the day clinic
treatment in life

REFERRAL FORM

OUTPATIENT DBT PROGRAMME ☐ INTENSIVE 5 DAY PROGRAMME ☐

DBT MAINTENANCE GROUP ☐ SOCIAL INTEGRATION SUPPORT GROUP ☐

Referred by: Email:

Tel: Date:

Psychiatrist ☐ Other Medical Specialist (Please specify) ☐ GP ☐ Psychologist ☐

Social Worker ☐ Nurse ☐ Teacher ☐ Self ☐ Other (Please specify) ☐

Patient name & ID no: Age: Date of birth

Email: Patient Tel: Tel: (family member)

Medical Aid: Medical Aid no:

Which of the following does the patient have difficulty with?

Mood swings	☐	Insomnia	☐	Panic attacks	☐
Depression	☐	Nightmares	☐	Loss of interest/numbing	☐
Irritability/anger	☐	Chronic pain	☐	Poor concentration	☐
Hopelessness	☐	Headaches	☐	Memory difficulties	☐
Suicidality	☐	Substance misuse	☐	Deliberate self harm	☐
Eating disorders	☐	Impulsivity	☐	Medication overuse	☐
Dissociation	☐	Identity confusion	☐	Interpersonal difficulties	☐
Flashbacks	☐	Ruminating thoughts	☐	Work deterioration	☐
Anxiety	☐	Lethargy/fatigue	☐	Behavioural difficulties	☐
Delusions	☐	Hallucinations	☐	Social withdrawal	☐

Past & current psychiatric treatment including psychotherapy:

Doctor's name:

Psychologist's name:

Relevant medical history:

Current medication:

DSM 5 Diagnosis: (Professional referrals only)

Please feel free to send any additional information that you deem necessary. This information is treated confidentially by The Day Clinic team.

Email: *referrals@thedayclinic.co.za* Tel: 010 350 0350 – www.thedayclinic.co.za

Thank you for your referral