DBT of Southern Oregon
PO Box 1251, Ashland, OR 97520
541-621-0303 Fax 458-226-207

# 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
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 #

| | | | |
|---|---|---|---|
| In network:<br>Session # | # used | Renewal date | Copay<br>Deductible |
| Out-of-network:<br>Session # | # used | Renewal date | Copay<br>Deductible |
| Pre-authorization required? | | Y or N | Pre-authorization # |