



Olmsted County DBT Referral Form (check all that apply)

2100 Campus Drive SE Ste. 200, Rochester, MN 55904
Phone: 507-328-6276 Fax: 507-328-6401

1	2	3
<p>Primary Diagnosis:</p> <p><input type="checkbox"/> Borderline Personality Disorder</p> <p><input type="checkbox"/> Bipolar Disorder</p> <p><input type="checkbox"/> Major Depression</p> <p><input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> Post Traumatic Stress Disorder</p> <div style="border: 1px solid black; border-radius: 50%; width: 150px; height: 150px; margin: 20px auto; display: flex; align-items: center; justify-content: center; background-color: #e0e0e0;"> <p style="text-align: center; padding: 5px;">REFER if you checked any items in box 1 AND 2a AND at least one item under 2b.</p> <p style="text-align: center; padding: 5px;">If any items in box 3 are checked, do not refer.</p> </div>	<p>2a. Because of a mental illness, person has substantial disability / functional impairment in the following:</p> <p><input type="checkbox"/> Impulsivity</p> <p><input type="checkbox"/> Intentional self-harm behaviors</p> <p><input type="checkbox"/> Significant risk of death, morbidity, disability, or severe dysfunction across multiple life areas</p> <p>2b. and because of a mental illness has one or more of the following;</p> <p><input type="checkbox"/> Frequent or recurrent hospitalizations</p> <p><input type="checkbox"/> Frequent use of mental health and related services yielding poor outcomes (for example – emergency departments, IRTS, crisis beds)</p> <p><input type="checkbox"/> Be at significant risk of one or more of the following if DBT is not provided:</p> <p style="margin-left: 20px;">a. Mental health crisis</p> <p style="margin-left: 20px;">b. Requiring a more restrictive setting such as hospitalization</p> <p style="margin-left: 20px;">c. Decompensation</p> <p style="margin-left: 20px;">d. Engaging in intentional self-harmful behavior</p>	<p style="text-align: center;"><u>If any items in this box are checked, DO NOT REFER.</u></p> <p>Primary Diagnosis of the following:</p> <p><input type="checkbox"/> Significant thought disorder</p> <p><input type="checkbox"/> Chemical Dependency that requires inpatient treatment</p> <p><input type="checkbox"/> Involuntary or unwilling to participate with in-house DBT therapy and groups</p> <p style="text-align: center;">Will consider referral if the functional limitations are correlated to the primary psychotic disorder indicated in number 1.</p>

To Make a Referral: Give this completed form to Becky Johnson (address/fax above). If the person is a likely DBT candidate, a client screening will be scheduled. Please attach a current Functional Assessment, Diagnostic Assessment (within 1 year), Treatment Plan, and any recent hospital admit/discharge reports.

Client Name:	DOB:	Phone:
Referral Source:	Referral Phone:	
Current Therapist:		
Current Psychiatrist:	Insurance:	