Penn Psychiatric Center

3774 Ridge Pike
Collegeville, PA 19426
Phone: (610) 489-3333
Fax: (610) 489-9390

601 Gay Street
Phoenixville, PA 19460
Phone: (610) 917-2200
Fax: (610) 917-2360

DBT Referral Form

Client Name: _____ Date of Birth: _____ Age: _____

Mailing Address: _____City:_____State:_____Zip Code:_____

Home Phone: _____Cell Phone: _____

E-mail: _____

Primary Insurance: _____ ID#: _____

Secondary Insurance: _____ ID#: _____

Consent to contact referral source (signature of client): _____

This section to be filled out by person making referral (Mental Health Professional or Self)

Referral Source (if applicable): _____

Contact Person: _____ Phone #: _____

E-mail: _____

Date of most recent Psychiatric Evaluation: _____ Completed By: _____

Primary Diagnosis: _____ ICD10 Code: _____

Secondary Diagnosis: _____ ICD10 Code: _____

D&A Diagnosis: _____ ICD10 Code: _____

Please check symptoms or write in number of occurrences within the last 12 months:

_____ # of Suicide Attempts
_____ # of Hospitalizations
_____ # of Partial Hospitalizations
_____ Self-Harm (explain below)
_____ D&A (explain below)
_____ Non-Compliance: [ ] Medications [ ] Appointments
_____ Behavior Dysregulation
_____ Emotional Dysregulation

Additional information (type and frequency of self-harm, drug use, etc.):

_____

_____

_____

Client Signature: _____ Date: _____

Referral Signature: _____ Date: _____

Please complete the referral form in detail and fax to: 610-917-2360. Attn: Program Administrator.
Questions about how to complete this form? Call the Program Administrator at (610) 917-2200 ext 223
A completed referral form will be reviewed by the DBT team for eligibility and consideration.
An intake appt. will be scheduled as soon as a therapist becomes available.