**Step Into Yourself** Dialectical Behavioural Therapy Service

**Referral Application**

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

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

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

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| **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: |

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

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| **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.*): |

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

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| **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:** **/** **/** |

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| **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:      /     / |