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:** ______ **Race/Ethnicity:** ____________
Female: ______ **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:** ______