



One Monarch Place · Suite 1500
Springfield, MA 01144-1500
413-787-4000 · 800-842-4464

DIALECTICAL BEHAVIOR THERAPY PROGRAM INITIAL REVIEW FORM

BEHAVIORAL HEALTH DEPARTMENT
PHONE: (413) 787-4000 EXT. 5028 FAX: (413) 233-2800

Please complete thoroughly. Send completed form to HNE Behavioral Health Department for review and decision.

MUST ENCLOSE RELEVANT CLINICAL DOCUMENTATION TO SUPPORT THIS REQUEST

Provider Name: _____ Office Phone: _____

Clinician Name: _____ Phone(s): _____

Client Name: _____ HNE ID: _____

Date of Intake Appointment: _____ Referred by: _____

Start Date: _____ Anticipated End Date: _____

Sequence of Modules Planned: _____

Diagnosis:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Agency Involvement: DMH DMR DCF DYS Probation

Therapist Name: _____ Psychiatrist Name: _____

Other important people involved in the member's and family's life: _____

If the client is a minor, complete the following:

Legal Guardian: _____ Physical Custodian: _____

Living situation / family system (e.g. family members, parents/caregivers, other non-family members in house): _____

School: _____ Grade: _____

Is child receiving special education services?: Yes No If yes, is IEP in place? Yes No

Medications: _____



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**DIALECTICAL BEHAVIOR THERAPY
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INITIAL TREATMENT PLAN

Must include details of target behaviors (frequency, severity and duration of symptoms/behaviors).

Problem Area #1: _____

Treatment Goal(s): _____

Treatment Intervention(s): _____

Problem Area #2: _____

Treatment Goal(s): _____

Treatment Intervention(s): _____

Problem Area #3: _____

Treatment Goal(s): _____

Treatment Intervention(s): _____

Problem Area #4: _____

Treatment Goal(s): _____

Treatment Intervention(s): _____
