COGNITIVE-BEHAVIOURAL PSYCHOTHERAPY DEPARTMENT
ST PATRICK'S HOSPITAL
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The Department of Cognitive Behavioural Psychotherapy accepts direct referrals from GP's.

The GP retains clinical responsibility for his/her patient. Following referral the patient will be sent an appointment through the post with a copy to yourself. Written liaison will take place after assessment, end of treatment, follow up and discharge. An €150.00 attendance fee is payable at each visit.

If during the course of assessment/treatment a psychiatric assessment/opinion is deemed necessary, this will be arranged after consultation by yourself in the normal manner.

Referral forms are enclosed and it would be appreciated if you could keep copies on file. Some information regarding problems which may be suitable for treatment is included along with guidelines/criteria for referral.

We hope that these arrangements meet with your approval. If you have any queries please contact a member of the department.

REFERRAL CRITERIA FOR COGNITIVE BEHAVIOURAL PSYCHOTHERAPY:

- The client is motivated and looking for an active and structured psychological/behavioural solution to his/her difficulties
- The client demonstrates an acceptance of personal responsibility for change
- The client demonstrates an ability to form a therapeutic alliance
- The client demonstrates an ability to focus on specific problems
- There are no contra-indications i.e. current severe depression, current acute psychosis, current excessive substance use, organic illness or current active suicidal intent.

ASSESSMENT CRITERIA THAT WILL BE USED BY THE ALLOCATED COGNITIVE BEHAVIOURAL PSYCHOTHERAPIST:

- The psychotherapist and client can agree to define the problem in terms of observable behaviour
- The psychotherapist can identify a current and predictable pattern
- The psychotherapist and client can agree on clear behavioural goals
- The client understands and agrees to the treatment offered and is willing to engage

SOME PROBLEMS THAT MAY BE AMENABLE TO COGNITIVE BEHAVIOURAL PSYCHOTHERAPY:

SPECIFIC PHOBIAS	MORBID GRIEF/JEALOUSY
AGORAPHOBIA	BODY DYSMORPHIC DISORDER
SOCIAL PHOBIA	LOW SELF-ESTEEM
GENERALISED ANXIETY DISORDER	IMPULSE CONTROL DISORDERS E.G. GAMBLING, SHOPLIFTING
PANIC DISORDER	MILD TO MODERATE DEPRESSION
OBSESSIVE COMPULSIVE DISORDER	ANGER MANAGEMENT
SEXUAL DIFFICULTIES	SLEEP DISORDERS
POST TRAUMATIC STRESS DISORDER	BEHAVIOURAL MEDICINE E.G. IRRITABLE BOWEL SYNDROME, PAIN CONTROL, CHRONIC FATIGUE, PRE-MENSTRUAL SYNDROME, EATING DISORDERS
HEALTH ANXIETY	BI-POLAR AFFECTIVE DISORDER
HABIT DISORDERS	

Please feel free to contact the therapist by phone prior to referring a client to discuss suitability if uncertain.

EXTERNAL / GP REFERRAL FORM FOR COGNITIVE-BEHAVIOURAL PSYCHOTHERAPY

PLEASE COMPLETE IN FULL AND RETURN TO: THE DEPARTMENT OF COGNITIVE-BEHAVIOURAL PSYCHOTHERAPY, ST PATRICK'S HOSPITAL, JAMES'S STREET, DUBLIN 8. PHONE: 01-2493423.

PATIENT'S NAME: DATE OF BIRTH:
ADDRESS:

TELEPHONE (HOME):
TELEPHONE (MOBILE): OCCUPATION:
TELEPHONE (WORK): MARITAL STATUS:

DESCRIPTION OF CURRENT PROBLEMS:

REASON FOR REFERRAL FOR A COGNITIVE-BEHAVIOURAL ASSESSMENT AT THIS TIME:

PREVIOUS TREATMENT FOR THE ABOVE (INCLUDING DATES):

PSYCHIATRIC HISTORY:

RELEVANT MEDICAL HISTORY:

CURRENT MEDICATION:

IS CLIENT A RISK TO SELF OR TO OTHERS:

ANY OTHER RELEVANT INFORMATION:

PLEASE INFORM THAT THERE IS AN ATTENDANCE FEE:
Referrer Name:
Telephone No:
Referrer Address:

I UNDERSTAND THAT I RETAIN CLINICAL RESPONSIBILITY FOR THIS PATIENT:
SIGNATURE: **DATE:** _____