# DBTeen

Mental wellbeing skills groups for young people and families

Lifeline WA

## 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: | | |
| Address: | | Postcode: |
| Telephone: | Email: | |

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) _____

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| |
|---|
| Country of Birth: |
| Is the Young Person of Aboriginal or Torres Strait Islander Australian descent?<br>If the Young Person is both Aboriginal and Torres Strait Islander Australian descent, please tick both 'Yes' boxes<br>☐ No ☐ YES Aboriginal Australian ☐ YES Torres Strait Islander Australian |
| *The DBTeen program participation requires a reasonable level of written, read and spoken English.*<br>Main language spoken at home: _____<br>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<br>(must be living in the same residence) | |
|---|---|
| Name in Full: | |
| Relationship to the Young Person: ☐ Parent ☐ Legal Guardian ☐ Other | |
| Address: | Postcode: |
| Telephone: | Email: |
| Is this person of Aboriginal or Torres Strait Islander Australian descent?<br>If this person is of both Aboriginal and Torres Strait Islander Australian descent, please tick both 'Yes' boxes<br>☐ No ☐ YES Aboriginal Australian ☐ YES Torres Strait Islander Australian | |
| The DBTeen program participation requires a reasonable level of written, read and spoken English.<br>Main language spoken at home: _____<br>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 this person of Aboriginal or Torres Strait Islander Australian descent?<br>If this person is both Aboriginal and Torres Strait Islander Australian descent, please tick both 'Yes' boxes<br>☐ No ☐ YES Aboriginal Australian ☐ YES Torres Strait Islander Australian | |
| The DBTeen program participation requires a reasonable level of written, read and spoken English.<br>Main language spoken at home: _____<br>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?<br>Please specify | ☐ Yes | ☐ No | ☐ Unknown |
| 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:<br>(if known) | Provider Number:<br>(if known) | |
| Address: | | Postcode: |
| Telephone: | Email: | |

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

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WA Primary Health Alliance
Better health, together

phn
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