

## ***SOUTHWESTERN PSYCHOTHERAPY REFERRAL SERVICE***

The Southwestern Psychotherapy Referral Service is part of the training program in the Department of Psychiatry at UT Southwestern Medical Center. Through this service, therapists in training receive referrals of people for whom exploratory individual psychotherapy or cognitive behavioral therapy is the principal treatment needed for emotional problems or mental illness. Psychiatry residents and psychology doctoral students conduct the treatment offered, doing so under supervision. These therapists accept referrals when they have openings in their schedules.

The individual psychotherapy offered by our training programs is only one of several possible treatment approaches. The needs of many patients are best met by treatments available elsewhere. People who require treatment such as hospital care, treatment for alcohol and other drug addictions, vocational counseling and social service assistance can seek this help at other centers.

We are enclosing a health history form for you to complete and return to the office. If the information suggests that the psychotherapy we offer may be of benefit to you, we will inform you. You will be contacted later when a trainee is able to arrange an appointment for further evaluation, and, if you and the interviewer agree, to begin treatment. If, on the other hand, the referral form suggests that other treatment would be more suitable, then we will send you a letter with a list of other care providers who may offer the appropriate help.

The Southwestern Psychotherapy Referral Service (214-648-7012) may be reached during regular office hours if you have any further questions. The fee for care offered by our therapists is \$10 for each treatment hour.

**We do not provide emergency services.** If you feel this is an emergency situation, please contact your nearest hospital emergency room.

If you would like to know about the possibility of receiving care on referral through Southwestern Psychotherapy Referral Service, please complete the enclosed form and return it to us. We shall then write to you or phone you about our recommendations.

**Return Referral Form to:**

**Phone 214-648-7012**  
**Fax 214-648-7370**

**Diana Griffin**  
**Psychiatry Department**  
**UT Southwestern Med Center**  
**5323 Harry Hines Blvd.**  
**Dallas, Texas 75390-9070**

# SOUTHWESTERN PSYCHOTHERAPY REFERRAL SERVICE

## CONFIDENTIAL QUESTIONNAIRE/ REFERRAL FORM

**(Note: Please complete all answers as failure to do so will delay review for treatment. It is important that you let us know some specifics about you (i.e., your life and the measure of your difficulties) in order for us to determine whether our services will benefit you)**

Date: \_\_\_\_\_

Are you a North Star patient?  
Are you a medical student?

Yes  
 Yes

No  
 No

Are you a VA patient?  
Gender?

Yes  
 Male

No  
 Female

Do you have (or have you applied for) Medicare or Medicaid?  Yes  No

Name: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
(Last) (First) (Middle Name or Initial)

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
(Street Address/Apt. #) \_\_\_\_\_  
\_\_\_\_\_  
(City) (State) (Zip Code) Mobile Phone: \_\_\_\_\_

Place of birth: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Employed?  Yes  No

Work Phone: \_\_\_\_\_

Occupation? \_\_\_\_\_ How long at present job? \_\_\_\_\_

If unemployed, how long? \_\_\_\_\_ Education completed: (Grades/Degrees) \_\_\_\_\_

Please describe past jobs you have had and any times you have been unable to work. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Who referred you to this service? \_\_\_\_\_ Relationship \_\_\_\_\_

Marital Status:

Single  Engaged  Co-habiting

Married/Date \_\_\_\_\_  Separated/Date \_\_\_\_\_  Divorced/Date \_\_\_\_\_

Widowed/Date \_\_\_\_\_  Other Relationship Number of Previous Marriages \_\_\_\_\_

Your present relationship is:  Very Happy  Happy  Average  Unhappy  Not applicable

Please describe the problems that are prompting you to seek treatment (please include stresses such as deaths, divorce, loss of job, etc., within the past few years.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please explain your desires and needs in your outpatient treatment. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current psychiatric/mental health treatment?  Yes  No

If yes, with whom? \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_

Currently, are you on any psychiatric medication(s)?  Yes  No

If yes, please list & give dosages: 1) \_\_\_\_\_ (Medication) \_\_\_\_\_ (Dose/Day) 2) \_\_\_\_\_ (Medication) \_\_\_\_\_ (Dose/Day)

3) \_\_\_\_\_ (Medication) \_\_\_\_\_ (Dose/Day) 4) \_\_\_\_\_ (Medication) \_\_\_\_\_ (Dose/Day) 5) \_\_\_\_\_ (Medication) \_\_\_\_\_ (Dose/Day)

Past psychiatric treatment?  Yes  No

If yes, with whom/when? \_\_\_\_\_  
\_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_

Have you been treated with psychiatric medication in the past?  Yes  No

If yes, please list & give dosages: 1) \_\_\_\_\_ (Medication) \_\_\_\_\_ (Dose/Day) 2) \_\_\_\_\_ (Medication) \_\_\_\_\_ (Dose/Day)

3) \_\_\_\_\_ (Medication) \_\_\_\_\_ (Dose/Day) 4) \_\_\_\_\_ (Medication) \_\_\_\_\_ (Dose/Day) 5) \_\_\_\_\_ (Medication) \_\_\_\_\_ (Dose/Day)

Prior psychiatric hospitalizations?  Yes  No

If yes; when, where and why? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Your Present Physical Health:  Excellent  Very Good  Good  Fair  Poor

Name of Personal/Family Physician: \_\_\_\_\_

Current/Past History of Illness or Medical Problems: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current Medications for above illness/ medical problems: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is there a **current** history of any alcohol/drug problems with you?  Yes  No

If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

Is there a **past** history of any alcohol/drug problems with you?  Yes  No

If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

Have you had any DWI's, DUI's or Public Intoxication?  Yes  No

If yes, please explain \_\_\_\_\_  
\_\_\_\_\_

**Present legal problems?**  Yes  No

If yes, please explain. \_\_\_\_\_  
\_\_\_\_\_

**Past legal problems?**  Yes  No

If yes, please explain. \_\_\_\_\_  
\_\_\_\_\_

Are you involved (or do you plan to become involved) in any law suit(s)?  Yes  No

If yes, please explain. \_\_\_\_\_  
\_\_\_\_\_

Please tell us anything else you would like us to know about yourself. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Return application to:**

**Diana Griffin  
Psychiatry Dept., UT Southwestern  
5323 Harry Hines Blvd.  
Dallas, TX 75390-9070  
Phone: 214-648-7012  
Fax: 214-648-7370**

**FOR OFFICE USE ONLY** \_\_\_\_\_  
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(Revised on May 2, 2007)