TRINITAS
Regional Medical Center

Child and Adolescent Outpatient Unit
New Point Campus
655 East Jersey Street
Elizabeth, NJ 07206

Adolescent Dialectical Behavior Therapy Program
Referral Form

Client Information

First name:_____ Last Name:_____
Parent(s') name (s): _____
Date of Birth: _____ Age: _____ Gender (circle one): M/F/Trans
Address:_____
City: _____ State:_____ Zip:_____
Phone:_____ Email:_____
Primary language spoken at home (circle applicable response(s)): English/Spanish/Other:_____
Best time to call:_____ Okay to leave a message? Yes/No

Referral Source

Relationship to client:_____
First name:_____ Last Name:_____
Address:_____
City: _____ State:_____ Zip:_____
Phone:_____ Email:_____
Best time to call:_____ Okay to leave a message? Yes/No

Client Insurance Information

Insurance company: _____
Member ID number: _____
Provider or customer service phone number: _____

Reasons or Concerns for Seeking Treatment

Difficulties with emotions? Yes/No

If yes (circle applicable response(s)): Depression/Anxiety/Anger/Shame/Other

Please describe:_____

_____

_____

Self-harming behaviors? Yes/No

Please describe:_____

_____

_____

Suicidal thoughts? Yes/No

If yes, how frequently: _____

_____

_____

Suicide Attempts? Yes/No

Please describe (include dates):_____

_____

_____

Eating disorder concerns? Yes/No

If yes (circle applicable response(s)): Restricting/Purging/Binging

Other:_____

_____

_____

Alcohol or drug abuse? Yes/No

If yes, drug(s) used:_____

_____

_____

Hospitalizations for mental health reasons? Yes/No

Please describe (include dates):_____

_____

_____

History of abuse/other trauma? Yes/No

If yes (circle applicable response(s)): Physical/Sexual/Emotional/Verbal/Other

If Other, please describe briefly: _____

_____

_____

Other reasons for seeking treatment: _____

_____

_____

_____

_____

_____

We appreciate you contacting us for services, and we will call you once we receive your referral. You may submit your referral to the attention of Atara Hiller, PsyD, via fax at (908) 994-7354, or via mail at 655 East Jersey Street, Elizabeth NJ, 07206. For follow-up questions, please contact Dr. Hiller at (908) 994-7378.

Note: If you are not the parent/guardian making a referral to the Adolescent DBT program, please make sure to include an 'authorization to release information' form signed by the adolescent and a parent/guardian.