Queens Counseling for Change, LCSW, LLP

Phone Screen – Referral- New Patient

Today's Date: _____

Clients Name _____ Sex: _____ DOB: _____ Age: _____

Address: _____

Cell #: _____ Home # _____ Employed? Yes____ No _____

Social Security #_____ Ethnicity: _____

Will client /parent need a Spanish Speaking counselor? ( ) Yes ( ) No

If Client is an Adolescent - Parents Name _____School: _____Grade: _____

Name of Caller: _____ Phone #: _____Calling for Self __ Referral Agent____

If self-referral-How did you hear about QCFC? _____

Referent Name: _____ Title: _____ Agency: _____

Email: _____ Phone: _____ Relationship to Client:_____

Been to QCFC Before? Yes ____ No ____ What Month/Year: _____Counselor_____

Reason for Referral:

SO ☐ AM ☐ DV ☐ DWI ☐ Bias ☐ Parenting ☐ Other ☐

Mandated to how many sessions? _____

Presenting Problem / Reason For Call / Special Needs / Notes

_____

_____

_____

_____

Insurance Coverage: No___ Yes ___ If so, which one_____ ID #_____

Insurance Phone Number _____

Medicaid: No _____Yes___ If so, Medicaid #_____