

Referral Form

DBTeen is a dialectical behaviour therapy (DBT) program for young people aged 14-18 who exhibit difficulty regulating their emotions and behaviour. For more information on the program visit lifelinewa.org.au/Services/DBTeen

Unfortunately young people who are already receiving tertiary psychiatric services 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 4436**

Date of Referral:

Referrer Details

Company Name:

Name:

Provider Number:

Telephone Number:

Email address:

Street Address:

Suburb:

State:

Postcode:

Relationship to the Young Person: General Practitioner ☐ School Counsellor / Psych ☐ Therapist ☐
Primary Care Youth Mental Health Agency ☐ A relative of the Young Person ☐ The Young Person ☐
Other

I have the permission of the young person to refer them to this service. ☐

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

About the Young Person

Family Name:

First Name:

D.O.B:

Gender: Male ☐ Female ☐ Non-Binary ☐

Phone Number:

Email Address:

Country of Birth:

Suburb:

Street Address:

State:

Postcode:

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 ☐

Main Language spoken at Home

How well does the person speak English: Very well ☐ Well ☐ Not well ☐ Not at all ☐

Referral Form

About the Adult

Parent / Guardian / Carer 1

Name:

Relationship to Young Person: Mother ☐ Father ☐ Legal Guardian ☐ Other ☐

Phone Number:

Email Address:

Address (if different to Young Person):

Is the adult of Aboriginal or Torres Strait Islander Australian descent?

If the adult is both Aboriginal and Torres Strait Islander Australian descent, please tick both 'Yes' boxes

No ☐ Yes – Aboriginal Australian ☐ Yes – Torres Strait Islander Australian ☐

Main Language spoken at Home

How well does the adult speak English: Very well ☐ Well ☐ Not well ☐ Not at all ☐

Parent / Guardian / Carer 2

Name:

Relationship to Young Person: Mother ☐ Father ☐ Legal Guardian ☐ Other ☐

Phone Number:

Email Address:

Address (if different to Young Person):

Is the adult of Aboriginal or Torres Strait Islander Australian descent?

If the adult is both Aboriginal and Torres Strait Islander Australian descent, please tick both 'Yes' boxes

No ☐ Yes – Aboriginal Australian ☐ Yes – Torres Strait Islander Australian ☐

Main Language spoken at Home

How well does the adult speak English: Very well ☐ Well ☐ Not well ☐ Not at all ☐

Referral Form

Young Person Presenting Issues

Does the young person have a mental health diagnosis? Yes ☐ No ☐ Unknown ☐ (Please specify below if Yes)

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 if Yes)

Does the young person present with any significant cognitive impairment? Yes ☐ No ☐ Unknown ☐

(Please specify if Yes)

Please list any current medications and doses: (Leave blank if N/A or not known.)

Other Comments:

GP Registration Details

If the referrer is not the GP please provide details below

Doctor Name:

Surgery Name:

Provider Number:

Telephone Number:

Email address:

Suburb:

Street Address:

State:

Postcode:

Other Mental Health Professional Details

If the young person is accessing a mental health service, please provide contact details below:

Provider Name:

Organisation:

Provider Number:

Telephone Number:

Email address:

Suburb:

Street Address:

State:

Postcode:

Program funded by: