



The Counseling Team International
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AUTHORIZATION TO EXTEND EAP SERVICES

(Beyond 6 sessions)

Case Number: _____ **Date:** _____

Admission Status (*check one*): Employee Relative TFO

Presenting Problem: _____

Prior Mental Health History: _____

Treatment Plan description (include progress to date and difficulties encountered): _____

Long term treatment assessment and prognosis: _____

Rationale for Extension Request: _____

_____ **Requested number of extended sessions** (*max 6 per request*)

Clinician: _____ (Type or print name) _____ (Clinician Signature)

Approved *Denied* *Number of Sessions Approved:* _____

EAP Administrator: _____ *Date:* _____