The Counseling Team International
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CONSULTATION SERVICE RECEIPT

Case Number _____ **Clinician's Name:** _____

Division: _____ **Requesting SAC/ASAC/RAC:** _____

Office Address: _____ **Phone consultation only:** ☐ **Y or** ☐ **N**

Date(s) of Consultation: _____

Type of Consultation: ☐ **Management** ☐ **Organizational** ☐ **Crisis Intervention**

Actual Case Problem/Situation Focus:

_____

_____

_____

Actions Taken – Methods Employed:

_____

_____

_____

Results Achieved:

_____

_____

_____

# of Managers Involved: _____ **# Employees Involved:** _____

Actual Consultation Hours Required: _____

Total Travel TIME (combined):_____ **Total MILES traveled (roundtrip):**_____

Total Travel Costs (Please attach ALL receipts): _____

SAC/ASAC/RAC Name: _____ _____ _____
Printed **Signature** **Date**