



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

Adolescent Dialectical Behavior Therapy Program Referral Form

Date: _____

Client Information

First name: _____ Last Name: _____

Parent(s)' name (s): _____

DOB: _____ Age: _____ Race: _____ Ethnicity: _____

Gender: _____ Preferred Pronouns: _____

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: _____

Phone: _____ Email: _____

Best time to call: _____ Okay to leave a message? Yes/No

Client Insurance Information

Insurance company: _____

Primary Subscriber: _____ DOB of Primary Subscriber: _____

Member ID#: _____ Group#: _____

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.