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 to participate.

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 **https://wa.lifeline.org.au/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:

- ☐ Self Referral
- ☐ General Practitioner
- ☐ Psychologist
- ☐ Psychiatrist
- ☐ Other Medical Specialist
- ☐ Mental Health Nurse
- ☐ Social Worker
- ☐ Occupational Therapist
- ☐ Aboriginal Health Worker
- ☐ Educational Professional

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 nominated on Page 2 understand the program is completed together.	☐ YES (mandatory field)

ABOUT THE YOUNG PERSON		
Name in Full:	Age:	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
The DBTeen program participation requires a reasonable level of written, read and spoken English. 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 this person of Aboriginal or Torres Strait Islander Australian descent? If this person is of both Aboriginal and Torres Strait Islander Australian descent, please tick both 'Yes' boxes ☐ No ☐ YES Aboriginal Australian ☐ YES Torres Strait Islander Australian	
The DBTeen program participation requires a reasonable level of written, read and spoken English. 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 this person of Aboriginal or Torres Strait Islander Australian descent? If this person is both Aboriginal and Torres Strait Islander Australian descent, please tick both 'Yes' boxes ☐ No ☐ YES Aboriginal Australian ☐ YES Torres Strait Islander Australian	
The DBTeen program participation requires a reasonable level of written, read and spoken English. 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 GP Mental Health Treatment Plan?	☐ 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? 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)		
Doctor's Name:		
Practice Name: (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:

WA Primary Health Alliance
Better health, together

phn
PERTH NORTH, PERTH SOUTH, COUNTRY WA
An Australian Government Initiative