DBT of Southern Oregon
PO Box 1251 Ashland, OR 97520
Phone (541)621-0303 Fax (458)226-2072
www.dbtcenterso.com

Interest Form: Request for Clinical Services:

Client Information **Date:** _____

Legal First Name: _____ **Legal Last Name**:_____

Chosen Name (if different): _____
Parent name(s) if under 18 years: _____
Date of Birth: _____ **Age**: _____

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*): ___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:* This is required for us to bill your insurance.)

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

Relation to client? (e.g. self, parent/guardian, partner, etc.): _____

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

Relation to client? (e.g. self, parent/guardian, partner, etc.): _____

Best time/day to call?: _____

Is it OK for us to leave voicemails? (*Mark one*): ___YES ___NO

Email address: _____
(*Note*: You will not be added to a bulk email list - email will be used to update wait list status, follow-up if we are unable to reach you by phone, or provide scheduling information.)

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

Do you have a strong preference regarding your therapist's gender? (*Note*: This may increase the wait time to be placed in our program) (*Mark one*): ___Male ___Female __Other gender:_____

____I do *not* have a strong preference and would like to be placed as quickly as possible.

Appointment availability (*Mark all that apply*): ___Morning ___Afternoon ___Evening (4pm or later) (*Note*: The more limited your availability, such as "evening only", the longer the wait may be to place you in our program.

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

Client Insurance Information

Will client be paying for services out-of-pocket (OOP)? (*Mark one*): ___YES ___NO

Primary Insurance: _____Other: _____

Member ID number: _____**Group ID number:** _____

Provider or customer service phone number: _____

Secondary insurance carrier?* (*Mark one*): ____YES ____NO

(*Note*: DBT will bill to secondary/tertiary insurances if your DBT provider(s) are in-network with those plans. Otherwise, you may request the necessary billing information to submit claims to any out-of-network insurances directly.)

Secondary Insurance: _____Other: _____

Member ID number: _____ **Group ID number:** _____

Secondary Insur provider/customer service phone number: _____

If applicable, does the client already have an authorization for services at DBT?

(*Mark one*): ____YES ____NO

Authorization info (auth #, dates, visit/$ amounts): _____

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

Relationship to client: _____ (e.g. self, therapist, PCP, family, case worker..)

First name: _____**Last name**: _____

Agency name: _____

Address: _____

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

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

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

Email address: _____

Referring party: How did you hear about us?:

Programs & Services Interest

Preferred Service: _____Teen services _____Adult services

Is this client returning for services? (*Mark one*): ____No, the client is new to DBT.

_____Yes, the client has previously received treatment at DBT .

Reasons or Concerns for Seeking Treatment

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

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

___Other (*please list*): _____

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: _____

Do you have access to a firearm? (*Mark one*): ___YES ___NO

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

If yes, most current date of hospitalization: _____

Reason for <u>most recent</u> hospitalization?: _____

Do you have any current legal involvement? (e.g. court/judge/parole officer has mandated therapy/treatment, restraining order, etc.): ____YES ____NO

If yes, please briefly describe the legal involvement:

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

If yes, please describe the drug/alcohol use, or substance abuse:

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

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

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

___Other (*please list*): _____

Are you interested in our Eating Disorder Intensive Outpatient Program (ED-IOP)?

Our ED- IOP is offered in 12-week cycles, 5 days a week (Mon-Fri), from 8:00am to 12pm noon. Clients may adjust length of treatment as needed. It is designed for young adults and adults who are medically stable and who struggle with:

- Complex and serious behavioral health problems
- A history of unhelpful, unsuccessful attempts with other ED treatment efforts
- One or more eating disorders: Anorexia, Bulimia, Binge Eating Disorder, Avoidant Restrictive Food Intake Disorder, ED-Other Specific Feeding/Eating Disorders

____ Yes, I am interested in the Eating Disorder Intensive Outpatient Program.

____ No/not at this time

Medical Requirements:

Unfortunately we are unable to accept clients who are extremely underweight, unless medically monitored weight restoration has already safely begun and close medical supervision continues. Additionally, we are unable to accept clients who are medically unstable and require hospitalization because of electrophysiological abnormalities, electrolyte imbalances, or other potentially dangerous conditions.

Interested in our Standard Adult DBT Intensive Outpatient Program (IOP)?

Our Standard Adult IOP is offered in 8-week cycles, four days a week (Mon, Wed, Thurs, Fri), from 12pm noon to 3:00pm. Clients are expected to repeat the eight-week cycle at least once and may stay longer when needed. This program is designed for adults 18 and older who struggle with:

- Debilitating depression/anxiety
- Suicidal behavior, suicidal ideation, and self-harm

- Poor emotion regulation
- Problematic impulsive behaviors related to difficulty regulating emotions
- Difficulty establishing and maintaining healthy relationships

____ Yes, I am interested in the Standard Adult Intensive Outpatient Program.

____ No/not at this time.

Interested in our Teen and Family DBT Intensive Outpatient Program (IOP)?

Our Teen and Family DBT IOP is offered in 8-week cycles, three days a week (Mon, Wed, Thurs), from 12pm noon to 3:00pm. Clients may repeat the eight-week cycle and stay longer when needed. This program is designed for teens 13 to 17 years old who struggle with:

- Depression/Anxiety
- Self-harm/Suicidal ideation
- Poor emotion regulation
- Difficulty establishing and maintaining healthy relationships

____ Yes, I am interested in the Teen and Family Intensive Outpatient Program.

____ No/not at this time.

Other reasons or concerns for seeking treatment? (*Please list briefly*)**:**

-END OF FORM-

Please fax your completed form to: **458-226-2072**
or mail to:
Attn: Intake Dept, 825 East Main St. Suite E, Medford OR 97504

Once your Interest Form is received and reviewed, an Intake Team member will contact you, typically within 5-10 business days.

Questions about this Interest Form or the referral process? Please contact our Intake Team at or 541-621-0303.

Thank you for your interest in clinical services at Southern Oregon DBT !