Non-binary/3rd gender ___Two Spirit ___Other (*please list*): _____ ___Prefer not to say

Gender currently listed on insurance policy (*Mark one*): __Female __Male [*Note: Required for us to bill insur.*]

Pronouns (*Mark all that apply or write in*): ___She, her, hers ___He, him, his ___They, them, theirs ___Other (*please list*): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Ext: _____ Type (*Mark one*): __Cell __Home __Work

Best time/day to call: _____

Is it OK for us to leave a voicemail? (*Mark one*): ___YES ___NO [*Note: We are unable to send text messages.*]

Email address: _____

Therapist gender preference? (*Mark one*): ___Male ___Female ___Other gender identity:_____

Appointment availability (*Mark all that apply*): ___Morning ___Afternoon ___Evening (i.e. 4pm or later)

Are there accommodations needed due to a disability? If so, please specify: _____

_____

Referral Source (*if client is self-referred, you may skip to next section*)

Relationship to client: _____

First name: _____ Last name: _____

Agency name (if applicable):

Address: _____

City: _____State: _____ Zip: _____

Phone: _____ Ext: _____ Type (*Mark one*): __Cell __Home __Work

Email address: _____

Best time/day to call: _____ OK to leave a voicemail? (*Mark one*): ___YES ___NO

Reasons or Concerns for Seeking Treatment

Eating disorder concerns? (*Mark one*): ___YES ___NO

If yes (*Mark all that apply*): ___Binging ___Purging ___Restricting ___Over-exercise

___Other (*please list*): _____

Self-harming behaviors? (*Mark one*): ___YES ___NO

If yes (*Mark all that apply*): ___Burning ___Cutting ___Picking

___Other (*please list*): _____

Alcohol or drug abuse? (*Mark one*): ___YES ___NO

If yes, which drug(s): _____

Hospitalizations in the past year for mental health reasons? (*Mark one*): ___YES ___NO

If yes, most current date of hospitalization: _____

Access to a firearm? (*Mark one*): ___YES ___NO

Suicidal thoughts? (*Mark one*): ___YES ___NO

If yes, how frequently? _____

Suicide attempts in the past six (6) months? (*Mark one*): ___YES ___NO

If yes, date of most recent attempt: _____

Any current legal involvement? (e.g. mandated therapy, restraining order, etc.): ___YES ___NO

History of assault/violence towards others? (*Mark one*): ___YES ___NO

Homicidal thoughts? (*Mark one*): ___YES ___NO

History of trauma/traumatic experiences? (*Mark one*): ___YES ___NO

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.