Referral Form
Dialectical Behaviour Therapy

Important Information About Your DBT Referral

Once this form is completed, please fax to headspace Cairns on 07 4041 6340
To discuss referral, contact DBT Coordinator Tracey Edwards phone: 07 4041 3780

Referral Criteria: 16-25 years old; diagnosis or emerging traits of Borderline Personality Disorder.

DBT Program runs for 12 months (6 months negotiable).

Young Person's Details

Full Name:	
Date of Birth:	
Gender:	
Address:	
Suburb:	Postcode:
Phone Number:	
Email Address:	
Preferred Person to Contact:	
Contact's number or email:	

Does the young person identify as: □ CALD □ Aboriginal □ Torres Strait Islander

Referrer's Details

Full Name:	
Organisation:	
Designation:	
Phone Number:	Fax Number:
Email:	

Presenting Issues and Relevant History

Please attach any relevant assessment notes, discharge summaries, and/or additional information.

Diagnosis:

Emerging traits of BPD:

Relevant background information:

Relevant treatment history:

Literacy/Numeracy Level:

Any other relevant information:

Current Support

What services are the young person currently engaged with?

Risk alerts

- ☐ Self harm
- ☐ Suicide attempts
- ☐ Risk to others
- ☐ Risk taking behaviours
- ☐ Current suicide risk

Comments:

Authorisation of referral by client

- I am aware that this referral is being made.
- I understand that I can withdraw from this referral or from the referred service at any time.
- I give permission for headspace Cairns to use my contact details above for future contact with me.
- I give permission for headspace Cairns staff to obtain further information relevant to this referral.

Signed: _____ Print Name: _____ Date: _____