

Referral Form

DBTeen is a dialectical behaviour therapy (DBT) program for young people aged 14-18 who exhibit difficulty regulating their emotions and behaviour. **The Young Person completes the program with an adult carer living in the same residence.**

Unfortunately, young people who are already receiving hospital and community mental health services (eg: CAMHS, CMHT, CATT, hospital inpatient) are not eligible for referral.

Please email the completed DBTeen Referral Form to DBTeen@lifelinewa.org.au. For further information contact Lifeline WA DBTeen on **08 9261 4444** or visit wa.lifeline.org.au/services/counselling-services/dbteen/

Date of Referral:

ABOUT THE REFERRER

Name:

Organisation:
(if applicable)

Provider Number:
(if applicable)

Address:

Postcode:

Telephone:

Email:

Relationship to the Young Person:

General Practitioner

Psychologist

Psychiatrist

Therapist

Primary Care Youth MH Agency

School Counsellor

Case Manager

A Relative of the Young Person

The Young Person

I have permission of the Young Person to refer them to this service.

I have permission of the parent(s)/guardian(s)/carers(s) to refer them to this service.

The Young Person and the Adult Carer nominated on Page 2 commit to attending together for the duration of the program

YES (mandatory field)

ABOUT THE YOUNG PERSON

Name in Full:

Date of Birth:

Preferred Name:

Gender:

Female

Transgender Male (FTM)

Non-binary

Male

Transgender Female (MTF)

Different Identity (please state) _____

Pronouns:

None/My Name

They/Them/Theirs

She/Her/Hers

He/Him/His

Other (please state) _____

Address:

Postcode:

Telephone:

Email:

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Country of Birth:				
Is the Young Person of Aboriginal or Torres Strait Islander Australian descent? If the Young Person is both Aboriginal and Torres Strait Islander Australian descent, please tick both 'Yes' boxes				
No	YES	Aboriginal Australian	YES	Torres Strait Islander Australian
<i>The DBTeen program participation requires a reasonable level of written, read and spoken English.</i>				
Main language spoken at home: _____				
How well does the Young Person speak English: Very well Well Not well Not at all				

PARENT / GUARDIAN / CARER 1 - PARTICIPATING WITH THE YOUNG PERSON (must be living in the same residence)				
Name in Full:				
Relationship to the Young Person: Parent Legal Guardian Other				
Address:			Postcode:	
Telephone:		Email:		
Is the Young Person of Aboriginal or Torres Strait Islander Australian descent? If the Young Person is both Aboriginal and Torres Strait Islander Australian descent, please tick both 'Yes' boxes				
No	YES	Aboriginal Australian	YES	Torres Strait Islander Australian
<i>The DBTeen program participation requires a reasonable level of written, read and spoken English.</i>				
Main language spoken at home: _____				
How well does the person speak English: Very well Well Not well Not at all				

PARENT / GUARDIAN / CARER 2				
Name in Full:				
Relationship to the Young Person: Parent Legal Guardian Other				
Address:			Postcode:	
Telephone:		Email:		
Is the Young Person of Aboriginal or Torres Strait Islander Australian descent? If the Young Person is both Aboriginal and Torres Strait Islander Australian descent, please tick both 'Yes' boxes				
No	YES	Aboriginal Australian	YES	Torres Strait Islander Australian
<i>The DBTeen program participation requires a reasonable level of written, read and spoken English.</i>				
Main language spoken at home: _____				
How well does the person speak English: Very well Well Not well Not at all				

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YOUNG PERSON'S PRESENTING ISSUES			
Does the young person have a mental health diagnosis?	Yes	No	Unknown
Principal Diagnosis:			
Additional Diagnosis:			
Is the young person having thoughts of suicide?	Yes	No	Unknown
Does the young person have any disability?	Yes	No	Unknown
Please specify			
Does the Young Person take any medications? If yes, please list	Yes	No	
1.	2.		
3.	4.		
Other Comments:			

GP REGISTRATION DETAILS: (if not the referrer)			
Name:			
Organisation: (if known)		Provider Number: (if known)	
Address:			Postcode:
Telephone:	Email:		

OTHER MENTAL HEALTH PROFESSIONAL DETAILS (if not the referrer)			
Name:			
Organisation: (if known)		Provider Number: (if known)	
Address:			Postcode:
Telephone:	Email:		

Program funded by:

