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:_____

Religion or spirituality: _____

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

Gender currently listed on insurance policy: ___Female ___Male [*Note: Required for us to bill insurance*]

Pronouns: ___She, her, hers ___He, him, his ___They, them, theirs ___Other: _____

Address: _____

City: _____ **State**: _____ **Zip**: _____

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

Secondary phone: _____ **Type** (*Mark one*): __Cell __Home __Work

OK for us to leave voicemails? (*Mark one*): ___YES ___NO Best time to call?: _____

Email address: _____

(*Note*: Email will be used to update wait list status, follow-up if we are unable to reach you by phone, or provide scheduling information.)

PDBTI uses a **secure text messaging service** to check in with individuals on the wait list every month. This service is ***optional*** but helps us contact you faster and give you more information about our wait list and available services. If you would like to receive these messages, please mark "YES" below and provide the cellphone number you wish to have enrolled in our text messaging service.

Text Message Status Enrollment: ___YES ___NO **Cell ph# to enroll**: _____

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 and Last name: _____ **Agency name**: _____

Address (street, city, state, zip): _____

(continued on next page)

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

Email address: _____

OK for us to leave voicemails? (*Mark one*): ___YES ___NO **Best time to call?**: _____

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 substances(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

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, an Intake Team member will reach out to you (typically within 5-10 business days). You may submit your referral via 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.