## Borderline Personality Disorder Treatment Program
## Referral Form

Dr. Clyde S. Marshall Building
294 Pleasant Street
Dartmouth, NS B2Y 3S3
Tel: 902-464-6093
Fax: 902-461-4220

**Please complete Referral Form with applicant and fax to 461-4220**

Name: _____ Date of Referral: _____
Address: _____
Phone: _____ Age: _____ Date of Birth: _____
Family Doctor: _____ HCN: _____
Name of Referring Service: _____
Referred by: _____ Phone: _____

**Brief History:**_____
_____
_____
_____

**Presenting Concerns**:

- ☐ Suicide Attempts (describe)_____
- ☐ Self-Harm (describe)_____
- ☐ Violence (describe)_____
- ☐ Drug / Alcohol use ☐ Present (specify) _____
  - ☐ Past (specify) _____
  - ☐ Current Treatment (specify) _____
- ☐ Other areas of impulsivity (e.g., gambling, sex, reckless driving)_____

_____

**History of Psychosis**: ☐ No ☐ Yes Describe _____
_____

**Diagnostic Impression**:
_____
_____
_____

**Relevant Medical Conditions**: _____
_____

**Medication Coverage**: ☐ No ☐ Yes Specify _____

**Medications**: _____
_____

**Present Living Arrangements**: _____

**Agency Involvement**:
☐ Dept. of Justice _____ ☐ Child Protection _____
☐ Education _____ ☐ Other (specify) _____

**Source of Income**:
☐ Employed - Employer_____
☐ EI ☐ DCS ☐ Other source, specify _____ ☐ No source

**Regular Mental Health follow-up with**: _____

**Date of next appointment**: _____

**Applicant is / has had**:
☐ Motivated ☐ Willing to work with treatment team
☐ Marginal benefit from other treatment ☐ Multiple ER visits / Hospital admissions
☐ *Participated in a DBT skills group:* ☐ *Completed Psychoeducation for DBT skills group*
a) 13 week
b) 26 week

**<u>TO BE COMPLETED BY APPLICANT</u>**:

**Goals for Treatment** 1) _____
2) _____

Barriers to participating in program (childcare, work schedule etc.) _____
_____

☐ I have received information about the program

_____ _____
Applicant Referring Mental Health Clinician

* Please include recent and relevant supporting documentation