

REFERRAL FORM

OUTPATIENT DBT PROGRAMME

INTENSIVE 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