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: _____

Parent/Guardian Relationship Status: __Married __Divorced __Separated __Widowed __Unmarried

If divorced/separated/unmarried can you provide proof of legal custody? __ Yes __ No

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