DBT of Southern Oregon
PO Box 1251, Ashland, OR 97520
541-621-0303 Fax 541-708-6557

**Referral Information**

Date: _____
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: _____
_____
CP Phone: _____ Can we leave a message? Y/ N Best times to call: _____
HM Phone: _____ Can we leave a message? Y/ N Best times to call: _____

**Referral source**

__ Hospital __Therapist:_____ __Self-referred
__Psychiatrist:_____ __Family Member __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:** Primary Carrier: _____ Secondary Carrier:_____

| | |
|---|---|
| ID# _____Group#_____ Customer Service #_____ | |
| Pre-authorization required?<br>Sliding Scale information: | Y or N Pre-authorization # _____ |

**Disposition: ____ Wants DBT ____ Wants to get back to us _____ Isn't interested**