The Ottawa Hospital | L'Hôpital d'Ottawa

Dialectical Behaviour Therapy – Lite Program
The Ottawa Hospital, Civic Campus
Fax # (613) 761-5328

REFERRAL FORM

******NOTE: Please review the Completing Referral Form Section in the information letter before submitting the referral.**

Date of referral: _____

PLEASE NOTE: All of the following criteria must be met for your patient to be entered into the program

1. ☐ Primary diagnosis of Borderline Personality Disorder or sufficient traits to benefit from the skills training.
2. ☐ Patient is committed to stop all suicide and self harm behaviours. Any current self harm behaviours are sufficiently controlled that they are not life threatening.
3. ☐ Patient is psychiatrically and medically stable enough to attend group regularly and participate.
4. ☐ Community therapist seeing patient **weekly** and will provide or arrange all crisis management.
5. ☐ Community therapist must be DBT friendly and willing to learn sufficient skills from the patient to understand assignments and encourage attendance.
6. ☐ The patient is not using benzodiazepines, opiods or medications highly toxic in overdose or the patient has stable use of these medications and there is no medical alternative.
7. ☐ Patient willing to reduce and stop all problematic alcohol or substance use/abuse.
8. ☐ Patients who have a recent history of substance dependence have been abstinent for 3 months.
9. ☐ Patient's treating physician or therapist is aware of and in agreement with referral.
10. ☐ Patient is engaged in a minimum of two hours twice a week of paid work, volunteer work, or schooling.

Referral source:

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

Best time to contact you: _____ Best # to contact you: _____

Your OHIP billing # (if applicable): _____

☐ Family Physician ☐ Psychiatrist ☐ GP Psychotherapist ☐ Psychologist
☐ Social Worker ☐ R.N. ☐ Counselor ☐ Other: _____

Signature: _____

Patient is aware of this referral? ☐ Y ☐ No

Please have the patient read and sign the patient acknowledgement form.

Patient Identifying Information:

Name: _____ D.O.B.: _____

Address: _____

Patient Email Address (Optional):

_____

Phone: Home: _____ Work: _____ Cell: _____

Where can we leave a message for this patient? Home ☐ Work ☐ Cell ☐

Sex: ☐ F ☐ M Marital status: _____

OHIP #: _____ Version Code: _____

Note: Patients require a valid OHIP # to be seen. We are not able to see Quebec patients at this time.

Reason for referral: (What are the specific areas in which your patient currently has difficulty?)

_____

_____

_____

_____

Brief History of Previous Treatment (if no assessment or report available)

_____

_____

_____

_____

_____

_____

_____

Current Treatment:

Is your patient receiving individual therapy **weekly**? ☐ Y ☐ N

Are **you** providing the weekly therapy? ☐ Y ☐ N

What type of treatment are you providing? _____

_____

Do you have an assessment report on this patient? ☐ Y ☐ N If yes, please attach to referral.

Is your patient receiving treatment from any other providers? ☐ Y ☐ N

If yes, please provide the name and contact information of other therapist, MD, psychologist or agency:

_____

Other community supports? (Please describe):

_____

Current Medications:

Medication	Dose	Frequency	Date started

Relevant Medical History:

_____

_____

_____

Other Comments or Information (if needed please attach a separate page):

_____

_____

_____

Thank you,

Christine Dickson, M.D, FRCP(C)

Please fax completed referral form to: Fax # (613) 761-5328