AYCC
Arlington Youth Counseling Center

Initial Case Referral Information

670R Massachusetts Ave
Arlington, MA 02476

Client Name:	Client Date of Birth:	Sex: M or F
Address:	Town/Zip:	School Attending/Grade: _____/_____
Home Phone:	Cell Phone:	Preferred Language:

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

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

Client Race/Ethnicity:

Who referred you to AYCC?	Relationship to the client: __parent __caregiver __other: _____

Please provide a brief summary for why counseling services are being sought for the client?

Primary Insurance Provider:	**Secondary Insurance Provider (if applicable):**
_____	_____
Policy Holder Name:	**Policy Holder Name:**
_____	_____
Policy Holder Date of Birth _____/_____/_____	**Policy Holder Date of Birth** _____/_____/_____
Policy #:_____	**Policy #:**_____
Group #:_____	**Group #:**_____

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

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

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