

**Portland DBT Program
Referral Information Form**

Data entered

Staff Member Receiving Call _____

Date _____
Name of Person Referring Client _____
Relation to Client _____
Address _____
Phone _____ Best time to call _____
Email _____ Can we leave message? Y or N _____

Client Information

Full Name _____ Date of Birth _____ Age _____ M or F
Address _____
Phone _____ Best time to call _____
Email _____ Can we leave message? Y or N _____
Parent name for teen _____

Referral Source

Hospital _____ Therapist _____ Returning client
 School _____ Psychiatrist _____ DHS
 Agency _____ PCP _____ Voc Rehab
 Insurance Co _____ In-house _____ Website
 Family member / Friend Other _____
 Self-referred. How did they hear about us? _____
Address/Phone # _____
(Note: Include the name of the agency and contact person.)

Concerns

ED A/D S/H Hosp # in last year _____ SI / SA Legal Abuse

Explain:

Time Availability

Days _____ Times _____

Payer Information

Payment type 1. Private: BCBS MHN of CA PBH/ UBH Other _____
2. Public: DHS OHP _____ Other _____
3. OOP: Self-pay Other _____

Benefit Information (Primary)

ID# _____ Group# _____ Customer Service # _____
In network: Session # _____ # used _____ Renewal date _____ Copay _____ Deductible _____
Out-of-network: Session # _____ # used _____ Renewal date _____ Copay _____ Deductible _____
Pre-authorization required? Y or N Pre-authorization # _____ Number of sessions authorized _____
Claims address: _____
_____ For teen referrals: Family Benefit (CPT 90847) ? Y or N
_____ For ED referrals: Nutrition Benefits? Y or N

Phone Log: Name Date Time VM/Phone Note

Attempt #1: _____
Attempt #2: _____

Intake Therapist: _____

Date of Intake: _____

Diagnoses:

Primary diagnosis _____ (DSM-IV Code) Category Code _____

Secondary diagnosis _____ (DSM-IV Code) Category Code _____

Other diagnosis _____ (DSM-IV Code) Category Code _____

Other diagnosis _____ (DSM-IV Code)

Category Code _____

DBT Treatment Plan (check one):

Adult _____ DBT-S _____ F/F Services _____

Young Adult _____ DBT-ED _____ Individual Only _____

Teen _____ ACES _____ Skills Training Only _____

Phase II _____ Consult Service _____ Trauma Services _____

Non-DBT/Other Services: _____

Codes:

DSM-IV Diagnosis:

Mood Disorder	1	Major Depression	296.3__
Anxiety Disorder	2	Dysthymia	300.40
Personality Disorder	3	Bipolar I	296.____
Cluster A	3A or 3AT	Bipolar II	296.89
Cluster B	3B or 3BT	Mood NOS	296.90
Cluster C	3C or 3CT	PTSD	309.81
Impulse Control Disorder	4	GAD	300.02
Eating Disorder	5	Dissociative NOS	300.15
Substance Abuse/Dep. Disorder	6	Social Phobia	300.23
Childhood Disorders	7	Anxiety NOS	300.00
Oppositional/Defiant	7A or 7AT	Avoidant PD	301.82
Conduct Disorder	7B or 7BT	Antisocial PD	301.70
ADHD	7C or 7CT	Borderline PD	301.83
Adjustment Disorder	8	Narcissistic PD	301.81
VCODE	9	PD NOS	301.10
Other	10	Impulse Control NOS	312.30
		Adjustment w/mixed	309.28
		Adjustment w/emot/heh	309.40

Hospital/ED visits last six months:

Hospital Name	Visit Type	Date in / Date Out
	ED Inpatient	
	ED Inpatient	
	ED Inpatient	
	ED Inpatient	
	ED Inpatient	
	ED Inpatient	
	ED Inpatient	