DBT of Southern Oregon
PO Box 1251, Ashland, OR 97520
541-621-0303 Fax 458-226-2072

Referral Information

Date: _____ Assigned to:_____

Name of person making referral: _____
Relation to client: _____
Address: _____
Phone:_____ Best times to call_____
Can we leave a message? Y or N

Client Information

Full Name; _____
Date of Birth:_____Age:_____M or F
Address: _____
Phone:_____Can we leave a message? Y or N
Email address: _____
Best times to call: _____

Referral source

__ Hospital __Therapist:_____ __Self-referred
__Family Member __Psychiatrist:_____ __School

__Other, please describe: _____

Concerns

__Suicidal thinking/behavior
__Self-harming behavior
__Psychiatric Hospitalization with the last year: Dates_____
__Alcohol and drug issues
__Eating Disorder behavior
__Other:

_____
_____
_____

Client availability for treatment: Days_____Times: _____

Client Insurance: Carrier: _____
ID# Group# Customer Service #
_____ _____
Pre-authorizationrequired?
In network:
Session #
_____ _____
Out-of-network:
Session #

# used			Copay Deductible	
	Renewal date		Y or N	Pre-authorization #
	Copay Deductible			
# used				
	Renewal date			