**Overview**

This is the referral form for District Health Boards (DHB) and Accident Compensation Corporation (ACC) to refer to the National Dialectical Behaviour Therapy (DBT) Service at Te Whare Mahana (TWM).

For more details, including eligibility and indicators of maximum benefit, please visit: <http://www.twm.org.nz/dbt-residential-programme>

**Please note:**

Referrals can be only be made by a DHB Clinician or an ACC approved clinician at this time. As funding must be in place before a referral can be considered, we recommend ensuring funding has been approved before referring.

To help us determine if our DBT service is suitable, we consider:

1. The ‘**TWM Client Application Form’** – this is a separate form the applicant can complete alone or with you.
2. This ‘**TWM Referral Form’**, including key contact details and signatures.

We need the applicant’s situation over the last six months, which you can detail in ‘Section 2’ of this form and/or send a current psychologist/therapist report covering the same information.

1. A **GP Report** including medication/treatments.
   * Please fill in the applicant details on ‘**GP Report Requirements**’ and send to the applicant’s current GP.
   * If a psychiatrist is involved we will need their agreement to continue their involvement (refer Section 3).
2. **Applicant’s History**; we can receive this from various health professionals, such as psychiatrists, psychologists, therapists and counsellors. We accept this information in many formats e.g. assessments, reports etc., covering:
   * Psychosocial history, particularly any trauma history and current symptoms
   * Current and previous diagnoses
   * Treatments / interventions received and response / outcomes
   * Detailed history of suicide attempts and self-harm
   * Personality assessment, if available
   * Details of any intellectual impairment if known or suspected and IQ Assessment, if required

We appreciate this could be a significant amount of information to collect. If you need help with your referral, please contact us: [**dbt@twm.org.nz**](mailto:dbt@twm.org.nz) **| (03) 525 9624 ext. 3 |027 259 9333**

Completed ‘referral form’ and accompanying documents can be couriered, faxed or emailed to:

**National DBT Service 163 Commercial Street, Takaka 7110 | 03 525 7105 |** [**dbt@twm.org.nz**](mailto:dbt@twm.org.nz)

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| **SECTION 1: APPLICANT AND REFERRER DETAILS** | | | | | | | |
| **Applicant** | | Please provide these details about the person you are referring. | | | | | |
| Full name | |  | | Date of birth | Click here to enter a date. | | |
| NHI number | |  | | Gender |  | | |
| **Referrer** | Please provide the details for the main point of contact for this referral. | | | | | | |
| Name |  | | Organisation | | |  | |
| Role |  | | Best contact | | | Email | Phone |
| Email address |  | | Fax | | |  | |
| Phone |  | | Mobile | | |  | |
| **ACC Only** | Please add claim number and case owner details. | | | | | | |
| Case owner |  | | Claim number | | |  | |
| Email |  | | Phone | | |  | |
| **Primary Clinician** | Please add details if different from referrer, e.g. keyworker, psychiatrist etc.  This is the person available for clinical consultation throughout the process. | | | | | | |
| Name |  | | Organisation | | |  | |
| Role |  | | Best Contact | | | Email | Phone |
| Email address |  | | Phone | | |  | |
| **GP** | | All applicants require a current physical health report, including medications. | | | | | |
| Name | |  | Organisation | | |  | |
| Email address | |  | Phone | | |  | |
| **Psychiatrist** | Please list details of current psychiatrist (if applicable) | | | | | | |
| Name |  | | Organisation | | |  | |
| Email address |  | | Phone | | |  | |
| **Other** | You can add an additional contact here if required, e.g. therapist etc. | | | | | | |
| Name/Role |  | | Organisation | | |  | |
| Email address |  | | Phone | | |  | |

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| **SECTION 2:**  **APPLICANT SITUATION** | You can send a current psychologist/therapist report for **the last six months** instead, if it covers the same information. |
| 1. **Primary mental health and social situation, including diagnosis and MH Act status.** | |
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| 1. **Risk behaviours, including self-harm and suicide ideation or actions and any inpatient admissions.** | |
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| 1. **Please detail criminal convictions** **E.g. history of violence.** | |
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| 1. **Current co-morbidities, including details, e.g. eating disorders, addiction, pain, etc. and current impact.** | |
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| 1. **Physical health including current stability status and any hospitalisations in the last six months.** | |
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| 1. **Sense of self, ability to regulate emotions and maintain healthy relationships.** | |
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| 1. **Any issue that may be a barrier to learning e.g. ability to concentrate** | |
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| 1. **Current level of commitment to treatment, including prior/current response to DBT e.g. attendance, participation, homework completion, etc.**   **Please let us know if the applicant is not receiving treatment/therapy due to unavailability.** | |
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| **SECTION 3: SHARED CARE UNDERSTANDING** | | | |
| We view collaboration between the service user and all their service providers as vital to understanding and supporting the service user’s aspirations and improving their quality of life.  To achieve this, it is important that we work together to make sure our DBT service is a good fit to achieve the applicant’s goals and that referral, residency and discharge happen as smoothly as possible.  Our shared care understanding works best when:   * **Funding is already approved or is known to be accessible.**   We want to avoid raising applicants’ hopes that a place is available and generating referral work on your behalf, only to find out funding is not accessible.   * + Remember to make use of the National Transport Assistance Scheme (NTAS) at Ministry of Health for any travel costs to get to and from Takaka.   + Also, remember to talk with applicants receiving Work and Income benefits; they may be eligible for the Residential Support Subsidy (RSS) and their stay with us may impact their benefits.      * **There is a positive working relationship our treatment team and the applicant’s treatment team.** * Our working relationship starts with this referral and continues until the service user fully transitions back to your care. * It is important that the ‘primary clinician’ is available to continue care by connecting with us via video or teleconferencing. * If a psychiatrist is involved in providing care it’s important they are available to connect. The psychiatrist will continue to provide the support they are giving now e.g. charting medication, monitoring symptoms and medication efficacy etc. * If the ‘primary clinician’ or psychiatrist is unavailable it’s important we have a replacement. * If a service user needs admission to our local acute mental health services at Nelson Marlborough DHB, they will contact you directly to arrange the transfer of resourcing for this. We then all work together with the service user to determine what the best next step is e.g. returning to you or us. | | | |
| **Role** | **Name Please print/type** | **Signature** | **Date** |
| **Referrer** |  |  |  |
| **Primary Clinician**  If different from referrer |  |  |  |
| **ACC Case Owner**  If different from referrer |  |  |  |
| **Psychiatrist**  If involved |  |  |  |

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| **SECTION 4: FUNDING DETAILS** | | | | | | | | |
| The applicant will be funded by: | | | | | | | | |
|  | DHB | |  | ACC |  | Private |  | Unsure | |
| Funding confirmation: | | | | | | | | | |
|  | Funding application process not started | | | | | | | | |
|  | Funding application in process | | | | | | | | |
|  | Funding confirmed: | | | | | | | | |
|  |  | Evidence attached | | | | | | | |
|  | Evidence to follow | | | | | | | |
|  | Other | | | | | | | | |
| Please detail any relevant information regarding funding: | | | | | | | | | |
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