**Step Into Yourself** Dialectical Behavioural Therapy Service

**Referral Application**

If you need help or advice with completing this form, please contact us.

|  |
| --- |
| **1. APPLICANT’S DETAILS**TITLE:       NAME:       DATE OF BIRTH:      /     /     HOME ADDRESS:      EMAIL ADDRESS:      TEL. NO:       MOB. NO:      NHS Number:        |

|  |
| --- |
| **2. REFERRER’S DETAILS**  |
| ***(Leave blank for self-referrals)***NAME & RELATIONSHIP TO APPLICANT:      ORGANISATION:      ADDRESS:                  EMAIL ADDRESS:      TEL. NO:       |

|  |
| --- |
| **3. OTHER SERVICES INVOLVED IN YOUR CARE** |
| Do you have contact with any other professionals or services, e.g. Social Worker, Probation Officer, Psychiatrist, GP, CPN, drop-in centre, resource/day centre, etc?Please give full details of main contact at each service.1. 2.NAME:       NAME:      SERVICE:       SERVICE:      EMAIL:       EMAIL:      PHONE NUMBER:       PHONE NUMBER:        |

|  |
| --- |
| **4. Please describe the difficulties you experience** |
|                                Have you been given a formal diagnosis? If yes, please specify:      |

|  |
| --- |
| **5. Other relevant information** |
| Please use this space to tell us anything else you think is important with regards your application(e.g. *English proficiency, disabilities, substance misuse, special requirements, etc.*):           |

|  |
| --- |
| **6. Please clarify your personal goals that led you to submit this application.** |
| Please specify:       |

|  |
| --- |
| **7. Consent** |
| **I confirm that the above information is correct and I give my permission for the Step Into Yourself Team to request information that may be relevant to my application from other professionals involved in my care** e.g. discharge summary / risk assessment.**APPLICANT SIGNATURE:** **DATE:** **/** **/**  |

|  |
| --- |
| **FOR OFFICE USE ONLY** |
| 1. Date referral received:       /       /       2. Confirmation letter sent:      /     /      3. Date assessment letter sent:      /     /     4. Date of assessment:      /     /     5. Outcome of referral:      /     /      |