mind mood
Clinical Care Network

fax: 1-833-333-1809
www.mindandmoodbc.ca

REFERRAL FORM DBT Group Skills Training

Thank you for your referral to our Dialectical Behaviour Therapy (DBT) Group Skills Training program for individuals with mood or anxiety disorders. This 6-month program includes weekly 2-hour online group sessions. Please see page 2 for eligibility criteria. All patients will be scheduled for a psychiatric consultation prior to acceptance.

INCOMPLETE REFERRALS WILL NOT BE ACCEPTED AND WILL BE RETURNED

Referring physician information

Name: _____ MSP number: _____

Office address: _____

Office phone: _____ Office fax: _____

Patient information

First name: _____ Last name: _____

MSP number: _____ Date of birth: _____

Assigned sex at birth: _____ Gender: _____ Pronouns: _____

Phone: _____ Email: _____

Address: _____

Medical information

Psychiatric diagnosis: _____

Additional notes to support referral: _____

_____

_____

Current medications: _____

If this patient has had a psychiatric consultation, please attach the consultation notes to this referral.

Therapist information

Does this patient have an individual therapist? Yes ❑ No ❑

If Yes, Therapist name: _____ Phone number: _____

It is recommended that the patient continues to attend individual therapy while participating in this program. *Patients need to provide consent for the therapist to communicate with us and vice-versa.*

Accordingly, we will ask the therapist to notify Dr. Saby Ramirez or Dr. Kayhan Ghatavi promptly if the patient:

- stops individual therapy, or is absent for 3 consecutive individual sessions, OR
- becomes actively suicidal, and/or self-harming behaviour(s) increase or become more severe.

Subject to Dr. Ramirez or Dr. Ghatavi's availability, patients who do not have an individual therapist may be able to receive individual therapy and/or medication management, if needed. However, there is no guarantee, and all patients must pursue individual therapy elsewhere.

Eligibility criteria

Before sending the referral, please confirm the following by checking each box:

- ❑ Patient can attend and participate consistently, including access to a computer and Zoom communications platform. Patients are expected to be on camera to facilitate group experience.
- ❑ Referral is not from a walk-in clinic, emergency department or inpatient unit
- ❑ Patient does not have severe borderline personality disorder requiring comprehensive DBT skills training including telephone coaching, weekly 1:1 DBT sessions and team consultations
- ❑ Patient has not had a suicide attempt in the last 6 months
- ❑ Patient has not had recent recurrent self-harm requiring medical intervention; unwillingness to commit to lowering suicidal/self-harm behaviours
- ❑ Patient does not have a recent history of and/or at risk of aggression or violence.
- ❑ Referral is not court-mandated
- ❑ Patient does not have an active substance use disorder interfering with their ability to engage in therapy
- ❑ Patients does not have an active eating disorder interfering with their ability to engage in therapy
- ❑ Patient does not have active psychosis
- ❑ Patient does not have moderate to severe autism spectrum disorders, intellectual disability, or cognitive impairment interfering with their ability to engage in therapy
- ❑ Patients does not have any other untreated major psychiatric disorders (e.g. severe panic disorder, OCD) requiring more specific evidence-based treatments for these conditions

Please have your patient complete the DBT Questionnaire on pages 3–5 of this form. This is required for assessing their goals and their ability to complete the program.

PLEASE FAX COMPLETED FORM, QUESTIONNAIRE, AND ANY ATTACHMENTS

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Dialectical Behaviour Therapy (DBT) Questionnaire

This questionnaire is to be completed by the patient. Please include the completed questionnaire along with the referral form and any other attachments. Thank you.

Name: _____

1. The purpose of this program is to help people manage negative emotions. **Please identify the main reasons why you want to learn how to manage your emotions.**

2. Please identify **five specific behaviors that you want to increase** and indicate how each change may help you. Some examples of behaviors you may want to increase may include: setting healthy limits, dealing with conflict, tolerating emotions without exploding, learning how to calm down, etc.

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3. Please identify **five specific behaviors that you want to decrease**, and indicate how each behavior interferes with your daily life. Some examples of behaviors to decrease may include: stopping self harm or impulsive behaviors, (such as road rage, cutting, getting drunk, taking drugs, eating too much or too little, impulsive sex, ending a relationship prematurely) avoidance behaviors (such as: avoiding friends, sleeping too much, not completing tasks).

4. Learning new skills requires repetition and practice. **Are there things you know about yourself that might get in the way of practicing skills?** Some things that might get in the way of learning new skills include: skipping meetings, not paying attention, forgetting to practice, chaotic lifestyle, substance misuse, etc.

5. **How might you prepare yourself in order to prevent some of your old habits from getting in the way of new skills?** Some ideas include: setting a regular time for practice, attending some sort of self help group like AA, or having a friend call to wake you up/remind you of the group meeting time.

6. **Is this the right time in your life to participate in this program?** Do you have the motivation and desire to make changes at this time? Please explain.

We very much appreciate your time and willingness to complete this questionnaire.

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