Dear Provider,

Thank you for your referral to the Allegheny County Comprehensive Dialectical Behavior Therapy (CDBT). This program is meant for individuals who have not responded to traditional therapy and treatment available in standard clinics. Please complete every section of the referral form as best you can. Get help from your consumer/client if you do not know the answers to some of the questions. Hopefully, the instructions and guidelines below will be helpful.

Sincerely,
CDBT Teams

Form Instructions

1. Please choose the ASCEND program at Staunton Clinic or the ADAPT program at Western Behavioral Health. Do not choose both programs.
2. Here are some tips for getting a timely response:
    a. Please write legibly.
    b. Please fill in all sections, even if the answer is "not applicable."
    c. Please include as much detail as you can.
3. Please know that signature of consumer/client is required. The CDBT team needs to know that the client is accepting the referral from the start.
4. Fax the completed referral to one of the providers listed below.
5. Once we receive the referral, we will get back to you as soon as we have had a chance to review the information that you sent. If it has been more than 1 week, please send the referral again or call us to confirm receipt.

Referral Source Responsibility

1. If the CDBT team is not able to make contact with the consumer/client, we will ask for your help with linkage or engagement.
2. Ultimately, if the consumer/client refuses the referral or decides not to do the CDBT program, we will expect your service to re-engage with the client/consumer.

Comprehensive Dialectical Behavior Therapy Providers In Allegheny County

The ASCEND Program: Staunton Clinic
412-749-7341 (ph)
412-749-6763 (fax)

The ADAPT Program: Western Psychiatric Hospital
412-246-5600 (ph)
412-246-5450 (fax)

Eligibility Criteria

Persons eligible for CDBT program are adults 18 year of age or older who have a history of pervasive emotion dysregulation which has caused significant impairment in functioning. Individuals must have history of high-risk behaviors including, but not limited to, self-injurious behavior and/or suicidal behaviors resulting in high utilization of treatment resources (i.e. multiple inpatient hospitalizations; over-utilization of crisis resources, emergency room visits, etc.). Individuals need to have the ability to learn coping skills to help better tolerate distress and manage their emotions.

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Demographics

Name: (First) _____ (Last) _____

DOB: *(mm/dd/yyyy)* _____

Address: _____

State: _____ City: _____ Zip: _____

Best Phone Number: *(no dashes)* _____ Backup Phone Number: *(no dashes)* _____

Are you an Allegheny County Resident? ◉ No ○ Yes

Are you a Community Care member? ◉ No ○ Yes If Yes, MA ID#: _____

Current Providers

Primary Therapist or Team Contact Person: _____

Phone Number: *(no dashes)* _____ Email Address: _____

Psychiatrist: _____ Phone Number: *(no dashes)* _____

Service Coordinator: _____ Phone Number: *(no dashes)* _____

Current Symptoms

Please provide detailed information on current behaviors and symptoms to be addressed by Comprehensive DBT program:

Service Utilization in the past year

Estimate # of hospital days: _____

Estimate # of behavioral health crisis or emergency department visits: _____

Estimate # of medical emergency department visits: _____

Estimate frequency of episodes of self-harm behaviors: _____

Estimate # of suicide attempts: _____

Recent IOP programs? _____

Recent PHP programs? _____

Describe any past DBT-related experience: _____

Estimate # of days in DAS: _____

If a previous treatment program or service was discontinued prematurely, please indicate why:

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History of Life Threatening Suicide Attempts/Self-Harm/High-Risk Behaviors

List history of life threatening suicide attempts, self-harm, and/or high-risk behaviors (e.g., fire settings, ingesting foreign objects, elopement, risky sexual behavior, etc.).

	Specific Behaviors/Methods	Outcome *(admitted to, etc.)*	Date *(mm/dd/yyyy)*
1.			
2.			
3.			
4.			
5.			

Additional Information

- ☐ Substance abuse? ◯ No ◯ Yes: _____
- ☐ Legal history? ◯ No ◯ Yes: _____
- ☐ Eating disorder? ◯ No ◯ Yes: _____
- ☐ Transportation needs? ◯ No ◯ Yes: _____
- ☐ Tobacco/vaping? ◯ No ◯ Yes: _____
- ☐ Accommodations needed? ◯ No ◯ Yes: _____
- ☐ Strengths: _____
- ☐ Support system: _____
- ☐ Housing placement history: _____

Diagnoses

Behavioral Health: _____

Behavioral Health: _____

Behavioral Health: _____

Medical Conditions/Physical Health Issues: _____

Medical Conditions/Physical Health Issues: _____

Medical Conditions/Physical Health Issues: _____

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Current medications and dosage

1. _____

2. _____

3. _____

4. _____

5. _____

Please list all current medical problems:

I certify that this specialized service has been explained to me and I am willing to accept these services at this time.

Member Signature confirming they are aware of this referral:

_____ _____

Signature Date

If no signature is obtained, please explain:

Person completing referral form and contact information:

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