VICTORIA TRANSCULTURAL CLINICAL CENTER

3541 Chain Bridge Rd. Suite 204, Fairfax, VA 22030
(Office) 703-218-6599 (Fax) 703-218-2012

VTCC Code: ______

PHONE-INTAKE FORM

TO BE COMPLETED BY VTCC STAFF ONLY:

Assessment Date: ____________ **Medicaid Type:** ____________

Assessment Time: ____________ **Medicaid Elegible:** **Yes:** **No:**

Assessor: ____________ **Authorization #:** ____________

TO BE COMPLETED BY REFERRAL SOURCE:

Date of Intake: ____________

Identified Client Name: ____________
Last Name: ____________
Date of Birth: ____________

Medicaid Number: ____________
Social Security Number: ____________

Please specify the type of
Intensive Home Base Counseling
Out patient Individual Counseling
Out patient Family Counseling
Out patient Group Counseling
Other, specify: ____________

FAPT Founding #: ____________

Address (where the client lives or services to be provided):	**Parent / Guardian Address :**

(Home): ____________ **(Home):** ____________
(Cell): ____________ **(Cell):** ____________
(Work): ____________ **(Work):** ____________

Gender: **Male:** ______ **Female:** ______

Race/Ethnicity: ____________
Language spoken child: ____________
Language spoken parent/guardian: ____________

School Name: ____________ **Grade:** ______
Name of Parent / Legal Guardian: ____________ **Telephone:** ____________
Parent / Guardian D.O.B: ____________
Name of Custodial / Institution: ____________ **Telephone:** ____________
Emergency Contacts: ____________ **Telephone:** ____________

Referred by: ____________ **County/City:** ____________

Referral Source: ____________
(CPS, CHINS, Foster Care, School, others)

(Cell): ____________
(Fax): ____________
(Work): ____________
(E-mail): ____________

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Presenting problems/Reason for referral:

Brief History of problem and previus interventions:

Community Agencies involved: ______________________________

____

Intake officer's signature: ______________________ **Date:** __________

Guidelines for screening EPSDT cases

1. Diagnosis: ______________________________________

(Does the child have a diagnosis of Autism, Developmental disability, Intellectual Disability?)

2. Behaviors:

BEHAVIORS	DESCRIPTION	FREQUENCY (How many times a hr/day/week)
Self-Injury (biting hands, head banging)		
Aggression (hitting, kicking others)		
Destruction (breaking furniture, punching holes in wall)		
Stereotypy (rocking, pacing)		
Communication (verbal or nonverbal)		
Tantrums and noncompliance (screaming, refusing to do anything)		
Other behaviors		

3. Are behaviors occurring in school? How often?

4. Has the child received ABA therapy before?

   - Which agency?

   - For how long?

   - Reason for discontinuation of services?