Visiting Counselors of New York
Healthcare Professional Referral Form

Client Information *

First Name Last Name

Primary Language *

Date of Birth *

Month Day Year

Phone Number *

Area Code Phone Number

Type of Housing *

Address *

Street Address

Street Address Line 2

City State

Zip Code

Email

example@example.com

Marital status *

- Single
- Married
- Other

Primary insurance or sliding scale fee *

Insurance ID #:

Secondary Insurance (if applicable)

Insurance Carrier and Insurance ID #

Requested Service Setting *

- In-home/ in-person**Please note in-home availability may be limited based on availability of our practitioners in your area at the time of request.
- Telehealth

Has everyone in the home obtained their COVID vaccine? *

- Yes
- No
- Unknown

If in-home services are not available does the individual agree to telehealth services? *

- Yes
- No
- Unknown

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Previously diagnosed mental health and/or medical conditions:

History or present concerns regarding any of the following:

Living Conditions? *
- ○ Yes
- ○ No
- ○ Unknown

Substance Abuse *
- ○ Yes
- ○ No
- ○ Unknown

Violence or DV? *
- ○ Yes
- ○ No
- ○ Unknown

Legal Problems? *
- ○ Yes
- ○ No
- ○ Unknown

Any Firearms/ Weapons in the home? *
- ○ Yes
- ○ No
- ○ Unknown

Any pets? *
- ○ Yes
- ○ No
- ○ Unknown

Risk of losing housing? *
- ○ Yes
- ○ No
- ○ Unknown

Is anyone residing in the home a registered sex offender? *
- ○ Yes
- ○ No
- ○ Unknown

If you answered yes to any of the questions above, please explain.

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Primary Contact (If other then the client)

First Name Last Name

Relationship to Client:

Contact Number

Area Code Phone Number

Referral Source *

First Name Last Name & Title

Phone Number *

Area Code Phone Number

Fax Number

Area Code Phone Number

Agency Name: *

Email

example@example.com

Address

Street Address

City State

Zip Code

Reason for the Referral : *

***If you are an inpatient mental health provider, please include a recent psychiatric evaluation and/or psychosocial.**

COMPLETED REFERRALS CAN BE SENT SECURELY BY CLICKING SUBMIT BELOW OR BY

FAX: 1-516-418-5377 OR EMAIL: INFO@VCOFNY.ORG

VCNY OFFICE USE ONLY

If Applicable: Copay or Session Fee / # of Session Approved:

Add. Info Attached:

Date

Practitioner

First Name Last Name