

**FOUNDRY VANCOUVER-GRANVILLE
DIALECTICAL BEHAVIOUR THERAPY
SCREENING FORM**

 Psychiatry
Referral

In order to determine eligibility of the youth being referred for Dialectical Behaviour Therapy (DBT) skills, please provide the following information.

Date of Referral: (dd/mmm/yyyy) _____ Is the youth aware and in agreement with this referral? Yes No

REFERRAL SOURCE		
Referring provider:	Phone number:	MSP number:
Referral form completed by:		Agency/Program:
Primary care provider: (if different from referring provider)		
YOUTH INFORMATION		
Legal name: (first/last)	Preferred name:	Preferred pronouns:
DOB:(dd/mmm/yyyy)	PHN:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary <input type="checkbox"/> Other:
Youth's address: _____ _____		
If No Fixed Address, where can we find this youth: <input type="checkbox"/> Shelter <input type="checkbox"/> Other:		
Best way to reach the youth: Phone: _____		Email: _____
If youth has no phone, contact: Name: _____		Phone: _____
Does the youth have stable housing: <input type="checkbox"/> Yes <input type="checkbox"/> No	Is youth attending school: <input type="checkbox"/> Yes <input type="checkbox"/> No	Is youth working: <input type="checkbox"/> Yes <input type="checkbox"/> No
YOUTH PROFILE (check all that apply)		
<input type="checkbox"/> Fear of abandonment	<input type="checkbox"/> Impulsive, self-destructive behaviours	<input type="checkbox"/> Chronic feelings of emptiness
<input type="checkbox"/> Unstable relationships	<input type="checkbox"/> Self-harm	<input type="checkbox"/> Explosive anger
<input type="checkbox"/> Shifting self-image	<input type="checkbox"/> Extreme emotional swings	<input type="checkbox"/> Feeling suspicious or out of touch with reality
Has there been suicide attempts/gestures in the last year?: <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Single attempt: Approximate date:(dd/mmm/yyyy) _____		Details: _____
<input type="checkbox"/> Multiple attempts: Approximate date of most severe attempt (dd/mmm/yyyy) _____		Details of most severe attempt: _____
Has there been active self-harm in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No Single: <input type="checkbox"/> Yes <input type="checkbox"/> No Multiple: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Approximate date of last self-harm: (dd/mmm/yyyy) _____		Details of self-harm: _____
<input type="checkbox"/> Self-harm history (more than one year ago):		
Details: _____		
<input type="checkbox"/> Have there been high utilization of services in the last year (multiple drop-ins and/or primary care visits related to emotional distress, ED presentations, and/or inpatient psychiatric admissions)?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
<input type="checkbox"/> Has the youth experienced psychogenic non-epileptic spells or seizures?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
<input type="checkbox"/> Does the youth experience dissociative phenomena of identity depersonalization, derealisation?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure

PLEASE TURN OVER

