Volunteers of America®
Massachusetts

Behavioral Health Services

To schedule an appointment at one of our locations, call our offices, email us at BHS@voamass.org, or complete an online referral at www.voamass.org (under mental health services).

PLEASE SELECT WHICH SITE YOU WOULD LIKE TO RECEIVE SERVICES AT:

☐ QUINCY SITE
1419 Hancock Street, Suite 202
Quincy, MA 02169
(P) 617-770-9690
(F) 617-770-9692

☐ TAUNTON SITE
5 Post Office Square
Taunton, MA 02780
(P) 508-822-4027
(F) 508-822-8257

SHORT INTAKE/REFERRAL FORM

Last Name | First Name | Middle Initial | DOB | SSN

Street Address | City | State | Zip Code

Primary Telephone Number | Mobile Telephone Number | Email

REFERRAL:

☐ PCP/PCP ☐ DCF/DYS ☐ COURT/LEGAL ☐ HOSPITAL ☐ VOA PROGRAM ☐ SELF ☐ OTHER

Referral Agency | Contact Person | Telephone Number | Reason for Referral

EMERGENCY CONTACT:

☐ YES ☐ NO

Last Name | First Name | Relationship to Client | Telephone number | Permission to contact

PRIMARY CARE PHYSICIAN: ☐ Client does not have PCP

Primary Care Physician | Office Location | Telephone Number | Date of Last Physical Exam

MEDICATION LIST: ☐ Client does not take medication

REASON FOR REFERRAL:
In your own words, please tell us why you are seeking services:

What services are you interested in?
☐ Individual Counseling ☐ Couples Counseling ☐ Family Counseling ☐ Medication Management ☐ Telehealth (online)
What day and time work best for scheduling appointments?

Have you recently been hospitalized for a psychiatric issue? ☐ YES ☐ NO If yes, When_____ Where_____

Do you currently or have you ever had an addiction to drugs, alcohol, or anything else? ☐ YES ☐ NO If yes, explain _____

Are you currently a safety risk to yourself or others? ☐ YES ☐ NO If yes, explain_____

INSURANCE PROVIDER | **POLICY #** | **VERIFIED BY** | **DATE**