Center for Dialectical and Cognitive Behavioral Therapies
Skills Class and Group Referral Form

MENTAL HEALTH PROVIDER INFORMATION

Referring Clinician Name ______________________________________ Date of Referral _____ / _____ / _______

Referring Clinician Office Number ________________________ Fax Number _____________________________

PATIENT INFORMATION

Patient Name ____ ☐ Female ☐ Male ☐ Non-binary

Email ________________________________ Phone ______________________ Date of Birth ____ /___ /______

Can we send e-mail to this address? ☐ Yes ☐ No

Can we leave a voicemail at this phone number? ☐ Yes ☐ No

CLINICAL INFORMATION

Referral for: ☐ RO DBT Adolescent Skills Class ☐ RO DBT Adult Skills Class ☐ DBT Adolescent Skills Group ☐ DBT Adult Skills Group ☐ Assessment or Unsure

Please provide any relevant clinical information you would like us to know: ________________________________

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What would you like us to do in the case of a clinical emergency during skills class/group? ___________________

___________________________________ Preferred Hospital, if necessary: ________________________________

Thank you for referring your patient to the Center for Dialectical and Cognitive Behavioral Therapies.
We look forward to collaborating in the care of your client.

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