

Ty Sanders
Administrator

Department of Psychiatry

UT SOUTHWESTERN PSYCHOTHERAPY CLINIC

The UT Southwestern Psychotherapy Clinic 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 UT Southwestern Psychotherapy Clinic (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 \$15 for each treatment hour.

We do not provide emergency services. . It could take 2 weeks to 3 months to be called in for an initial intake appointment. 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:

Clinic: (214) 648-7012
Fax: (214) 648-7370

Ty Sanders
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? Yes No Are you a **VA** patient? Yes No
Are you a medical student? Yes No Gender? Male 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 _____
