Visiting Counselors of New York
Healthcare Professional Referral Form

Client Information *

First Name Last Name

Primary Language *

Date of Birth *

Month Day Year

Gender Identity *

Please Select

Marital status *

Phone Number *

Type of Housing *

Home Address *

Street Address

Street Address Line 2

City State

Zip Code

Type of number

Please Select

Secondary Phone Number

Type of number

Please Select

Email

example@example.com

Primary insurance *

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

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.

Primary contact person to schedule the appointment (If other than the client)?

First Name Last Name

Relationship to Client:

Contact Number

Is this person also the emergency contact?

Please Select

Visiting Counselors of New York
Healthcare Professional Referral Form

Referral Source *

First Name

Last Name & Title

Agency Name: *

Phone Number *

Fax Number

Email

example@example.com

Address

Street Address

City

State

Zip Code

Reason for the Referral : *

Submit

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

COMPLETED REFERRALS CAN BE SENT TO

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:

Practitioner

First Name Last Name

Date