AYCC
Arlington Youth Counseling Center

670R Massachusetts Ave
Arlington, MA 02476

Initial Case Referral Information

Client Name:	Date of Birth:	Gender:
Address:	Town/Zip:	School Attending/Grade: _____/_____
Home Phone:	Cell Phone:	Work Phone: Email:

When AYCC calls you, may we identify ourselves and the purpose of this call?

___ Yes, At which number(s) __Home __Cell __Work ___ No, please do not identify yourself

Who referred you to AYCC?	Relationship to the client: __parent __caregiver __other: _____
Has client received services at AYCC before?	Does client have any known allergies?

Please provide a brief summary for why counseling services are being sought for the client, including any safety concerns.

Primary Health Insurance Provider: _____

Mental Health Insurance Provider: _____

Secondary Insurance Provider (if applicable): _____

Secondary Mental Health Insurance Provider: _____

Name as Listed on Insurance Card: _____

Name of Subscriber: _____

Card # _____

Subscriber Date of Birth: ____/____/_____

Group #_____

Parent/Legal Guardian #1:	Parent/Legal Guardian #2:
Address (if different than above):	Address (if different than above):
Home Phone: Cell:	Home Phone: Cell:

What days and times will the client be available for ongoing therapy?

Any additional information you would like us to know?

In the event emergency services are required before client's first appointment, please call the Crisis Intervention Team serving Arlington (781-893-2003.)

Please fax this form to 781-316-3261 from 9am to 5pm weekdays or email to LLabrecque@town.arlington.ma.us